Prior Authorization Reform

Prior authorization approval is required for a wide range of services and medications in Medicare, Medicare Advantage (MA) and commercial health insurance plans. This process is intended to control costs and can delay necessary medical care and negatively influence patient outcomes. A recent American Medical Association survey found that 34% of physicians reported a serious adverse event for a patient—death, hospitalization, disability/permanent bodily damage, or other life-threatening event—due to prior authorization delays[i]. The same report found medical practices spend an average of two business days every week completing prior authorization requests, taking away valuable time that could be used to treat patients.

The *Advancing Interoperability and Improving Prior Authorization* Processes (e-PA) rule issued in January 2024 requires MA plans to convey prior authorization determinations within 72 hours for expedited requests and seven days for standard requests. MA plans must also report metrics for denials and appeals as part of new reporting and transparency requirements.

Why Prior Authorization Reform Matters

Without reform, prior authorization processes will continue to be an administrative burden on surgeons and an unnecessary barrier to care for patients. Reforms to the prior authorization process in MA plans are made even more timely as MA enrollment surges, with nearly half of all Medicare beneficiaries being enrolled in a MA plan in 2022.[ii] *The Improving Seniors' Timely Access to Care Act* would streamline the prior authorization process within MA plans by making it electronic and transparent. It would require MA plans to adopt fully electronic processes for approving prior authorization requests, mandate that routinely approved services are approved within a timely manner, and also require MA plans make available statistics on the services they deny, and how long it takes them to approve or deny services, and the successful rates of appeal.

In April 2022, the Office of Inspector General (OIG) for the U.S. Department of Health and Human services released a report which found that MA plans inappropriately denied up to 85,000 prior authorization requests in 2019, and nearly 20% of reimbursement payments were denied despite meeting Medicare coverage rules[iii]. The report included dozens of individual examples of improper denials for orthopaedic patients, including wrongful denials of MRIs, shoulder and knee x-rays, inpatient admission, rehab admission, durable medical equipment, and follow-up visits.

What Congress Should Do

Congress must pass the Improving Seniors' Timely Access to Care Act into law to codify the essential reforms the e-PA provides.

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[i] Ama Prior Authorization (PA) Physician Survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[ii] Meredith Freed, Jeannie Fuglesten Biniek "Medicare Advantage in 2022: Enrollment Update and Key Trends." KFF, 25 Aug. 2022, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-keytrends/#:~:text=Medicare%20Advantage%20enrollment%20has%20increased,Medicare%20Advantage%20plans%20in%202022.

[iii]iii Some Medicare Advantage Organization Denials of Prior Authorization ... https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

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