# STATEMENT

# of the

# American Medical Association

# before

# The 2024 ERISA Advisory Council

# on

# Employee Welfare Benefit Plan Claims and Appeals Procedures

# September 11, 2024

The American Medical Association (AMA) appreciates the opportunity to submit the following statement to the 2024 ERISA Advisory Council on Employee Welfare Benefit Plan Claims and Appeals Procedures (the Council).

The AMA considers the work of this committee to be timely and important, as overly burdensome and opaque claims and appeals procedures and the use of inappropriate utilization management programs are increasingly harming patients, intruding in the patient-physician decision-making process, and undercutting the stability of physician practices. The AMA has long advocated for measured reforms to these programs through state and federal legislation and regulation, as well as directly to the health plans themselves. Promisingly, there has been progress impacting Medicare Advantage (MA), Medicaid Managed Care, Qualified Health Plans (QHPs), and many state-regulated plans; however, little reform progress has impacted employer-sponsored plans regulated by the Department of Labor (DOL) under the Employee Retirement Income Security Act of 1974 (ERISA).

This testimony will emphasize some of the most pressing issues that AMA members face when it comes to ensuring care coverage for their patients, though certainly not provide an inclusive list, and the impact those barriers have on patients and physicians. Following, we will highlight successful reforms and recommendations that the Council may want to consider in its report.

## Barriers to Care

### *Prior authorization*

Prior authorization is a health plan cost-control process that requires health care professionals to obtain advance approval from the insurer before a prescription medication or medical service qualifies for payment and can be delivered to the patient. While health plans and benefit managers contend prior authorization programs are necessary to control costs, physicians and other providers find these programs to be time-consuming barriers to the delivery of necessary treatment. Prior authorization's negative impact reaches across stakeholder groups.

First and foremost, patients suffer from care delays and denials associated with prior authorization and often experience poorer health outcomes. The AMA conducts an annual survey of 1,000 practicing

physicians to quantify the impact of prior authorization on patients, practice burdens, employers, and overall health care costs. The AMA's 2023 survey data underscore the ongoing and significant deleterious impact of this process across the health care system.[1] An overwhelming majority (94 percent) of physicians report that prior authorization delays access to necessary care. Meanwhile, patients may clinically deteriorate while they are forced to wait, with 93 percent of physicians reporting that prior authorization can negatively impact clinical outcomes. Most alarmingly, nearly one-quarter (24 percent) of physicians say that prior authorization has led to a serious adverse event (hospitalization, disability, or even death) for a patient in their care.

Patient burden and harm are common themes in studies and reports on prior authorization. A 2022 survey conducted by the American Society for Clinical Oncology found that nearly all oncology providers reported that a patient had experienced harm because of prior authorization processes, including significant impacts on patient health such as disease progression (80 percent) and loss of life (36 percent).[2] Another survey done by the American Cancer Society Cancer Action Network showed that one in three cancer patients and caregivers of cancer patients (34 percent) report experiencing delays in their or their loved one's cancer care because their physician was waiting on approval from their health insurer for a cancer treatment, test, or prescription medicine.[3] Younger cancer patients and caregivers are more likely to report they or their loved one have experienced delays in cancer care.

Similarly, prescription prior authorization implementation for medications to treat diabetes, depression, schizophrenia, and bipolar disorder has been associated with worsening disease status, increased hospitalization, and higher net medical costs.[4,5] Conversely, the *removal* of prior authorization requirements can increase patient access to medically necessary care and improve patient outcomes. For example, a 2020 study found that Medicare Part D plans that removed prior authorization for buprenorphine-naloxone medications showed a 29 percent decrease in emergency room visits related to substance use disorder (SUD) and a 29 percent decrease in SUD-related inpatient admissions.[6]

Overuse of the prior authorization process is also placing significant strain on physicians and their practices. The administrative burdens associated with these requirements are wasting significant practice resources, as practices report completing an average of 43 prior authorizations *per physician*,

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[1] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[2] https://old-prod.asco.org/news-initiatives/policy-news-analysis/nearly-all-oncology-providers-report-prior-authorization#:%7E:text=Prior%20authorization%20is%20harming%20individuals,from%20caring%20for%20their%20patients.

[3] https://www.fightcancer.org/sites/default/files/National%20Documents/ACS%20CAN%20UM%20Survey%20Key%20Findings%203.28.19%20FINAL.pdf.

[4] Bergeson JG, Worley K, Louder A, Ward M, Graham J. Retrospective database analysis of the impact of prior authorization for type 2 diabetes medications on health care costs in a Medicare Advantage prescription drug plan population. *J Manag Care Pharm*. 2013;19(5):374-384. doi:10.18553/jmcp.2013.19.5.374.

[5] Seabury SA, Goldman DP, Kalsekar I, Sheehan JJ, Laubmeier K, Lakdawalla DN. Formulary restrictions on atypical antipsychotics: impact on costs for patients with schizophrenia and bipolar disorder in Medicaid. *Am J Manag Care*. 2014;20(2):e52-e60.

[6] Mark TL, Parish WJ, Zarkin GA. Association of Formulary Prior Authorization Policies With Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries. JAMA Netw Open. 2020;3(4):e203132. doi:10.1001/jamanetworkopen.2020.3132.

per week, with this weekly workload consuming 12 hours of physician and staff time—time that is not being spent on patient care as a result.[7] Over one-third (35 percent) of physicians report having staff who work exclusively on prior authorization.

But physicians are also facing another prior authorization cost that cannot be easily measured through statistics or surveys—the moral injury to those who are struggling to hire staff for their practices, get back on their feet following the pandemic, and focus on what they were trained to do and why they went to medical school, which is to provide quality care to their patients. Instead, physicians are being forced to accommodate endless health insurer requirements that dictate how they treat their patients and recklessly intrude into the patient-physician decision-making process. These insurer requirements are demoralizing for our members because it means they are not able to provide the care that their patients need. Unfortunately, 95 percent of physicians indicate that prior authorization increases burnout.[8] For policymakers, it is critical to recognize that this growing burden is taking place against the backdrop of a looming physician workforce shortage,[9] with data suggesting that one in every five physicians is planning to leave practice within two years.[10]

Finally, employers and other payers may experience a paradoxical *increase* in spending if prior authorization issues drive up overall service utilization and costs. AMA survey data cast doubt on the claim that prior authorization saves money, as a strong majority (87 percent) of physicians report that the process leads to *higher* overall utilization of health care resources caused by ineffective initial treatments, additional office visits, immediate care/emergency room visits, and hospitalizations.[11] For example, 59 percent of physicians report that prior authorization has destabilized patients already stable on a specific treatment plan. In addition, over half (53 percent) of surveyed physicians with patients in the workforce indicate that prior authorization has impacted patient job performance—an obviously unfavorable economic proposition for employers and other payers. Additionally, prior authorization can be used to steer patients to treatment that may be favorable to the health insurer or benefit manager but may increase costs for the patient or employer. For example, more than half of physicians report that prior authorization has been required for a generic medication.[12]

***Denials of care or payment***

Denials can happen at any point in the claims process—pre-claim (prior authorization), during ongoing care (concurrent review), or post-care. Provider surveys and other studies suggest that denial rates across the revenue cycle are increasing. For example, nearly three-quarters (73 percent) of surveyed physicians reported that prior authorization denials have increased over the past five years, with over one-quarter (27 percent) stating that prior authorizations are often or always denied.[13] Similarly, a KFF study found that prior authorization denials by Medicare Advantage plans rose from 5.7 percent in 2019

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[7] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[8] Ibid.
[9] https://www.mcpiqojournal.org/article/S2542-4548(21)00126-0/fulltext.
[10] https://www.ama-assn.org/press-center/press-releases/physician-burnout-rate-spikes-new-height.
[11] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[12] Ibid.
[13] Ibid.

to 7.4 percent in 2022.[14] A Premier survey of 118 provider groups, ranging from large health systems to independent physician offices, found that private payers deny nearly 15 percent of medical claims, with denials more common for high-cost treatment (≥$14,000).[15] While health plans' decisions to deny coverage may be based on a number of factors, including eligibility, out-of-network status of the provider, failure to follow complex administrative requirements, etc., it is the denials of care and payment based on medical necessity that the AMA hears about most from members.

*Faulty clinical criteria being used by health plans to determine coverage*

The clinical criteria that health plans use to determine coverage is the foundation of medical necessity decisions, but too often that foundation may be based on nontransparent, proprietary criteria created and licensed by for-profit publishers that may be influenced by financial self-interest and the financial interest of the plans. In fact, more than one in three physicians report that clinical criteria used by health plans to make medical necessity determinations are rarely or never evidence based.[16] Moreover, a 2022 Office of Inspector General (OIG) report found that 13 percent of prior authorization requests denied by MA plans met Medicare coverage rules, and 18 percent of payment request denials met Medicare and MA billing rules.[17] The OIG report cited numerous cases of MA plans applying dubious clinical criteria, such as a 76-year-old with multiple orthopedic conditions and at-risk for falls being denied a walker because the patient had received a cane within the past five years. In another troubling case, a 67-year-old was denied admission to an inpatient rehabilitation facility for not meeting the MA plan's coverage rules, despite the patient's recent ischemic stroke, difficulty swallowing, and significant risk for aspiration and pneumonia.

These findings call into serious question the validity of the clinical criteria being used by health plans in coverage decisions and suggest a consistent failure among plans to base criteria on nationally recognized standards of care as determined by the appropriate national medical specialty society. However, the lack of transparency in plans' utilization management programs and clinical criteria make it extremely difficult to assess their mechanics and validity. Indeed, a majority of physicians report that it is difficult to determine if a particular medical service or prescription drug *even requires* prior authorization;[18] far more difficult is it for physicians to actually access the underlying clinical criteria used by a plan to make coverage decisions. Denial letters often provide scant rationale for coverage decisions, with plans merely stating that a request "did not meet coverage criteria." Health plans frequently claim that their internal

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[14] Kaiser Family Foundation. Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022. August 8, 2024. Available at: https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/.

[15] Premier. Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims. March 21, 2024. Available at: https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims.

[16] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[17] US Department of Health and Human Services Office of Inspector General. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. April 2022. Available at: https://oig.hhs.gov/documents/evaluation/3150/OEI-09-18-00260-Complete%20Report.pdf.

[18] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

clinical criteria are "proprietary"; unfortunately, the resulting black box leaves physicians in the dark when trying to understand and overcome denials—and patients suffering while they wait for medically necessary treatment.

*Reviewers are often unqualified to make adverse determinations*

Making a medical necessity determination is the practice of medicine, yet health plans place this critical responsibility in the hands of employees who have never met or examined the patient. Furthermore, the health plan representatives making such decisions often do not have the needed qualifications or experience. For example, only 15 percent of surveyed physicians participating in peer-to-peer reviews with health plans report that the plan's "peer" regularly has the appropriate qualifications.[19] Unqualified reviewers make erroneous decisions, threatening patients' health and wasting resources. Moreover, the frustration of engaging with unqualified reviewers compounds the moral injury of physicians who must plead their patient's case with someone who has no familiarity with the disease or treatment in question. Current AMA President Bruce Scott, MD, details this common scenario: "In my own practice I deal with the burden of prior authorization every day. Part of my frustration is that the person on the other end of the phone has never had an opportunity to get a history from the patient, examine the patient—and what's even worse—a lot of times they haven't even been to medical school. Rarely, in my experience, are they otolaryngologists. Heck, most of the time they can't even pronounce otolaryngology."[20]

*Implications of denials for patients and physicians*

A recent survey by the KFF found that approximately 18 percent of insured adults had experienced a denied claim in the previous year; among patients who use the most health care, this number rose to 27 percent.[21] Care denials can have dire health and financial consequences for patients. The KFF survey found that of patients who experienced claim denials, 26 percent experienced significant treatment delays, 24 percent were unable to receive recommended care, and 24 percent experienced a decline in health. Patients also experience economic harm: 55 percent of patients who experienced claim denials reported paying more for care than they had expected.

Claim denials take a significant toll on physicians and other health care providers. When a claim is denied post-service, either fully or partially (e.g., a payer downcodes a claim to a lower level of service), plans shift the cost of care onto physicians and place practices—many of which are still operating on razor-thin margins following the pandemic—at financial risk. Physicians treat a plan's members with the expectation that they will be fairly paid for services provided. When plans do not honor this obligation by unfairly refusing to pay for care that has already been delivered, physicians and other providers suffer financially from unexpected revenue loss.

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[19] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[20] Strazewski L. The AMA is the otolarnyngologists' powerful ally in health care. May 2, 2024. Available at: https://www.ama-assn.org/practice-management/prior-authorization/ama-otolaryngologist-s-powerful-ally-health-care.

[21] *Consumer Survey Highlights Problems with Denied Health Insurance Claims, KFF, Sept. 29, 2023, by Karen Pollitz, et al.*

The administrative burdens associated with attempts to overturn denials further increase the economic damage: a survey by Premier estimates that hospitals and health systems spend an average of $43.84 per claim fighting denials.[22] In addition, physician practices increasingly struggle with a proliferation of health plan coding edits and algorithms that automatically deny or reduce payment without a review of supporting medical documentation. For example, many national plans now employ algorithms that automatically reduce the level of service solely based on the final diagnosis code reported on a claim. Use of a diagnosis code as a proxy for the level of care is wholly inappropriate, as documentation from the medical record is needed to confirm the appropriate level of service. Such automatic payment reductions or denials with unjustified, blunt payment adjustment tools force physicians to waste valuable time filing appeals to fight for correct payment for care *already delivered* to the plan's members. The current lack of an electronic standard to submit clinical documentation to health plans compounds the significant administrative practice burdens associated with this time-consuming fight for proper payment.

***Appeal process***

While physicians routinely dispute invalid prior authorization and claim denials, the onerous process often deters and discourages appeals. Numerous data sources report a meager appeal rate; for example, only 18 percent of surveyed physicians report that they always appeal an adverse prior authorization decision.[23] Similarly, a KFF study found that only 9.9 percent of prior authorization denials by MA plans were appealed in 2022.[24] The OIG reported that between 2014 and 2016, beneficiaries and providers appealed only 1 percent of MA prior authorization or claim denials to the first level of appeal.[25] Finally, while a KFF survey found that 84 percent of consumers took some action to dispute denied claims, such as calling the insurance company or asking their physician for help, only 15 percent filed a formal appeal.[26]

When the stakes are so high (i.e., health care outcomes and/or fair payment and coverage), why do so few physicians and patients appeal denials? The complicated, time-consuming process discourages busy clinicians from engaging in appeals: 48 percent of surveyed physicians reported that they don't appeal prior authorization decisions because they lack sufficient practice staff resources and time.[27] The growing number of frustrating peer-to-peer reviews may also discourage appeals: over half (56 percent) of physicians indicated that requirements to speak with a health plan "peer" have increased over the last

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[22] Premier. Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims. March 21, 2024. Available at: https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims.

[23] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

[24] Kaiser Family Foundation. Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022. August 8, 2024. Available at: https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/.

[25] US Department of Health and Human Services Offices of Inspector General. Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials. September 2018. Available at: https://oig.hhs.gov/documents/evaluation/3140/OEI-09-16-00410-Complete%20Report.pdf.

[26] *Consumer Survey Highlights Problems with Denied Health Insurance Claims, KFF, Sept. 29, 2023, by Karen Pollitz, et al.*

[27] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

five years. Negative past experiences also discourage appeals, with 62 percent of physicians reporting that they do not appeal prior authorization denials because they do not believe they will be successful. Finally, nearly half (48 percent) of physicians report not appealing denied prior authorizations because patient care cannot wait.

What makes these data particularly troubling is that when patients and physicians *do* appeal, health plans often overturn adverse decisions. A recent KFF study found that an overwhelming majority (83.2 percent) of MA prior authorization denials that were appealed were subsequently overturned.[28] This aligns with a 2018 OIG report that found that MA plans overturned 75 percent of their own prior authorization and claim denials between 2014 and 2016.[29] In its survey, Premier found that 54.3 percent of initial claim denials are eventually reversed and paid.[30] The shockingly high rate of overturned denials raises serious questions about the validity of plans' initial prior authorization and claim denials. Whether the source of these decision reversals is faulty underlying clinical criteria or more benign system errors, the end result is negative clinical outcomes and financial duress for patients and physicians.

**Meaningful reforms and opportunities for policymakers**

There has been widespread agreement across health care stakeholder groups on the urgent and critical need to address barriers to care, and prior authorization, denials, and appeals are certainly targets for reform at the state and federal levels.

In January 2018—over six and a half years ago—the AMA and other national organizations representing health care providers and insurers released the Consensus Statement on Improving the Prior Authorization Process.[31] This document represented a landmark agreement between providers and health plans on the need to make critical reforms, with a focus on overall reduction in the volume of requirements, improving transparency, protecting patient continuity of care, and automating the process. Unfortunately, as illustrated in the results of the AMA's 2023 survey, physicians report that insurers have voluntarily made little progress in implementing these agreed-upon reforms.[32] In response to health plans' sluggish progress in honoring their 2018 commitment, federal and state legislators and regulators have stepped forward to mandate changes in the prior authorization process to prevent patient harms and reduce provider burdens.

As the Council considers its recommendations, these new federal and state policies can be leveraged to inform those considerations. For example, from 2023-2024, more than two dozen state laws have been

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[28] Kaiser Family Foundation. Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022. August 8, 2024. Available at: https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/.

[29] US Department of Health and Human Services Offices of Inspector General. Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials. September 2018. Available at: https://oig.hhs.gov/documents/evaluation/3140/OEI-09-16-00410-Complete%20Report.pdf.

[30] Premier. Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims. March 21, 2024. Available at: https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims.

[31] Consensus Statement on Improving the Prior Authorization Process. January 2018. Available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.

[32] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

enacted that address prior authorizations, denials, and appeals processes. Similarly, new regulations issued by the Centers for Medicare & Medicaid Services (CMS) address health plans' utilization management programs, the clinical criteria used to make determinations, and automation in the processing of claims.[33] Below are specific reforms that the AMA suggests should be prioritized and where state and federal action has been taken, for the Council's consideration.

***Reducing delays and requiring faster health plan response times***

When care is delayed, a patient's condition can worsen and disease can progress, often irreversibly. As such, it is no surprise that federal and state prior authorization reforms often establish maximum response times to reduce such delays in care. **The AMA supports a maximum 24-hour response time for urgent requests and 48 hours for nonurgent requests**.

Federal and state policy has shifted to more closely reflect AMA policy, especially when it comes to urgent requests. Current Medicare Part D and Part B drug requirements establish 24-hour maximum response times for urgent requests, as do states such as Kentucky, New Jersey, Vermont, and the District of Columbia. Current ERISA claims and appeals rules are outdated in this this respect, allowing up to 15 days for preservice claims decisions and 72 hours for urgent care claims and would seem to be ripe for reconsideration in order to protect patients' access to timely care.

Additionally, automation, when combined with judicious use of the process and guardrails to protect patients, could help relieve the prior authorization burden and harm. However, physicians report phone as the most commonly used method, and only 23 percent of physicians report that their EHR offers electronic prior authorization (ePA) for prescription medications,[34] despite a standard transaction being available for many years. Significant progress has been made at the federal level to promote automation in the prior authorization process, and states such as Colorado, Minnesota, Virginia, Washington, and others are working to mirror federal requirements in their state laws. Specifically, for medical services, policy should align with federal requirements under the CMS Prior Authorization and Interoperability final rule and require that health plans offer a Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interface (API) that allows the physician to determine if a service being ordered requires prior authorization, the documentation requirements necessary for approval, and whether the request is approved, denied, or requires additional information before a determination can be made. To automate the prescription drug prior authorization process, health plans should support the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard for ePA transactions, as currently required under Medicare Part D. **The AMA recommends that all health plans—including those regulated by the DOL—mirror these federal and state mandates and be required to implement 1) FHIR-based APIs for medical services prior authorizations and 2) NCPDP ePA transactions for prescription drug PAs.** Expanding requirements for prior authorization automation will bring process efficiency and faster care delivery to all patients.

While the AMA strongly supports process automation and embracing new technology to reduce practice burdens, we stress the need for appropriate guardrails when health plans utilize algorithms, automated

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[33] On January 17, 2024, CMS published the Prior Authorization and Interoperability final rule. In April 2023, CMS published the 2024 MA and Part D final rule.

[34] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.

decision-support, and augmented intelligence (AI) in making coverage determinations. Without full transparency on the data used to train such technologies and human oversight by qualified clinicians, such tools have the potential to exacerbate existing problems with inappropriate prior authorization and claim denials. Along with the previously mentioned concerns regarding health plans using coding software and algorithms to automatically reduce claim payments solely based on diagnosis code, recent investigative journalism reports have uncovered troubling trends in health plans' use of AI and other technology. For example, a March 2023 *ProPublica* investigation uncovered Cigna's use of an automated claim review system that enabled their physicians to deny over 300,000 requests for payment and spend an average of *1.2 seconds* on each case.[35] Similarly, *STAT News* reported on a UnitedHealth Group algorithm that encourages denials or shortened stays for post-acute care rehabilitation, such as expecting an older patient nearing his discharge date following knee surgery to learn how to do a seated bump up and down stairs.[36] To combat outrageous practices such as these, the AMA addressed health plans' use of AI in our recently adopted AI principles.[37] These principles advocate that all payer AI systems be based on evidence-based clinical guidelines and fully transparent, with any limitations or denials in care or payment requiring evaluation by a qualified physician prior to issuance of a final decision.

***Improving continuity of care***

To ensure that patients who are stable on treatment are not harmed by disruptions due to prior authorizations, changes in clinical criteria, formulary changes, and other barriers, policymakers are continuing to consider reforms that protect continuity of care for patients. For example, the 2024 MA final rule prohibits repeat prior authorizations, especially for those with chronic conditions, and the Vermont legislature recently joined several other states in enacting the same policy. Similarly, Virginia now prevents repeat prior authorization for approved formulary drugs for treatment of mental illness when certain conditions are met and requires health plans to honor an authorization for a drug, even if it is removed from formulary once prescribed.

Another common continuity of care protection provides an authorization grace period when patients switch health plans. The 2024 MA final rule requires a 90-day grace period for patients when they switch health plans, allowing them to continue their care as they transition. Tennessee, Illinois, and other states also require at least a 90-day grace period for patients switching between plans to ensure continuity for patients receiving an active course of treatment.

Similar continuity of care policies would benefit patients in employer-sponsored plans. Plan turnover is high in the commercial market, with one study finding that 21.5 percent of commercial enrollees

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[35] Rucker P et al, for *ProPublica*. How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them. March 23, 2023. Available at: https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims.

[36] Ross C and Herman B. UnitedHealth pushed employees to follow an algorithm to cut off Medicare patients' rehab care. *STAT News*. November 14, 2023. Available at: https://www.statnews.com/2023/11/14/unitedhealth-algorithm-medicare-advantage-investigation/.

[37] American Medical Association. Principles for Augmented Intelligence Development, Deployment, and Use. Available at: https://www.ama-assn.org/system/files/ama-ai-principles.pdf.

disenroll annually.[38] For group plans, 25 percent of this churn resulted from the employer's choice to leave the insurer, while 75 percent was associated with member choices to leave the insurer and/or employer. The frequency of turnover in employer-sponsored plans raises obvious concerns regarding continuity of care. A health care reporter's account of his struggle to obtain insulin for type 1 diabetes following a change in employer-sponsored insurance underscores how switching plans can disrupt care continuity for chronic conditions; it took this savvy health care consumer 17 days and 20 phone calls to receive his life-saving treatment, with only a 12-hour insulin supply to spare.[39] This examples highlights just how dangerous care disruptions due to changes in employer-sponsored coverage can be.

***Increasing the clinical integrity of decision-making at the initial and appeal levels***

The 2024 MA final rule took important steps toward ensuring that MA plans are not frequently using internal or proprietary clinical criteria and recognizing that clinical criteria must be evidence based. Policymakers in states including Illinois and California are also working to clarify that clinical criteria must be consistent with applicable nationally recognized standards, meaning standards of care and clinical practice that are generally recognized by physicians and providers practicing in relevant clinical specialties. It is critical that all health plans and benefit managers rely on valid, evidence-based sources, including but not limited to recommendations of non-profit health care provider professional associations and national medical specialty societies, patient placement criteria and clinical practice guidelines, and peer-reviewed scientific studies and medical literature, when establishing clinical criteria.

Policymakers should also build on the 2024 MA final rule and require that, beginning at the initial determination level, health plan reviewers be true peers of the treating physician—of the same specialty, licensed in the same state, and with experience treating the patient's condition. While such a policy is more common at the appeal level, few patients pursue appeals after an adverse determination, as noted above, and it is therefore critical that the reviewers are qualified at the initial determination level.

***Increased transparency of insurer requirements***

Transparency of health insurers' utilization management requirements is critical for patients and physicians to navigate the system, yet such transparency is often difficult to come by.

*Transparency of insurer requirements*: A majority of physicians report that it is difficult to determine whether a prescription medication (63 percent) or medical service (59 percent) requires prior authorization, and nearly one in three physicians report that the prior authorization information provided in their EHR/e-prescribing system is rarely or never accurate. In order to ensure that patients are fully informed when purchasing a product and making care decisions and that physicians have the information they need to help patients access care, policy must require health plans to be transparent about when prior authorization is required and the supporting clinical documentation needed to meet such requirements. The information should be publicly available, accurate and current, and include an effective date to be relied upon by physicians and patients. Additionally, health plans should be required

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[38] Fang H, Frean M, Sylwestrzak G, Ukert B. Trends in Disenrollment and Reenrollment Within US Commercial Health Insurance Plans, 2006-2018. *JAMA Netw Open*. 2022;5(2):e220320. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789399.

[39] Sable-Smith B. Writing about America's health-care labyrinth didn't shield me from its absurdity. Washington Post. January 22, 2022. Available at: https://www.washingtonpost.com/health/health-insurance-insulin-/2022/01/21/103711f2-759c-11ec-8b0a-bcfab800c430_story.html.

to provide at least 60-day notice to patients and physicians before any new requirement, formulary change, change in clinical criteria, or other modification takes effect.

*Transparency when care is denied*: A planned course of treatment is the result of careful consideration and collaboration between a patient and physician, and a plan's denial of care requires deviation from this course. But fewer than one in five physicians always appeal adverse prior authorization decisions.[40] The current ERISA claims procedure rules put certain notification requirements on plan administrators when an adverse determination is being made, including requiring that the patient receive the reason for care denial, the provisions on which the determination is based, and information on how to submit an appeal. The rules also require that upon request, the patient be provided with an explanation of the scientific or clinical judgement for the determination. The AMA recommends that to increase the transparency of decisions and the likelihood of appeal, policies should go farther by aligning with the CMS Prior Authorization and Interoperability final rule and require plans to provide specific justification for denials; indicate covered alternative treatment; detail appeal options; and provide the relevant plan provision, coverage criteria citation, narrative explanation, or an indication that the submitted documentation did not support the request. Such information should also communicate actions needed to obtain coverage, whether that be submitting an appeal or additional information or selecting an alternative treatment option identified by the plan.

***Data transparency, collection and reporting***

To help identify where policy reforms are needed most, as well as promote accountability among health plans, increased transparency and disclosure of prior authorization, denial, and appeal data are needed. The CMS Prior Authorization and Interoperability final rule placed requirements on health plans to publish prior authorization data and statistics on their websites to allow for objective evaluation of the efficiency of prior authorization practices. Similarly, states including Texas, Arkansas, and Illinois require health plans to accessibly post on their public website prior authorization approval and denial information that includes categories such as the requesting physician specialty, the medication or service, the indications offered, the reason for denial, whether a denial was appealed, the outcome of the appeal, and the time between submission and response. Still other states such as Michigan and Washington require health plans to submit such data to their Departments of Insurance for evaluation.

The Affordable Care Act (ACA) requires transparency-in-coverage data reporting by employer-sponsored health plans and by non-group plans sold on and off the marketplace to the Exchange (if applicable), the Health and Human Services (HHS) Secretary, and the State insurance commissioner, and includes data on the number of claims that are denied.[41] Although this requirement has not been fully implemented, some data are available on healthcare.gov, though largely consumer-unfriendly. Meanwhile, states are beginning to publish their transparency-in-coverage data for public consumption. For example, Pennsylvania's Department of Insurance published its Transparency in Coverage report for claims, claim

[40] 2023 AMA Prior Authorization Physician Survey. Available at: https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[41] 42 U.S.C. § 18031(e)(3); 42 U.S. Code § 300gg–15a

denials, and appeal information for health insurers doing business in the state.[42] Making such data from all payers accessible could help regulators identify enforcement gaps and opportunities for policy reform.

***Mental health and substance use disorder parity enforcement***

As the Council compiles its recommendations, we urge members to take into special consideration the importance of enforcing the Mental Health Parity and Addiction Equity Act (MHPAEA), as well as the opportunities to improve access to care through such enforcement. Delayed and denied care are contributing factors to the ongoing mental health and overdose epidemic that continues to kill more than 100,000 Americans every year and, as stated in the 2023 proposed rule on requirements related to MHPAEA, "[P]lans and issuers continue to fall short of MHPAEA's central mandate to ensure that participants, beneficiaries, and enrollees do not face greater barriers and restrictions to accessing benefits…"[43] In the context of this council's charge, it is appropriate to focus on the use of non-quantitative treatment limits (NQTLs), such as prior authorization, concurrent review, and other utilization management techniques, and the role they play in obstructing access to care for patients with mental health needs and substance use disorders.

To comply with MHPAEA, health plans' policies and practices related to NQTLs—as-written and as-applied—must not be more restrictive or stringent for mental health and substance use disorder (MH/SUD) treatment than medical/surgical treatments.[44] Fortunately, under the Consolidated Appropriations Act of 2021, health plans imposing NQTLs on MH/SUD benefits must prepare "comparative analyses" documenting the design and application of NQTLs to MH/SUD and medical/surgical benefits.[45] The comparative analyses require health plans to document the factors they use to determine when each NQTL applies to MH/SUD and medical/surgical benefits, the evidentiary standards these factors rely on, and how the standards and factors are comparable across MH/SUD and medical/surgical benefits.[46] (In September 2024, the federal government published new regulations implementing the 2021 law and strengthening the requirements for NQTLs.) As such, regulators are supposed to be provided with the necessary information they need to identify and address the inappropriate use of NQTLs under MHPAEA. Unfortunately, health plans often fail to provide regulators with accurate or sufficient information in the comparative analyses, and when that information is provided, errors and violations are common. Moreover, regulators are too often not conducting meaningful enforcement or requiring sufficient corrective actions to protect against future violations.

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[42] Pennsylvania's Transparency in Coverage Report outlines data on claims, claim denials, and appeal information for health insurers doing business in the Commonwealth

[43] https://www.federalregister.gov/documents/2023/08/03/2023-15945/requirements-related-to-the-mental-health-parity-and-addiction-equity-act.

[44] MHPAEA's regulations describe the general rule for NQTLs, which include prior authorization, as follows: "A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification." 29 C.F.R. § 2590.712(c)(4)(i).

[45] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, § 203 (2020)

[46] 42 U.S.C. § 300gg-26(a)(8)(A).

The AMA urges the Council to recommend greater enforcement of MHPAEA, and particularly the use of NQTLs in the MH/SUD benefit, in its report.

***Limiting the use of utilization management requirements***

While the AMA strongly advocates for all the reforms outlined above, we note that there is a critical need to address the current *overwhelming volume of prior authorization requirements* that is harming patient's health and needlessly burdening physician practices. Health plans should regularly—at least annually—review their lists of drugs and medical services that require prior authorization and remove those that are routinely approved. Such low-value prior authorizations do nothing but introduce administrative waste into the health care system and delay patient care.

Another opportunity to reduce prior authorization volume is through programs that exempt physicians with high approval rates from requirements. This concept, often referred to as "goldcarding," has gained significant traction in recent years, and several states, including Texas, Vermont, and Michigan, now require state-regulated insurance plans to offer goldcarding programs. In addition, the federal GOLD CARD Act (H.R.4968) would require all MA plans to offer goldcarding programs. As major national insurance companies are already implementing goldcarding programs for other lines of business, a logical next step would be to require DOL-regulated plans to follow suit and exempt physicians with high approval rates from prior authorization requirements.

***Conclusion***

AMA physician members regularly raise concerns about the adverse impact that prior authorization, claim denials, and appeals have on the quality of care and outcomes of their patients. While encouraged by the progress that has been made for state- and CMS-regulated health insurers, physicians lament that these reforms often do not extend to DOL-regulated plans, as such plans comprise a significant proportion of the care provided to Americans.

Health plans often hold their employer clients responsible for harsh policies that limit patient access to care, deny payment for treatment already provided, and burden health care professionals, claiming that employers demand tight controls on health care costs. However, we suspect that insurers are presenting these policies and programs to their clients as cost-saving measures without offering a full picture of the impact on employees and overall health care costs. We encourage employers and the DOL to consider that our recommendations for improvement represent *good business*. Ensuring timely access to care through prior authorization reform promotes employee health and prevents absenteeism and presenteeism. Moreover, proper coverage and payment for medically necessary care ensures that employers receive return on their investment in health care premium dollars.

We urge the Council to consider recommending that the DOL undertake rulemaking to the extent possible to bring similar improvements to ERISA plans. All patients—including those covered by plans regulated by the DOL—should be protected from draconian health insurer practices that limit access to and payment for clinically appropriate medical services and drugs. We urge the DOL to consider implementing the impactful recent reforms made by states and CMS to bring much-needed relief to millions of patients.

Please contact Heather McComas, Director, administrative simplification initiatives, at heather.mccomas@ama-assn.org or Emily Carroll, senior attorney, at emily.carroll@ama-assn.org with any questions. Thank you for this opportunity to engage with the Council.