AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-24)

Introduced by: Ohio

Subject: Insurer Accountability When Prior Authorization Harms Patients

Referred to: Reference Committee G

Whereas, prior authorization (PA) is an advanced approval process that insurers and other payers use as a healthcare utilization management tool to deny payment for covered benefits when the payer deems the benefit clinically unnecessary[1]; and

Whereas, prior authorization requirements are rapidly increasing each year, which leads to not only increased administrative duties for physicians and their practice staff but also delayed care for patients[2]; and

Whereas, a 2022 study by our AMA on PA demonstrated that 88% of physicians experience high or extremely high administrative burdens due to prior authorization requirements and that 94% of physicians believe prior authorizations delay patient access to necessary care[3]; and

Whereas, the process of PA reviews, which health plans are frequently known to delegate to third-party contractors, causes significant delays in appropriate patient care that can lead to prolonged suffering and unnecessary deaths[4]; and

Whereas, the 2022 physician survey by our AMA found that 89% of physicians believe PA requirements have a negative impact on clinical outcomes for patients, with 33% of physicians reporting that PAs have led to their patients experiencing serious adverse health outcomes, including hospitalization, life-threatening events, or disability[3]; and

Whereas, other surveys by the American Society of Clinical Oncologists (ASCO), the American Cancer Society Cancer Action Network (ACS CAN), and the American Society for Radiation Oncology (ASRO) have reported similar findings, with nearly all oncologists in the 2023 ASCO reporting a patient experienced harms due to PA, including 35% who specifically attributed a patient's loss of life to prior authorization requirements[5-8]; and

Whereas, the data strongly suggests that insurers are denying justified healthcare, with the 2022 AMA physician survey reporting that only 1% of physicians believe that PA criteria are always based on evidence-based medicine or specialty society guidelines[3]; and

Whereas, capitated payment models like Medicaid Managed Care and Medicare Advantage Organizations (MAOs), in which private companies are paid fixed amounts per enrollee based on expected costs regardless of whether the actual cost was higher or lower, create an incentive to minimize enrollee services and maximize PA denials[9]; and

Whereas, reporting by the Office of Inspector General (OIG) for the United States Department of Health and Human Services has frequently shown that many denials were inappropriate, with a 2022 report finding that 13% of PA denials met Medicare coverage requirements and 18% of payment denials met Medicare coverage rules and internal reimbursement guidelines[9]; and

Whereas, a 2023 Kaiser Family Foundation (KFF) study as well as two separate OIG reports found that, although just 11% of PA denials by MAOs are appealed, the vast majority of appeals were either completely or partially overturned[10-12]; and

Whereas, the KFF study and OIG reports noted that their findings were particularly concerning because the appeals process was largely underutilized by beneficiaries and providers with only 1% to 27% of initial denials ever being appealed, meaning insurers are incentivized to deny coverage knowing only a small portion of PA decisions will be formally appealed[10-12]; and

Whereas, despite increasing evidence of inappropriate PA denials by insurers, there currently is no consensus on how to hold insurers liable for denials that result in preventable injury to patients, with largely unsuccessful litigation strategies ranging from bad faith breach of contract to negligent breach of duty, and at least one effort in Texas preempted by the Employment Income & Retirement Act of 1974 (ERISA)[4,13-14]; and

Whereas, even when state statute or case law permits a bad faith claim against an insurance company for a wrongful coverage denial and the claim is not preempted by ERISA, it's often impossible to recover punitive damages, which may require proving that the insurance company acted with a higher degree of intent than that required for compensatory damages[15]; and

Whereas, in a recent New York case in which a delayed PA approval resulted in the preventable, rapid progression of a woman's cancer, the U.S. District Court for the Southern District of New York ruled against the woman when it held that existing New York law does not impose a duty of reasonable care on insurance companies that engage in PA review, highlighting the need for aggressive state legislative reform to increase liability for state-regulated insurers[16]; and

Whereas, efforts to hold insurers liable for PA denials that result in preventable injury have been slowed by the increasing use of mandatory arbitration clauses in beneficiary contracts, which require beneficiaries to settle disputes out of court by an impartial third party rather than before a jury or judge and often include waivers that prevent beneficiaries from bringing class action suits[17-18]; and

Whereas, a 2019 review of arbitration clauses used by Fortune 100 companies found that many of the nation's largest health insurance companies, including UnitedHealth Group, Anthem, Aetna, and Cigna, impose mandatory arbitration clauses with class waivers on consumers[18]; and

Whereas, mandatory arbitration clauses are particularly insidious in health insurance contracts given the wide gap in bargaining power between the insurance company and beneficiary and limited selection of alternate insurers as a result of increasing consolidation in insurance markets[19-20]; and

Whereas, while arbitration may be preferred by some individuals, data suggests it is generally bad for consumers, as the median award for medical malpractice claims in Kaiser Permanente's arbitration program is nearly $400,000 less than median awards for medical malpractice jury trials in California[21]; and

Whereas, in addition to the federal Improving Seniors' Timely Access to Care Act (H.R.3173), nearly 90 prior authorization reform bills have been proposed in current state legislatures, many of which draw on our AMA's model legislation, but none of these proposed bills that have

received AMA support address insurers' legal liability when patients are harmed by prior authorizations[22-26]; therefore be it

RESOLVED, that our American Medical Association advocate for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration and limitation on class action clauses in beneficiary contracts. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 4/26/2024

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RELEVANT AMA POLICY

H-320.939 Prior Authorization and Utilization Management Reform
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. [CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22]

D-320.978 Fair Reimbursement for Administrative Burdens
Our AMA will: (1) continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices; (2) continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes; (3) oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services; and (4) advocate for fair reimbursement of established and future CPT codes for administrative burdens related to (a) the prior authorization process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials. [Res. 701, A-22]

D-285.960 Promoting Accountability in Prior Authorization
Our AMA will: (1) advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion; (2) advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments; (3) advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable; (4) continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency; (5) advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations; and (6) advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization. [CMS Rep. 4, A-21]

D-320.979 Processing Prior Authorization Decisions
Our AMA will advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends. [Res. 712, I-20; Reaffirmation: A-22]

H-185.936 Lung Cancer Screening to be Considered Standard Care
Our AMA: (1) recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit; (2) will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States; and (3) will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees. [Sub. Res. 114, A-14; Appended: Res. 418, A-22; Appended: Res. 112, A-23]