Weekly Checkup

Prior Authorization – Do Not PA-ss Go

JACKSON HAMMOND | JANUARY 19, 2024

This week, the Biden Administration released a long-awaited final rule on prior authorization reforms in Medicare Advantage (MA), Medicaid, the Children's Health Insurance Program (CHIP), and federally facilitated exchange (FFE) plans. **Prior authorization has long been used as a cost-containment tool, but doctors have argued for decades that the short-term cost savings come at the expense of long-term doctor burnout and worse patient care. Let's explore the new rule and the problems it's trying to solve.**

A bit of background: Prior authorization is the practice of insurers requiring physicians to obtain advanced approval before paying for care. **The goal is to reduce overuse of services and prevent the use of expensive services when cheaper ones are available. Seeking this approval involves a lot of time and paperwork on the part of providers**, much of which is done manually – only 28 percent of prior authorizations in 2022 were fully electronic.

The final rule seeks to ease those burdens by increasing electronic prior authorization usage. Starting in 2027, all impacted payers (MA plans, state and managed care plans for Medicaid and CHIP, FFE plans) will be required to create and maintain electronic interfaces that contain lists of covered items and services, document requirements for approval, support prior authorization requests and responses, and communicate approval or denial (as well as the reasons for denial). Providers will be given monetary incentives through the Merit-based Incentive Payment System to adopt electronic prior authorization processes. **In addition to the interface requirements, the rule requires prior authorization decisions from payers within 72 hours for urgent requests and seven calendar days for regular requests.** Beginning in 2026, payers will be required to provide specific reasons for denials and report specified prior authorization metrics to their websites. The rule does not apply to prior authorization for drugs, only medical services.

There are a few reasons behind this rule and the push for prior authorization reform in general. **First, according to a 2022 Index developed by the health care data analysis firm CAQH, there's a potential $449 million in annual savings to be had by switching to electronic prior authorization – $310 million of which would be realized by providers.** Additionally, a survey by the American Medical Association (AMA) found that 94 percent of physicians reported prior authorization delayed access to necessary care and 33 percent reported prior authorization led to a serious adverse event for a patient, while 88 percent said prior authorization burdens were high or extremely high. Thirty-five percent of physicians surveyed employed staff members exclusively for tasks involving prior authorization, and the survey estimated 14 hours a week were spent on prior authorization. CAQH estimated that electronic prior authorization could save 11 minutes per transaction, and at 45 prior authorization requests per week, that equates to 8.25 hours saved. While the rule doesn't cover drug prior authorizations, providers should expect to see at least some fiscal and time savings.

Prior authorization is a double-edged sword: It saves money, but it takes a major toll on physicians. One paper from 2023 estimated an administrative burden of $10 per beneficiary-year for drug prior authorizations, while saving $112 per beneficiary-year. This is in the context of findings that overtreatment/low-value care resulted in $75.7–$101.2 billion in waste while administrative complexity cost $265.6 billion in waste (of a total

$760–$935 billion in annual waste). How much of this is a result of prior authorization is not clear, but it's hard to believe it's not a contributor of some consequence. Additionally, physicians routinely cite administrative hassles (including prior authorization) as a primary cause of burnout (which leads to worse care), and that burnout is accelerating: One survey of physicians from 2014-2017 found burnout rates increased from 40.6 percent to 45.6 percent, citing administrative burdens as a key factor, and a 2021 survey found 33 percent of medical practices had physicians retire early or leave due to burnout, while a 2022 survey found 40 percent of medical groups reported a physician retiring early or leaving due to burnout. Assuredly, much of the burnout increase in the last three years is pandemic-related, but prior authorization's rising contribution to administrative burden in the last five years – weekly average prior authorization requests rose from 31 in 2018 to 45 in 2023 – is certainly a contributing factor.

Why all this matters: A dwindling supply of doctors while demand for health care increases will cause health care costs to rise over the long term – basic economics that no amount of cost management can overcome. **Prior authorization isn't going away anytime soon, but health policy observers will no doubt be on the lookout to see if this final rule reduces prior authorization's perceived burdens.**