Solidify Prior Auth Reform

Prior Authorization Hassles

94% Delay necessary care

86% Lead to higher use of health care resources

89% Have a negative impact on patient clinical outcomes

85% Are not always evidence-based

Source: American Medical Association

Research has shown over and over that health plans' excessive use of prior authorizations are anything but healthy for patients and physician practices.[1,2]

In finalizing new rules to help address the problem,[3] the Centers for Medicare & Medicaid Services (CMS) in its own words said such red tape can "be an obstacle to necessary patient care when providers must navigate complex and widely varying payer requirements or face long waits for prior authorization decisions."

Those new regulations – which CMS estimates will generate $15 billion in savings over the next decade – represent welcome steps toward reform. But they must be codified in law to ensure and enhance health plan accountability, efficiency, and transparency across all Medicare health plans and services.

Under the new rules, beginning in 2026 certain Medicare Advantage, Medicaid, and Children's Health Insurance Program (CHIP) plans must:

- Respond more timely to physicians' prior authorization requests;
- Include specific reasons for denial;
- Publicly report on metrics; and
- Implement electronic processes to automate prior authorization.

However, CMS' rules **do not apply** to Medicare drug plans (Part D) and **exclude certain services** within Medicare Advantage plans (Part C) – which impact more than 30 million patients.

Inspired, in part, by Texas' precedent-setting "gold card" exemption process for certain medical services and medications,[4] bipartisan legislative efforts already are afoot to expand upon and cement Medicare prior authorization reform with medicine's endorsement. **The Getting Over Lengthy Delays in Care as Required by Doctors Act of 2023 (House Resolution 3173)** is co-sponsored by U.S. Reps. Vicente Gonzalez (D-Texas), Pete Sessions (R-Texas), and Lloyd Doggett (D-Texas).

When prior authorization is imposed, physician practices often face long wait times to get critical care approved for their patients. Physicians spend nights and weekends treating patients – when emergencies typically occur – but health plans are not available to respond to their prior authorization requests. The same goes for patients with chronic conditions simply to re-up long-term, repeat treatment. Moreover, physician practices are having to dedicate staff solely to work on prior authorizations instead of spending time with patients.

All this adds up to patients not getting care that's truly needed in a timely, efficient manner. And at a time when physician practices already operate on thin margins, health plans' red tape acts as yet another erosion of physician practice viability and ultimately patient access to care.

It's time to solidify prior authorization reforms once and for all.

TMA's Legislative Recommendations

- Support the prior authorization exemption process in all Medicare programs and stop costly delays in patient care.
- Make real-time, 24/7 prior authorization approval a standard practice among health plans, because health care can't wait.
- Limit prior authorization for patients with chronic conditions, for whom gaps in care are especially harmful.
- Standardize electronic, transparency, and enforcement mechanisms for prior authorization across all Medicare programs.

1. American Medical Association
2. U.S. Department of Health and Human Services Office of Inspector General
3. Centers for Medicare & Medicaid Services
4. Texas House Bill 3459, 87th Regular Session, enrolled version

Texas Medical Association

Physicians Caring for Texans

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