Prior Authorization Exemption

Prior authorization was originally meant to be a check on the medical necessity of expensive and less common services and treatments; however, insurers increasingly apply prior authorization to basic and routine patient care, which unnecessarily delays and sometimes denies Kentuckians access to much-needed services. As a result, prior authorization of health care services has become a burden and a barrier to physicians providing patient care.

Physicians confirm the problems associated with the prior authorization process.

According to a 2020 American Medical Association (AMA) survey of 1,000 practicing physicians, more than nine in 10 physicians (94%) reported care delays while waiting for health insurers to authorize necessary care, and nearly four in five physicians (79%) said patients abandon treatment due to authorization struggles with health insurers.

Nearly one-third (30%) of physicians reported that prior authorization requirements have led to a serious adverse event for a patient in their care, according to the AMA survey. More specifically, prior authorization requirements led to the following repercussions for patients:

- Patient hospitalization – reported by 21% of physicians.
- Life-threatening event or intervention to prevent permanent impairment or damage – reported by 18% of physicians.
- Disability or permanent bodily damage, congenital anomaly, birth defect, or death – reported by 9% of physicians.

While the health insurance industry says prior authorization criteria reflect evidence-based medicine, the physician experience casts doubt on the credibility of this claim. Only 15% of physicians reported that prior authorization criteria were often or always based on evidence-based medicine.

Other critical physician concerns highlighted in the AMA survey include:

- Nine in 10 physicians (90%) reported that prior authorizations programs have a negative impact on patient clinical outcomes.
- A significant majority of physicians (85%) said the burdens associated with prior authorization were high or extremely high.
- Medical practices complete an average of 40 prior authorizations per physician, per week, which consume the equivalent of two business days (16 hours) of physician and staff time.
- To keep up with the administrative burden, two out of five physicians (40%) employ staff members who work exclusively on tasks associated with prior authorization.

KMA supports legislation that removes these barriers to patient care and allows physician practices to spend more time with patients.

KMA's Legislative Recommendations: SUPPORT HOUSE BILL 343 #KYGA22

- HB 343 would require state-regulated commercial health benefit plans as well as Medicaid Managed Care Organizations (MCOs) to "gold card" certain physicians from prior authorization by creating an automatic approval or exemption on a physician-by-physician basis that waives prior authorization requirements if that physician is approved for a specific procedure/service or medication a vast majority of the time.