Support Prior Authorization Reform, Pass House Bill 423

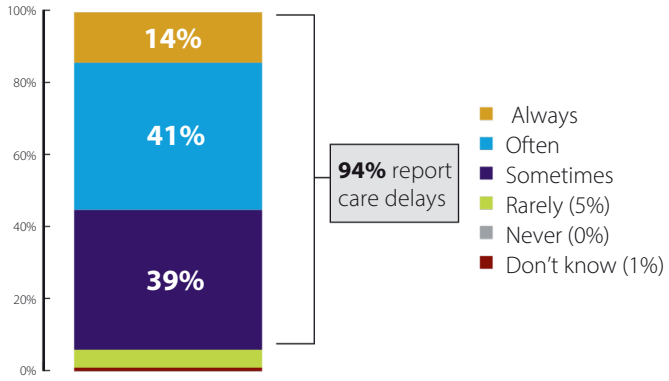
Prior authorization (PA) is a health plan cost-control process that requires health care professionals to obtain advance approval from the health plan before a prescription medication or medical service qualifies for payment and can be delivered to the patient. To assess the ongoing impact the PA process has on patients, physicians, employers and overall health care spending, the American Medical Association (AMA) annually conducts a nationwide survey of 1,000 practicing physicians. As this year's findings demonstrate, the PA process continues to have a devastating effect on patient outcomes, physician burnout and employee productivity.

KMA **supports HB 423**, which would establish a prior authorization exemption program designed to automatically waive prior authorization requirements if a physician has been approved for a specific procedure/service (not more than) 93% of the time. This prior authorization exemption program would ensure patients have timely access to the care they need, reduce administrative burdens for physicians, and lower healthcare costs. Further, this legislation establishes robust prior authorization reporting requirements, giving the General Assembly the direct ability to discern whether number of prior authorizations are increasing or decreasing.

Patient impact

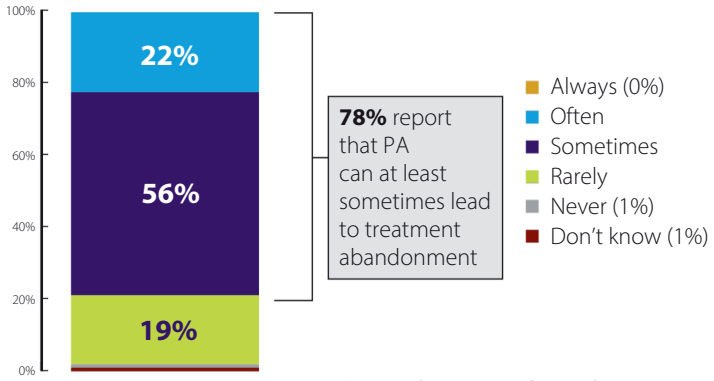
Care delays associated with PA

Q: For those patients whose treatment requires PA, how often does this process delay access to necessary care?



Treatment abandonment due to PA

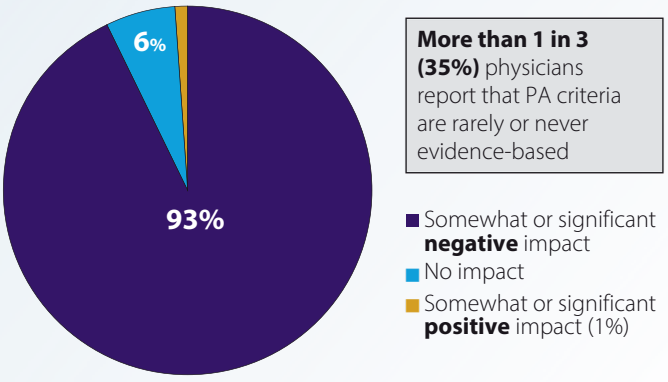
Q: How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?



Percentages do not sum to 100% due to rounding.

Impact of PA on clinical outcomes

Q: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?



(Survey completed by the American Medical Association, 2024)

Nearly 1 in 4 physicians 24%

report that PA has led to a **serious adverse event** for a patient in their care.

19% of physicians report that PA has led to a patient's hospitalization

13% of physicians report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage

7% of physicians report that PA has led to a patient's disability/ permanent bodily damage, congenital anomaly/birth defect or death

Physician impact

PA leads to substantial administrative burdens for physicians, taking time away from direct patient care, costing practices money and significantly contributing to physician burnout. PA undercuts the financial stability of physician practices that are already struggling to stay solvent in this time of dwindling Medicare payments.

On average, practices complete

43

PAs per physician, per week

Physicians and their staff spend

12 HOURS

each week completing PAs

More than **1 in 3** or

35%

of physicians have staff who work exclusively on PA

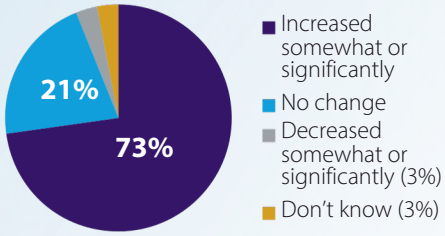
PA denials

More than

1 in 4 (27%)

physicians report that PAs are **often** or **always** denied

Q: How has the number of PA denials changed over the last five years?



95%

of physicians report that PA **somewhat or significantly** increases physician burnout

PA appeals

Fewer than

1 in 5 (18%)

physicians report that they **always** appeal an adverse PA decision

Why don't physicians appeal?

62% report that they do not believe the appeal will be successful based on past experience

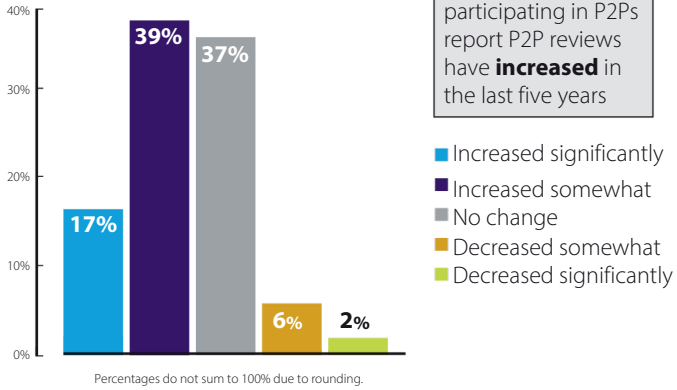
48% report that patient care cannot wait for the health plan to approve the PA

48% report that they have insufficient practice staff resources/time

When navigating the PA process, especially when appealing an adverse health plan PA decision, physicians are often required to participate in a "peer-to-peer (P2P) review" with a health plan representative. In fact, **almost two out of three physicians (61%)** report **at least sometimes** having to participate in P2P reviews.

P2P reviews require the physician to speak directly with a health plan representative, disrupting patient appointments and consuming significant physician time. As the findings demonstrate, the frequency of P2Ps is increasing, and physicians often do not speak to an appropriately qualified "peer."

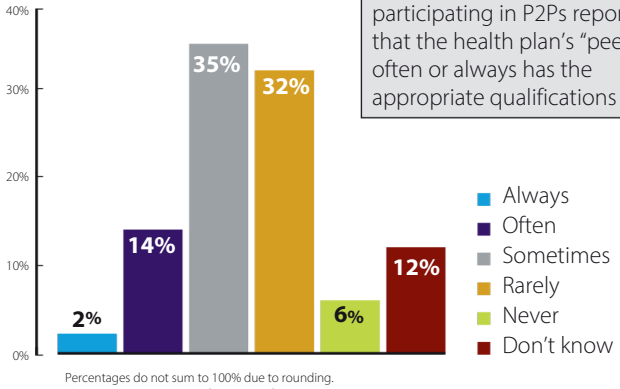
Q: How has the frequency of peer-to-peer reviews during the PA process changed over the last five years?



56% of physicians participating in P2Ps report P2P reviews have **increased** in the last five years

Percentages do not sum to 100% due to rounding.

Q: How often does the health plan's "peer" have the appropriate qualifications to assess and make a determination regarding the PA request?



Only 15%* of physicians participating in P2Ps report that the health plan's "peer" often or always has the appropriate qualifications

Percentages do not sum to 100% due to rounding.
*Percentages sum to 15% due to rounding.

(Survey completed by the American Medical Association, 2024)