Improving Prior Authorization for Patients & Providers

Prior Authorization – A Critical Safeguard in Patient Care

Addressing the cost of health care is a top priority for Americans. Recent surveys reinforce that the overwhelming majority of Americans view health care affordability as a significant problem facing the country.[1] There is also broad recognition that a significant portion of U.S. health care spending is inefficient or of low value. An estimated 25% of health care spending is considered unnecessary due to overtreatment, use of low-value care, lack of care coordination, outdated technology and fraud.[2]

Variation in provider practice often contributes to instances in which care deviates from evidence-based guidelines and recommendations. While the majority of physicians follow the appropriate and evidence-based standards of care, as defined by their respective specialty societies, a number of physicians do not.[3]

Prior authorization is an important safeguard used by both public and private payers to ensure patient care follows clinical guidelines. It helps reduce patients' exposure to low-value, unsafe or inappropriate care by making sure services and/or prescriptions align with the latest research and guidelines for effectiveness. This leads to better health outcomes for patients.

At the same time, health plans recognize patients are often frustrated when their prescription medications or doctor-recommended procedures are not promptly approved or are denied following prior authorization review. Health plans are voluntarily taking steps to improve prior authorization for patients and providers by:

- Standardizing electronic prior authorization;
- Reducing the scope of claims subject to prior authorization;
- Ensuring continuity of care on benefit-equivalent prior authorizations when patients switch health plans;
- Enhancing communication and transparency on prior authorization determinations;
- Expanding near real-time response on prior authorization requests submitted electronically; and
- Ensuring continued medical review of non-approved requests.

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1 https://www.pewresearch.org/politics/2024/05/23/top-problems-facing-the-u-s/
2 https://jamanetwork.com/journals/jama/article-abstract/2752664#
3 https://ahiporg-production.s3.amazonaws.com/documents/AHIP_AppropriatenessMeasures_2022.pdf

In a 2024 survey of AHIP's members, health plans reported that the vast majority of Commercial claims – 96% of prescription drug claims and 93% of medical claims – are not subject to prior authorization.

Use of Prior Authorization

When developing prior authorization, health plans follow the clinical standards established by leading medical organizations and supported by peer-reviewed research. Medical professionals employed by health plans and with expertise in specific areas of medicine, such as cardiology, oncology or psychiatry, are central to developing the prior authorization requirements.

Importantly, prior authorization is only selectively used. In a 2024 survey of AHIP's members, health plans reported that the vast majority of Commercial claims – 96% of prescription drug claims and 93% of medical claims – are not subject to prior authorization.

Prior authorization serves as an important patient safety check, helping to prevent dangerous drug interactions and inappropriate use of certain treatments. In these instances, prior authorization acts as a guardrail to ensure medications and/or treatments are not used in a manner inconsistent with established medical guidelines. Or, when appropriate alternatives are available, prior authorization can ensure patients have the option to obtain affordable alternatives that are consistent with evidence-based guidelines, such as generic medicines.

Benefits of Electronic Prior Authorization

Electronic prior authorization offers significant benefits to the health care system by streamlining the traditionally manual and time-consuming process of obtaining prior approvals for medications and services. Electronic prior authorization reduces administrative burden for providers, accelerates patient access to necessary treatments and minimizes delays in care.

Health plans have recognized these advantages and continue to invest in the infrastructure needed to drive adoption. These investments include integrating electronic prior authorization capabilities into electronic health record (EHR) systems, partnering with technology vendors and providing training and incentives for providers. Such efforts not only improve operational efficiency but also enhance the overall patient experience by ensuring timely and appropriate care delivery.

To ensure electronic prior authorization works effectively end-to-end, hospitals and doctors must also invest in modern electronic systems and operations. According to AHIP's 2024 survey, nearly half of prior authorization requests for medical services (45%) and prescription drugs (47%) are currently submitted by providers manually, using phone, fax or traditional mail.

Without the greater use of modern technologies, continued reliance on manual processes negate the efficiencies electronic prior authorization is designed to deliver. A coordinated effort from both health plans and providers is essential to fully streamline the prior authorization process and improve patient outcomes.

Prior Authorization: A Critical Safeguard in Patient Care

Improves Health Care Outcomes

Reduces Patient Costs

Developed By Medical Professionals

Based on Evidence-Based Clinical Standards

Prior Authorization Reduces Exposure to Low-Value Care

Instead of an expensive CT scan for abdominal pain, which can expose patients to unnecessary radiation and higher costs, prior authorization can direct a patient to a more affordable ultrasound as a better first line of diagnosis, consistent with evidence-based medical guidelines.

Instead of inpatient treatments for joint procedures requiring extended hospital stays, prior authorization can direct a patient to outpatient treatment resulting in the same or better health outcomes and lower costs for patients.

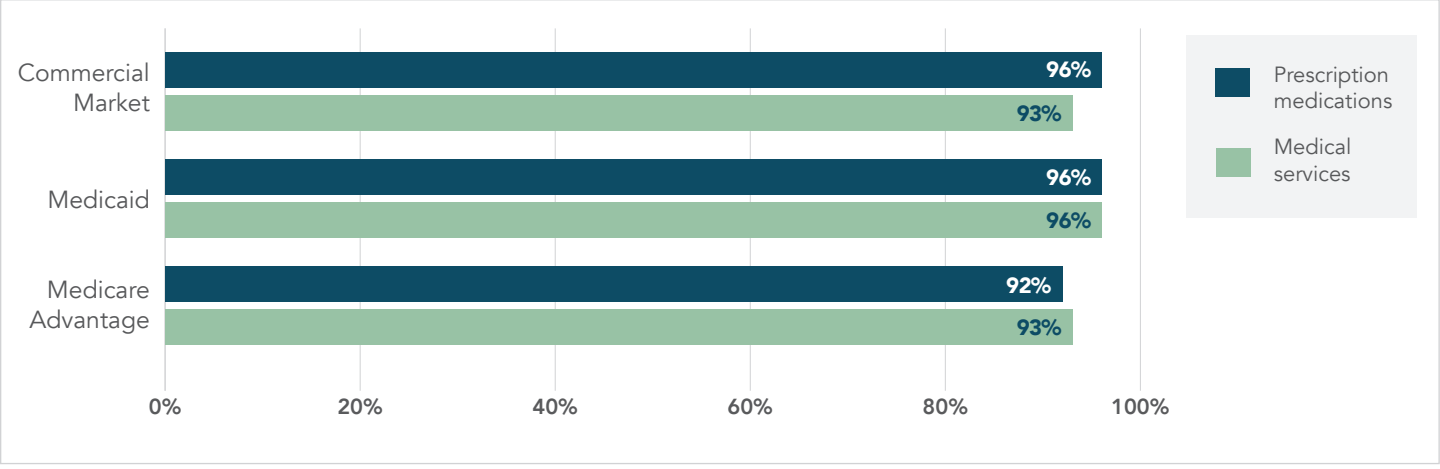
AHIP Survey on Prior Authorization in the Commercial Market, Medicaid, and Medicare Advantage Programs

AHIP conducted a survey of its member companies in October 2024. The survey asked respondents to provide information on the prior authorization processes used in the Commercial, Medicaid, and Medicare Advantage markets. For the Commercial market, 32 health plans responded, representing 109 million lives or 51% of national Commercial market enrollment. For Medicaid, 21 health plans responded, representing 53% of Medicaid managed care enrollment. For Medicare Advantage, 21 health plans responded, representing 42% of MA enrollment.

AHIP's survey found:

- Prior authorization is **evidence-based**. Health plans develop prior authorization programs based on clinical literature, professional treatment guidelines and other evidence-based resources on safety, efficacy and quality.
- Prior authorization relies on and incorporates **provider input**, including Pharmacy and Therapeutics (P&T) committees, utilization management committees and clinical experts.
- The **vast majority of medical services** are not subject to prior authorization review.
  - In the Commercial market, approximately **96% of prescription medication claims** and **93% of medical service claims** are not subject to prior authorization review.
  - For Medicaid, **96% of prescription medication claims** and **96% of medical service claims** are not subject to prior authorization review.
  - For Medicare Advantage, **92% of prescription medication claims** and **93% of medical service claims** are not subject to prior authorization review.

Figure 1: Portion of Claims Not Subject to Prior Authorization Review

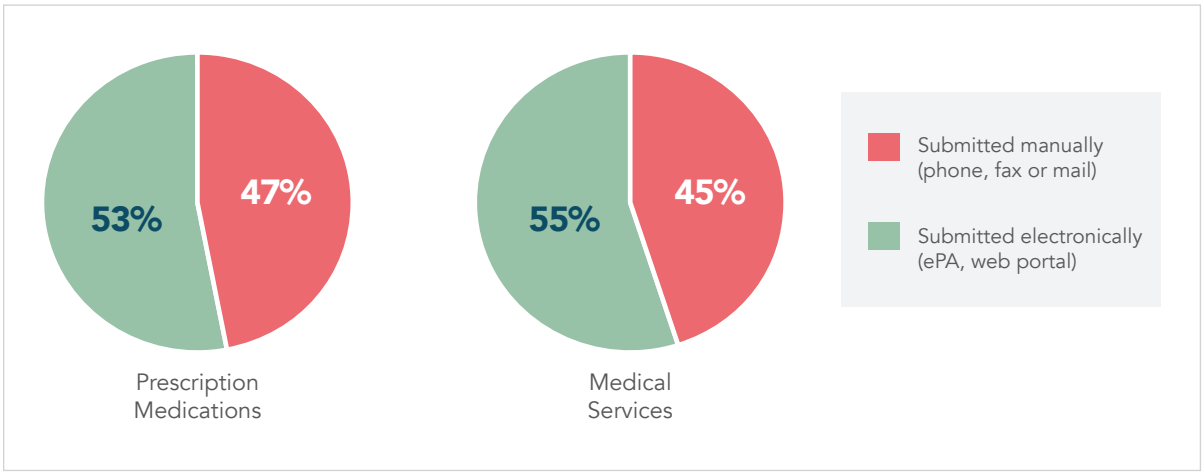


- The **vast majority of prior authorization requests are approved** following final review.
  - In the Commercial market, approximately **90% of prescription medications** and **97% of medical services** are approved.
  - For Medicaid, approximately **91% of prescription medications** and **97% of medical services** are approved.
  - For Medicare Advantage, approximately **90% of prescription medications** and **98% of medical services** are approved.
  - Approximately **20% of prior authorizations** for medical services are **approved in real-time.**
- Today, **almost half of prior authorization requests are submitted manually by phone, fax or mail**. On average, 47% of requests for prescription medications and 45% of requests for medical services are submitted manually.

All responding health plans reported that AI is not used to deny prior authorization requests that involve medical necessity or clinical considerations.

- Cases in which prior authorization requests are initially denied in the Commercial market, Medicaid, and Medicare Advantage, are often a result of incomplete information from providers. Ultimately, most prior authorization requests are approved, with average final denial rates for Commercial plans of only **3% for medical services and 10% for prescription medicines.**
- All responding health plans (100%) reported that **AI or algorithms without clinician or practitioner review are not used to deny prior authorization requests** that involve medical necessity or clinical considerations.

Figure 2: Portion of Prior Authorization Requests Submitted Manually vs. Electronically



Health Plan Commitments to Improve Prior Authorization

In an effort to improve the overall experience for patients and providers, participating health plans have voluntarily committed to a set of reforms aimed at increasing transparency, reducing administrative burden and accelerating access to care. These commitments represent important steps forward and allow for flexibility in order for health plans and providers to implement each one successfully. The commitments outline a shared vision among health plans to streamline prior authorization, support faster and fully integrated electronic processing and strengthen communication and engagement with patients and providers. To view the list of participating health plans, visit www.ahip.org.

1. Standardizing Electronic Prior Authorization

Greater standardization and harmonization of the clinical data utilized to process prior authorization requests has the potential to benefit patients and providers by achieving greater consistency and clarity on the criteria and data elements and reducing variability. Health plans are exploring opportunities for greater standardization. The goal is for the new framework to be operational and available to plans and providers by January 1, 2027.

Commitment: Signatory Plans will work toward the development and implementation of common, transparent submissions for electronic prior authorization. This commitment includes the development of standardized data and submission elements (using FHIR® APIs) that will support seamless, streamlined processes and faster turn-around times.

2. Reducing the Scope of Claims Subject to Prior Authorization

To ensure prior authorization continues to be applied to services most prone to variation, health plans providing fully insured, ACA marketplace and Medicare Advantage coverage commit to specific reductions to prior authorization as appropriate for the local market each health plan serves, with demonstrated reductions by January 1, 2026. This commitment is consistent with health plans' ongoing efforts to regularly review and adjust their prior authorization lists based on current data and their enrollees' needs.

Commitment: Signatory Plans providing fully insured, ACA marketplace coverage and Medicare Advantage coverage commit that they will individually reduce the volume of in-network medical prior authorizations by January 1, 2026. Signatory Plans further commit that they will provide data to allow industry reporting of the extent of such reductions reflecting actions taken since January 2024.

3. Ensuring Continuity of Care When Patients Change Health Plans

Continuity of patient care is essential, particularly for patients undergoing an active course of treatment or who have a chronic condition. When a patient has been approved for a particular item, service or medication and then switches health plans, honoring the previous health plan's authorization for a specified period of time, provided that item, service or medication is a covered benefit under the new health plan with an in-network provider, will help smooth the care transition for patients.

Commitment: By January 1, 2026, Signatory Plans commit to support continuity of care by honoring a previous health plan's prior authorization for the same service, under the same type of benefit in network for a 90-day transition period when a member changes health plans after starting a course of treatment.

4. Enhancing Communication and Transparency on Determinations

Health plans continue to improve the readability of their member communications, which are often dictated by specific state and federal requirements. In cases for which a request for a prior authorization is not approved, notices and letters must be easy to understand and clearly explain available next steps for assistance, including simple instructions for how to appeal the decision. To ensure all communications are actionable, Signatory Plans commit to a meaningful improvement of these communications. Existing member support services will provide specific assistance designed to help members navigate the prior authorization process.

These commitments include providing simple explanations and easy-to-access assistance for prior authorization determinations, including clear information about next steps and support for appeals processes if needed.

Commitment: By January 1, 2026, for fully insured and self-insured Commercial coverage and ACA marketplace coverage, Signatory Plans commit to explaining with clear and personalized language about any prior authorization denials, including information about next steps and available appeals processes. Signatory Plans also will explore seeking regulatory changes to facilitate expansion of this commitment. Signatory Plans serving Medicare Advantage beneficiaries will work with CMS to improve existing mandatory member communications on prior authorization denials and appeals.

Commitment: By January 1, 2026, for fully insured and self-insured Commercial coverage and ACA marketplace coverage, Signatory Plans commit to providing staff to help members understand the prior authorization process and their options after a prior authorization determination is made.

5. Expanding Real-Time Responses

Health plans continue to make significant investments in capabilities that enable real-time or near real-time prior authorizations – as have many providers. Today, millions of electronic prior authorizations are approved in real-time or near real-time (i.e., within minutes). To speed approvals for patients and providers and to encourage broader provider adoption of electronic prior authorization, Signatory Plans commit to meaningful acceleration of these capabilities. Adoption of new technical standards (FHIR® APIs) by health plans and providers will accelerate real-time responses.

Commitment: Signatory Plans commit to an acceleration of the percentage of prior authorization requests for medical services answered in real-time if submitted electronically by providers with all necessary clinical documentation. By 2027, for all coverage types at least 80% of prior authorization approvals will be answered in real-time.

Commitment: While existing regulations require new technical standards for electronic prior authorization for certain health plans in federal programs beginning January 1, 2027, health plans subject to these forthcoming rules will support these standards (FHIR® APIs) for all lines of business.

6. Ensuring Medical Review of Non-Approved Requests

AI automation can improve the prior authorization process for patients, providers and health plans. This will accelerate timely approvals, promote access to care, improve the patient experience, minimize administrative burden and reduce costs. AI will only be used to facilitate quicker approvals, not for denials based on medical necessity without a clinician review.

Commitment: For all coverage types, Signatory Plans commit that all prior authorization denials based on medical necessity for clinical factors will be reviewed by a licensed and qualified clinician. This commitment reflects existing practices and is in effect now.