

Introduction

Health care coverage has never been more important as the nation battles the COVID-19 pandemic – now and for the foreseeable future. Two-thirds of the population relies on the private sector for health insurance coverage and thus access to health care.¹ While private health insurance coverage has long served as the backbone of our national system, that very coverage and the security it offers millions of Americans is eroding at an alarming pace. Health care insurance was originally designed to be a straightforward financial agreement between a health plan and a consumer: the consumer paid a premium in exchange for coverage of a set of health care services offered by a certain group of providers. If disputes arose, consumers could expect that adjudication of the claim would follow a fair, efficient, and transparent process. This agreement, underpinning America’s system of health insurance for decades, is beginning to slip away in some markets across the country, and the COVID-19 public health emergency is further shining light on its erosion.

Not only are private health insurance plans the dominant source of health care coverage for most Americans, but employers, as well as the Medicare and Medicaid programs, rely on private health plans to provide or administer their health benefits. Approximately one-third of Medicare beneficiaries are enrolled in a private Medicare Advantage health plan, and nearly all states enroll some or all of their beneficiaries into Medicaid managed care plans.

Coverage through these plans is eroding as some health insurers restrict access to health care services by abusing utilization management programs and changing health plan rules in the middle of a contract year. For example, prior authorization, one of the most widely used utilization management tools, is designed to help patients obtain the right care in the right place. Insurers use prior authorization to ensure that providers order care that is consistent with clinical guidelines and protocols, as well as to confirm that such care is covered by the patient’s plan. This tool was designed to primarily help guide (and monitor) providers’ decision-making around treatments that are new, particularly high cost, or that have a history of questionable use. However, some plans are now applying prior authorization to a wide range of services, including those for which the treatment protocol has remained the same for decades and there is no evidence of abuse.

Unjustified use of utilization management tools like prior authorization has a number of negative implications for patients and the health care system. Patients are often blindsided by denials and can face unexpected medical bills as a result. The extensive approval process that doctors and nurses must go through adds billions of wasted dollars to the health care system and contributes to clinician burnout.²

Evidence of the negative impact of these practices is mounting. The Department of Health & Human Services Office of the Inspector General (OIG) warned in a September 2018 report that high rates of Medicare Advantage (MA) health plan payment denials and prior authorization delays could negatively impact patients’ access to care.³ In 2019, a federal court found that the largest commercial insurer in the United States was abrogating the *entire point* of health insurance by systematically denying medically necessary, covered behavioral health services for financial reasons.⁴ It is worthy of note that in response to COVID-19, many health insurers, including at the urging of government, scaled back the use of many of these tactics precisely because they create barriers to care. State governments, as the primary regulators of insurance, have also taken action. For example, New York State passed a number of insurer accountability measures at the beginning of the COVID-19 to help ensure patient access to care and to remove unnecessary burdens on providers on the front lines.⁵

In 2019, the American Hospital Association (AHA) fielded a survey to better understand the impacts of health plan utilization management practices on patients and providers. More than 200 hospitals and health systems responded. Their data was supplemented with interviews and group discussions with several hundred additional hospital and health

system executives. The following report documents our findings related specifically to prior authorization and payment delays and denials. While these findings pre-date the COVID-19 public health emergency, they remain not only relevant but serve to underscore the urgency to address these issues as hospitals remain on the front line of care for COVID-19 patients. The report offers policymakers solutions to reduce the risk and burden of these programs while still enabling health insurance plans to compete on quality, benefit package design, provider networks, and other important aspects of coverage.

Prior Authorization

Prior authorization is a process whereby a provider, on behalf of a patient, requests approval from the health plan before delivering a treatment or service in order to qualify for coverage and payment by the health plan. According to America's Health Insurance Plans, prior authorization is implemented by health plans "to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, while providing benefit to the individual patient."⁶ Philosophically, we agree with these laudable goals, and, indeed, some health plans use prior authorization in ways that accomplish them. However, many health plans apply prior authorization requirements in ways that create dangerous delays in care, contribute to clinician burnout, and drive up health system costs.

Inappropriate use of prior authorization can negatively impact the quality of care. A survey of more than 1,000 physicians found that more than 90 percent of respondents said prior authorization "had a significant or somewhat negative clinical impact, with 28 percent reporting that prior authorization had led to a serious adverse event such as a death, hospitalization, disability or permanent bodily damage, or other life-threatening event for a patient in their care."^{7,8} The federal government has also acknowledged the risk of delays in care caused by prior authorization requirements, which is why it urged health plans to ease such requirements during the COVID-19 public health emergency, stating "New guidance for individual and small group health plans encourages issuers to utilize flexibilities related to utilization management processes, as permitted by state law, to ensure that staff at hospitals, clinics, and pharmacies can focus on care delivery and ensure that patients do not experience care delays."⁹

Prior authorization also puts a heavy burden on clinicians and contributes to workforce burnout. According to the National Academies of Medicine, "Among clinicians, burnout is associated with job demands related to workload, time pressure, and work inefficiencies, **such as burdensome administrative processes which divert clinicians' attention away from patients and detract from patient care.**"¹⁰ Prior authorization is one of the administrative processes most frequently cited by clinicians as a contributing factor to burnout. A few real world examples of the burden associated with prior authorization include:

- One 17-hospital system spends \$11 million annually just complying with health plan prior authorization requirements.
- A single 355 bed psychiatric facility needs 24 full-time staff to deal with authorizations.
- A large, national system spends \$15 million per month in administrative costs associated with managing health plan contracts, including two to three full-time staff that do nothing but monitor plan bulletins for changes to the rules.
- Physicians report that their offices spend on average two business days of the week dealing with prior authorization requests, with 89 percent rating the burden level as high or extremely high.¹¹

The costs associated with prior authorization go beyond workforce burnout. These processes require significant technological infrastructure and staff time, and delays often mean that a patient consumes more health care resources than required, e.g., by remaining in an inpatient bed when they should have already been discharged to another site of care. Health plans rarely pay for those additional days, forcing the health care system to absorb those costs.¹² According to one health system executive, the transition to value-based payment arrangements could help alleviate much of the burden associated with health plan administrative requirements. However, the cost associated with complying with

these utilization management functions expends the resources they would need to build in the value-based payment infrastructure.

Why is the administrative burden so cumbersome? Reasons include:

- **Variation in Submission Processes.** Plans vary widely on accepted methods of prior authorization requests and supporting documentation submission. While some plans accept electronic means, the most common method remains using fax machines and contacting call centers, with regular hold times of 20 to 30 minutes. Additionally, plans offering electronic methods of submission most commonly use proprietary plan portals, which require a significant amount of time spent logging into a system, extracting data from the provider's clinical system and completing idiosyncratic plan requirements, thereby reducing the administrative efficiencies of the process. For each plan, providers and their staff must ensure they are following the right rules and processes, which may change from one request to the next. Inevitably, providers commit inadvertent errors that result in denials that must be reprocessed or appealed.
- **Inappropriate Application of Prior Authorization.** Health plans increase administrative burden when they broadly apply prior authorization even to services or treatment protocols that are neither new nor have history of unwarranted variation. **For example, one AHA survey respondent indicated that they had cared for a patient newly diagnosed with diabetes who presented with a fasting blood glucose level of 520 mg/dL. Despite this level being at a critically dangerous five times the acceptable range, the patient's health plan informed the treating clinician that insulin, a standard lifesaving medication that has been widely used for nearly 100 years, was subject to prior authorization and review would take up to 24 hours.** The clinician was forced to provide the patient with samples to immediately start treatment while awaiting the health plan's decision. In this example, the health plan's prior authorization procedures could easily have imperiled the health of the patient except for the ability of the clinician to make do with samples.
- **Unreasonable or Unrelated Requests for Documentation.** Some health plans require different information as part of prior authorization requests, even for patients with the same clinical condition, and health plans often change those requirements unilaterally in the middle of a contract term. This frequently occurs for long stays, high dollar accounts, and higher acuity care. For example, after submission of a prior authorization request for rehabilitation services following a six-week inpatient hospital stay, one health plan responded that it needed to know whether the patient was taking any medication that would impact the need for rehab services, and whether the patient had experienced shortness of breath during the (six week) hospital stay. Neither of these pieces of information were relevant to a determination regarding rehabilitation. However, both the health system and health plan medical directors spent an hour on the phone before the care was ultimately approved based on the information that was originally submitted.
- **Insufficient Personnel or Network Gaps.** Some health plans do not have the personnel to process the growing number of prior authorization requests. A limited sample of 98 hospitals and health systems from our survey reported approximately 865,000 prior authorization requests in 2018 to which health plans did not respond at all and which required follow up by the provider. This most frequently occurs when the patient comes in overnight or on the weekend when the health plan does not have staff available to review routine requests. In fact, 92% of respondents to our survey have contracts with health plans that do not have prior authorization review available round the clock, seven days a week. Patients can end up waiting for days in the emergency department or in an inpatient bed, jeopardizing the patient's plan of care and the treating physician's discharge orders, and creating hospital backlogs that strain capacity.

Delays sometimes appear to be the result of inadequate provider networks. In other words, the health plan delays authorizing a service because there are not enough providers in the plan's network that are available to accept a referral. This is particularly problematic for patients in need of behavioral health or post-acute care services. Specifically, hospitals report significant challenges accessing inpatient mental health/substance use

disorder recovery services, medication assisted therapy, long-term acute care hospital services, and home health services. In many cases, patients wait in emergency departments or acute care inpatient beds for days awaiting authorization and placement. **One real-life example is when a patient with traumatic brain injury was medically ready for discharge but sat for four additional days in the hospital without access to essential post-acute care because the health plan would not respond to the provider’s request to move the patient into a rehabilitation facility.**

- **Denials of Unanticipated but Medically Necessary Care.** It is not always possible to know in advance everything a patient may need during a procedure. Providers will obtain authorization for the primary procedure and what they expect to be any ancillary items and services. However, it is not uncommon once a treatment or procedure is underway for the clinician to discover new information that necessitates other items and services to deliver the best patient care. A common reason that this may occur is when a patient’s condition changes quickly during a procedure. Plans routinely deny coverage for any item or service not pre-authorized, even if the plan authorized the overall procedure or treatment. In many instances, plans will not consider retro-authorization to account for these unanticipated changes in the course of care. This approach is inconsistent with the nature of medical procedures and treatments and may narrow necessary treatment options.
- **Appeals of Inappropriate Denials.** Medical necessity is the most common reason health plans deny prior authorization requests.¹³ However, hospitals and health systems frequently experience situations where a service was clearly medically necessary, but the plan denies it anyway, resulting in additional staff time to resolve the dispute. In fact, the routine denial of medically necessary care was highlighted by the 2018 OIG report, which found that Medicare Advantage Organizations overturned 75 percent of denials that were appealed between 2014 and 2016.¹⁴ For example, one hospital recently reported that a plan denied prior authorization for the hospitalization a young adult experiencing their first psychotic episode because there was no prior history of psychosis for that patient.¹⁵

Other factors contributing to inappropriate denials include the use of proprietary clinical criteria and health plan staff without appropriate clinical knowledge. Health plans frequently use different clinical guidelines from providers, as well as from each other, and even modify the guidelines that are broadly available. These proprietary modifications are not always shared with providers. In addition, plans often fail to match clinicians’ expertise with review requests. For example, a health plan may assign a urologist to assess whether a cancer patient should receive the type of chemotherapy referred by the treating oncologist.¹⁶

- **Role of Delegated Entities.** In some parts of the country, financial risk and responsibility for utilization management is outsourced by the plan to another entity, such as an independent physician group (IPA). Most often, these groups have limited experience in managing care in post-acute or behavioral health settings, and insufficient knowledge of medically necessity guidelines for these services, leading to additional delays. Moreover, challenging an unfavorable decision requires communicating with both the IPA and the delegating plan, oftentimes with no clear determination as to who is ultimately responsible.

Table 1: Prior Authorization Denial Rates

Product Type	Prior Authorization Denial Rate
Medicaid Managed Care	14.7%
Medicare Advantage	12.4%
Commercial PPO	11.3%
Commercial HMO	9.6%

The rate of prior authorization delays and denials is not uniform across all health plan products. Our survey data shows that health plans serving public programs are more likely to deny prior authorization requests. Specifically, Medicaid managed care plans have the highest prior authorization denial rate, followed by Medicare Advantage, and

then commercial products. These rates vary despite physicians following the same clinical guidelines regardless of a patient's type of coverage. (see [Table 1](#)). These data suggest that the rate of denials is linked to financial, not clinical, considerations.

Reimbursement Delays and Denials

Health plans are increasingly denying provider reimbursement for medically necessary care. Our survey found that 89% of respondents have experienced an increase in payment denials over the past three years, with 51% having experienced a "significant" increase in denials.¹⁷ There are several different ways in which plans deny claims, including initial claim denials (or pre-payment denials), post-payment audit denials, partial or line-item denials, and downcoding. Below are several examples of payment denial strategies in use by some health plans:

- **Failure to Obtain Prior Authorization:** In order to prevent harm and adequately care for patients, providers sometimes must begin treatment or move a patient to a more appropriate site of care before obtaining a response to a prior authorization request. In such instances, some health plans will deny care that they acknowledge to be medically necessary simply because the provider did not wait on the prior authorization processing. Additionally, if a health plan is reviewing an authorization request for treatment that already has started or occurred, some plans will adjudicate the request based on the patient's condition at the time of review rather than at the time the request was made. If the patient has improved due to the treatment received, the request will be denied as not medically necessary.
- **Observation Status/Short Stay Denials:** Hospitals and health systems report a steep increase in short stay denials, even when clinical indicators and the severity of illness meet the standards for inpatient admission. In these instances, the commercial insurers downcode the inpatient claims to observation status and, in some instances, use the downcoding to deny the claim altogether by arguing that the provider did not seek prior authorization for observation status.
- **Sepsis:** Several health plans are now reimbursing providers for sepsis care using the Sepsis-3 clinical criteria, instead of the broadly-adopted Sepsis-2. The primary difference between the two sets of criteria is that Sepsis-3 recognizes only more severe forms of sepsis. This move is inconsistent with the CMS sepsis quality measure ("Severe Sepsis and Septic Shock: Management Bundle"), as well as some state laws. Indeed, CMS has expressly rejected adoption of Sepsis-3.¹⁸ However, by moving to Sepsis-3, these health plans are not reimbursing providers for early sepsis interventions. In other words, their adoption of Sepsis-3 is not intended to change how providers assess and treat patients; they simply will not pay for care provided to patients in the early stages of sepsis.

Adoption of the Sepsis-3 criteria introduces conflict and confusion in the field around the right clinical pathway and signals a retreat on standardization of clinical care. Early treatment is critical to prevent the progression of sepsis and any reduction in early intervention could result in increased mortality. The misguided adoption of Sepsis-3 clinical criteria results in underpayment for these very critical early interventions. This change misaligns incentives among providers and insurers to achieve a shared goal of reducing sepsis.

- **Site of Service Exclusions:** Many health plans will only cover services when provided in certain sites of care. While these policies may in part be intended to drive care to the most cost-effective (while safe) site of care, they often do not take into account the full range of considerations for when a patient may need a higher level of care. In addition, such decisions by a health plan amount to a change in coverage and yet they are often put into place mid-contract term, thus undermining a patient's understanding of their coverage, as well as the basis for negotiating contract terms with providers.

These policies are most often applied to certain diagnostic tests and surgical procedures; however, they have also been applied in the emergency setting. Specifically, health plans have questioned a patient's use of the emergency department without full regard to why the individual sought emergency services and thus have

subsequently denied the claim. These decisions risk dis-incentivizing patients from seeking emergency treatment in the future. Avoiding necessary emergency treatment could result in serious harm to or death of a patient.

Of special concern are payment denials for some covered diagnostic tests and surgeries in certain sites of care. These changes are often made mid-year after enrollees have purchased their coverage and providers have signed contracts. This means that consumers evaluated and selected their coverage options based on one set of rules, only to find themselves with a very different health plan product with little recourse.

These site of service exclusions also make the coordination of routine care more difficult. Health plans often require that patients go to alternate sites of care that are unaffiliated with their primary providers, cannot offer the exact service required (most frequently an issue with certain types of sophisticated imaging), or cannot easily communicate results back to the referring provider.

- **Inaccurate Enrollment Files.** Insurers frequently deny claims based on inaccurate enrollment files. These errors can occur both when the insurer denies the patient has coverage when they actually do, as well as when an insurer pays a claim only to subsequently claw back the payment when they realize the patient is no longer enrolled in their plan. In the latter scenario, the correct payer often will not allow retroactive authorization and denies the claim as well. These problems occur most frequently in the first quarter of the year when insurers do not update membership files on a timely basis.

The rate of health plan denials varies by type of product, consistent with our findings on prior authorization denials. Privately administered Medicare and Medicaid plans have higher rates of claims denials than commercial products, which again suggests that the denials are financially motivated and not based on what is clinically best for the patient.

Many plans contract with vendors to analyze claims and make reimbursement determinations. Hospitals and health systems report being told one thing by the health plan only to have it contradicted by the vendor. This frequently happens with respect to whether a prior authorization is required or not. Health plan staff will tell the provider that prior authorization is not necessary, but the vendor will deny the claim for lack of authorization. Hospitals and health systems report that they are frequently unable to communicate with health plans on these issues because they are not provided accurate contact information and often get caught in endless automated voice answering service loops.

Table 2: Health Plan Claims Denial Rates

Product Type	Claims Denial Rate
Medicaid Managed Care	17.7%
Medicare Advantage	11.8%
Commercial PPO	11.2%
Commercial HMO	7.9%

Policy Solutions

Our health care system must serve patients and providers better than it currently does today. Patients and the providers who care for them deserve a rational, predictable and efficient system in order to ensure access to the highest quality care. Below are a series of policy solutions to ensure fair rules for contracting between health plans and providers.

1. Standardize Prior Authorization Requirements and Processes

Variation in prior authorization requirements and transmission processes result in inappropriate denials, create significant burden, and add additional cost to the health care system. The AHA urges federal and state regulatory bodies, including CMS, the Department of Labor (DOL), and state insurance commissioners, to standardize prior authorization processes in the following ways.¹⁹

- **Standardize the format for communicating services subject to prior authorization.** While health plans generally provide lists of services subject to prior authorization via their websites, it can be challenging for providers to locate the right list for the right plan, and keep up with any changes, especially when health plans and their vendors provide inconsistent information. Health plans should adhere to a standard format for posting prior authorization requirements, provide accurate staff contact information for follow up, and ensure oversight of vendors. Ideally this information could be conveyed within a provider’s clinical information system, which would ensure that the provider knows when developing a treatment plan whether or not prior authorization is required.
- **Standardize the format for prior authorization requests and responses.** All health plans should accept requests using a standardized electronic format, including the submission of clinical documentation, and return responses in the same way. The format for requests should have standardized fields for the clinical information required. Denials should include a detailed rationale. Providers and health plans also should use the same electronic processes for transmitting requests and responses. Where feasible, electronic standards should integrate with a provider clinical information systems in order to eliminate time spent transposing clinical data from one system to another. Alternate mechanisms, such as fax, only should be used in rare circumstances, such as in areas with limited broadband or other technical limitations. One member estimates that switching from verbal/fax processes to an electronic transmission process would reduce the amount of provider staff time for each request by at least 50% — from a current average of 30 to 45 minutes per request to 15 minutes per request. In addition, they expect 25% fewer inappropriate denials simply as a result of better compliance with prior authorization requirements.
- **Require 24/7 prior authorization capabilities.** Hospitals care for patients 24-hours a day, 365 days per year. In order to prevent patients from waiting unnecessarily for care, often in the emergency department, plans should be required to have staff available 24-hours, 7 days a week to respond to prior authorization requests.
- **Establish standard timelines for responses.** All health plans should abide by the same timeframes for responses: 72 hours for certain scheduled, non-urgent services and 24 hours for urgent services. The “clock” should begin when the provider submits the request with the information available at the time the provider’s determination is made. Plans should not be permitted to delay decisions by requesting additional information not available at that point. There also should be a period of retroactive consideration of prior authorization requests for urgent services for which the patient’s clinical condition warranted immediate intervention or for situations when prior authorization was not possible (e.g., a patient’s condition changes during a procedure or treatment requiring a change in the course of care).
- **Require full and complete denials.** Plans should communicate denials in writing immediately and transmit them electronically to allow for timely appeals. Plans should not be permitted to verbally deny an authorization without immediately following it with a complete denial letter.
- **Standardize appeals processes.** Health plans should follow a standard appeals process, which should include an opportunity for external review of denials.

Implementing standards in the above areas would reduce significantly the administrative burden and associated costs over time and better ensure that patients receive access to the services they need. Health plans would still have ample opportunity to differentiate their products through unique constellations of providers, benefit structures, quality, and enrollee experience, among other aspects of coverage. We recognize that standardization will require effort on the part of all parties, including by requiring providers to adjust their technology applications and implement new work flows. However, we believe it is critical to take on this additional effort in the short-term to reduce the complexity and burden associated with prior authorization over time.

2. Increase Oversight of Health Plans to Stop Inappropriate Payment Delays and Denials

Regulators must do more to ensure that health plan enrollees have access to covered services, the rules are fair for

contract providers, and, as appropriate, taxpayer dollars are well-spent. We urge CMS, the DOL, and state insurance commissioners to increase their oversight and enforcement activities using existing statutory authority in the following ways:

- **Set thresholds.** Oversight bodies should establish thresholds for “appropriate” levels of prior authorization and payment delays and denials in order to target potential bad actors for increased scrutiny.
- **Apply financial penalties for inappropriate denials.** Regulators should create a financial disincentive for plans to inappropriately deny prior authorization requests or claims for reimbursement. Specifically, we recommend that plans be required to pay 50% above the normal payment rate if a denial is overturned by internal review and 200% of normal payment if a denial is overturned by external review or arbitration.
- **Test provider networks:** Inadequate networks – particularly for behavioral health and post-acute care – may contribute to prior authorization delays. We urge regulators to more routinely test health plan’s networks (or delegated network), including through “secret shopping” efforts to ensure that providers are indeed in-network and accepting patients from that health plan or a delegate.
- **Publish performance data.** Regulators should make available statistics on health plan and third party administrator (TPA) performance on measures related to prior authorization and payment delays and denials, including the rate of denials overturned upon appeal.
- **Increase oversight.** Regulators should increase the frequency of health plan and TPA audits for those found to exceed established thresholds for prior authorization and payment delays and denials. In addition, regulators should work towards real-time reporting for early intervention on issues that could negatively impact patient access to care.
- **Apply appropriate disincentives.** Regulators should consistently apply penalties to plans and TPAs, which should also be applied to any contractors or delegates, found to be out of compliance with the identified thresholds.

Role of Contracts in Dispute Resolution

Health plans and providers enter into contracts to define the terms of their agreements, including things such as reimbursement, network participation, licensing and insurance requirements, and credentialing. Health plans also use provider manuals to further elaborate on certain elements of the contract, especially how certain provisions may be operationalized, such as prior authorization requirements and appeals processes. These manuals can be unilaterally changed by the health plan during the contract period.

Contracts are one of the most important tools that health plans and providers have to ensure that the terms of the relationship are fair and allow for appropriate redress if either party violates a term.

Contracts are limited by certain factors, including the relative negotiating power of each party and that enforcement of the terms can be expensive and lengthy. Terms or requirements that should be universally adopted are more appropriately handled through federal or state policy. An example of this is prompt pay policies.

Federal agencies may need additional authority to conduct comprehensive oversight of health plans. For example, statutory language barring CMS from intervening in private contracts appears to have hampered the agency’s ability to address a number of systemic payment and prior authorization abuses by health plans. Federal law should not unduly restrict regulators’ abilities to ensure access to care and coverage for patients and fair reimbursement for providers.

Conclusion

Certain health plan practices threaten patient access to care and drive excessive administrative costs and burden in the health care system. While these concerns pre-date COVID-19, the current public health emergency both highlights and demands immediate action to protect patients and providers. Regulators should increase their oversight of health plans and implement a comprehensive simplification agenda, beginning with streamlining prior authorization requirements and

processes, as well as monitoring for abusive payment delays and denials. These efforts will go a long way to addressing unnecessary costs in the system and allow for a more rational, navigable health system for patients.

Endnotes

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19. For simplicity, we use "health plan" as shorthand throughout; however, we encourage the DOL to apply these policies to third party administrators and employers administering self-funded coverage, in addition to the fully insured large group products.