FIXING PRIOR AUTHORIZATION

REFORMS TO ADDRESS THE OVERUSE AND ABUSE OF PRIOR AUTHORIZATION

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Congress should pass the *Improving Seniors' Timely Access to Care Act* (H.R.3514/S.1816) to address prior authorization abuse in Medicare Advantage, because the inappropriate use of prior authorization has consistently denied or delayed necessary medical care and imposed significant administrative burdens on providers and patients alike.

PRIOR AUTHORIZATION REFORM TO IMPROVE ACCESS

The primary legislative vehicle for prior authorization (PA) reform before Congress is the *Improving Seniors' Timely Access to Care Act* (H.R.3514/S.1816), which would streamline the PA process for the roughly 32 million Americans enrolled in Medicare Advantage plans. The bill improves transparency and reduces unnecessary delays in patient care by:

- Establishing **standardized electronic prior authorization (e-PA) systems across all Medicare Advantage plans**, modernizing PA processing, and moving away from the current outdated system of slow and burdensome faxes and proprietary portals;
- Requiring **real-time decisions for routinely approved services and 24-hour decisions for emergency care;**
- Improving transparency by requiring plans to **publicly report approval/denial rates, PA policies, and the use of artificial intelligence (AI)** within PA systems;
- Ensuring that PAs receive appropriate review by **requiring PA decisions to be made by licensed physicians board-certified in the relevant specialty**; and
- Creating **accountability through data collection and Congressional reporting**.

REFORM HAS BIPARTISAN CONGRESSIONAL AND STAKEHOLDER SUPPORT

H.R.3514/S.1816 has received **overwhelming bipartisan and health care stakeholder support.** The bill has previously received:

- More than **half of the members of the House of Representatives (248)** and a **supermajority of U.S. Senators (64)** are co-sponsors.
- Over **500 health care organizations** representing patients, providers, medical technology innovators, biopharmaceutical companies, and health plans. Of that number, **more than 120 national medical specialty societies and state medical associations** have supported the bill.



3 in 4 Medicare Advantage enrollees are subject to unnecessary delays due to prior authorization



Over 1 in 4 physicians say PAs have led to a **serious adverse event** for a patient in their care



94% of physicians reported that PAs **delay care**



Physicians and their staff spend **13 hours each week completing PAs.**



On average, a practice completes **43 prior authorizations for each physician per week.**



Government audits found that Medicare Advantage plans subjected enrollees to **unnecessary delays**, **incorrectly denied medically necessary care**, and **ultimately approved 75% of requests that were initially denied**.

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ADDITIONAL PA REFORMS

Additional bills to address PA abuses include:

- The ***Patient Access to Autoimmune Treatments Act*** **(H.R.5467)**, which limits prescription drug PAs used by Medicare Advantage and stand-alone Part D plans to once per year for patients with autoimmune diseases or blood disorders.
- The ***Prior Authorization Relief Act*** **(S.3762)**, which reforms PAs in Medicare Advantage by directing HHS to perform PA audits, standardizing PA requirements, and exempting certain providers from PAs.
- The ***Medicare Advantage Improvement Act*** **(H.R.8375/S.4384)**, which reforms PAs in Medicare Advantage by requiring standard prior authorization decisions to be made within 72 hours of submission and expedited PA decisions to be made within 24 hours. The bill would implement other Medicare Advantage reforms, including establishing a compliance scoring system tied to financial penalties, ending retroactive denials, and requiring plans to follow Medicare fee-for-service standards for medical necessity (preventing them from using more restrictive criteria).
- The ***Stop Deadly Denials Act*** **(H.R.8377)**, which eliminates PAs for all Medicare Advantage Part A and Part B services unless required in traditional Medicare.

DELAYED AND DENIED CARE

PAs delay and deny care that a patient's **provider has already determined to be medically necessary**. Those barriers can lead to **abandoned treatment**, **financial strain**, and **worse health outcomes** through disease progression and increased hospitalization risk.

TIME-SENSITIVE CARE BARRIERS

The negative impacts of PA barriers are **particularly acute for time-sensitive care delivery**, such as cancer care and chronic disease treatment.

PROVIDER BURDEN AND BURNOUT

Providers spend **significant time submitting PA documentation**, **appealing denials**, and **navigating plan-specific rules and systems**. PAs have become a major contributor to **provider burnout** at a time when the US is already facing provider shortages.

OPAQUE, INCONSISTENT CRITERIA

PAs rely on **non-standard and opaque criteria** that vary across plans. The lack of transparency and consistency conflicts with the stated purpose of PAs as a clinically legitimate utilization management tool.