OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution No. 22 – 2024

Introduced by: Medical Student Section

Subject: Insurer Accountability When Prior Authorization Harms Patients

Referred to: Resolutions Committee No. 2

- -

WHEREAS, prior authorization (PA) is an advanced approval process that insurers and other payers use as a healthcare utilization management tool to deny payment for covered benefits when the payer deems the benefit clinically unnecessary;[1] and

WHEREAS, prior authorization requirements are rapidly increasing each year, which leads to not only increased administrative duties for physicians and their practice staff but also delayed care for patients;[2] and

WHEREAS, a 2022 study by our AMA on PA demonstrated that 88% of physicians experience high or extremely high administrative burdens due to prior authorization requirements and that 94% of physicians believe prior authorizations delay patient access to necessary care;[3] and

WHEREAS, the process of PA reviews, which health plans are frequently known to delegate to third-party contractors, causes significant delays in appropriate patient care that can lead to prolonged suffering and unnecessary deaths;[4] and

WHEREAS, the 2022 physician survey by our AMA found that 89% of physicians believe PA requirements have a negative impact on clinical outcomes for patients, with 33% of physicians reporting that PAs have led to their patients experiencing serious adverse health outcomes, including hospitalization, life-threatening events, or disability;[3] and

WHEREAS, other surveys by the American Society of Clinical Oncologists (ASCO), the American Cancer Society Cancer Action Network (ACS CAN), and the American Society for Radiation Oncology (ASRO) have reported similar findings, with nearly all oncologists in the 2023 ASCO reporting a patient experienced harms due to PA, including 35% who specifically attributed a patient's loss of life to prior authorization requirements;[5-8] and

WHEREAS, the data strongly suggests that insurers are denying justified healthcare, with the 2022 AMA physician survey reporting that only 1% of physicians

believe that PA criteria are always based on evidence-based medicine or specialty society guidelines;[3] and

WHEREAS, capitated payment models like Medicaid Managed Care and Medicare Advantage Organizations (MAOs), in which private companies are paid fixed amounts per enrollee based on expected costs regardless of whether the actual cost was higher or lower, create an incentive to minimize enrollee services and maximize PA denials;[9] and

WHEREAS, reporting by the Office of Inspector General (OIG) for the United States Department of Health and Human Services has frequently shown that many denials were inappropriate, with a 2022 report finding that 13% of PA denials met Medicare coverage requirements and 18% of payment denials met Medicare coverage rules and internal reimbursement guidelines;[9] and

WHEREAS, a 2023 Kaiser Family Foundation (KFF) study as well as two separate OIG reports found that, although just 11% of PA denials by MAOs are appealed, the vast majority of appeals were either completely or partially overturned;[10-12] and

WHEREAS, the KFF study and OIG reports noted that their findings were particularly concerning because the appeals process was largely underutilized by beneficiaries and providers with only 1% to 27% of initial denials ever being appealed, meaning insurers are incentivized to deny coverage knowing only a small portion of PA decisions will be formally appealed;[10-12] and

WHEREAS, despite increasing evidence of inappropriate PA denials by insurers, there currently is no consensus on how to hold insurers liable for denials that result in preventable injury to patients, with largely unsuccessful litigation strategies ranging from bad faith breach of contract to negligent breach of duty, and at least one effort in Texas preempted by the Employment Income & Retirement Act of 1974 (ERISA);[4,13-14] and

WHEREAS, even when state statute or case law permits a bad faith claim against an insurance company for a wrongful coverage denial and the claim is not preempted by ERISA, it’s often impossible to recover punitive damages, which may require proving that the insurance company acted with a higher degree of intent than that required for compensatory damages;[15] and

WHEREAS, in a recent New York case in which a delayed PA approval resulted in the preventable, rapid progression of a woman’s cancer, the U.S. District Court for the Southern District of New York ruled against the woman when it held that existing New York law does not impose a duty of reasonable care on insurance companies that engage in PA review, highlighting the need for aggressive state legislative reform to increase liability for state-regulated insurers;[16] and

WHEREAS, efforts to hold insurers liable for PA denials that result in preventable injury have been slowed by the increasing use of mandatory arbitration clauses in beneficiary contracts, which require beneficiaries to settle disputes out of court by an impartial third party rather than before a jury or judge and often include waivers that prevent beneficiaries from bringing class action suits;[17-18] and

WHEREAS, a 2019 review of arbitration clauses used by Fortune 100 companies found that many of the nation's largest health insurance companies, including UnitedHealth Group, Anthem, Aetna, and Cigna, impose mandatory arbitration clauses with class waivers on consumers;[18] and

WHEREAS, mandatory arbitration clauses are particularly insidious in health insurance contracts given the wide gap in bargaining power between the insurance company and beneficiary and limited selection of alternate insurers as a result of increasing consolidation in insurance markets;[19-20] and

WHEREAS, while arbitration may be preferred by some individuals, data suggests it is generally bad for consumers, as the median award for medical malpractice claims in Kaiser Permanente's arbitration program is nearly $400,000 less than median awards for medical malpractice jury trials in California;[21] and

WHEREAS, in addition to the federal Improving Seniors' Timely Access to Care Act (H.R.3173), nearly 90 prior authorization reform bills have been proposed in current state legislatures, many of which draw on our AMA's model legislation, but none of these proposed bills that have received AMA support address insurers' legal liability when patients are harmed by prior authorizations;[22-23] and

WHEREAS, though the OSMA has advocated extensively for the reformation of PA, its efforts have focused largely on streamlining the process rather than creating or enforcing legal liability for PA denials that injure patients;[27,28] and therefore

BE IT RESOLVED, that our OSMA advocate for increased legal accountability of insurers and other payers when prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration and limitation on class action clauses in beneficiary contracts.

Fiscal Note: $ (Sponsor)
$ 500 (Staff)

References:

1. Prior authorization practice resources. American Medical Association [web]. Updated May 18, 2023. Accessed August 26, 2023. https://www.ama-assn.org/practice-management/sustainability/prior-authorization-practice-resources

136 2. Ernst C. Virtually all medical groups say payer prior authorization requirements
137 aren't improving. MGMA Stat [web]. Published March, 2, 2022. Accessed August
138 26, 2023. https://www.mgma.com/mgma-stats/virtually-all-medical-groups-say-
139 payer-prior-authorization-requirements-aren-t-improving
140 3. 2022 AMA prior authorization (PA) physician survey. American Medical
141 Association [web]. Accessed August 26, 2023. https://www.ama-
142 assn.org/system/files/prior-authorization-survey.pdf
143 4. Henry TA. Cancer killed Kathleen Valentini, but prior auth shares the blame.
144 American Medical Association [web]. Published June 16, 2022. Accessed August
145 26, 2023. https://www.ama-assn.org/practice-management/prior-
146 authorization/cancer-killed-kathleen-valentini-prior-auth-shares-blame
147 5. New survey: utilization management delays cancer care; leads to more stress
148 and contributes to worse outcomes. ACS CAN Press Release [web]. Published
149 March 28, 2019. Accessed August 26, 2023.
150 https://www.fightcancer.org/releases/new-survey-utilization-management-delays-
151 cancer-care-leads-more-stress-and-contributes
152 6. Press kit: prior authorization obstacles to cancer patient care. ASTRO News and
153 Media Center [web]. Updated October 25, 2021. Accessed August 26, 2023.
154 https://www.astro.org/News-and-Publications/News-and-Media-Center/Press-
155 Kits/2019/priorauthpress
156 7. Association for Clinical Oncology. ASCO prior authorization survey summary.
157 ASCO [web]. Published November 2022. Accessed August 26, 2023. https://old-
158 prod.asco.org/sites/new-www.asco.org/files/ASCO-Prior-Auth-Survey-Summary-
159 November-2022.pdf
160 8. Trapani D, Kraemer L, Rugo HS, and Lin NU. Impact of prior authorization on
161 patient access to cancer care. ASCO Educational Book. May 23, 2023; 43. doi:
162 10.1200/EDBK_100036
163 9. Grimm CA. Some Medicare Advantage Organization denials of prior
164 authorization requests raise concerns about beneficiary access to medically
165 necessary care. US DHHS Office of Inspector General. April 2022.
166 https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf
167 10. Biniek JF and Sroczynski N. Over 35 million prior authorization requests were
168 submitted to Medicare Advantage plans in 2021. Kaiser Family Foundation [web].
169 Published February 2, 2023. Accessed August 26, 2023.
170 https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-
171 requests-were-submitted-to-medicare-advantage-plans-in-2021/
172 11. Levinson DR. Medicare Advantage appeal outcomes and audit findings raise
173 concerns about service and payment denials. DHHS Office of Inspector General.
174 September 2018. https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf
175 12. Murrin S. Some Medicare Part D beneficiaries face avoidable extra steps that
176 can delay or prevent access to prescribed drugs. DHHS Office of Inspector
177 General. September 2019. https://oig.hhs.gov/oei/reports/oei-09-16-00411.pdf
178 13. Mariner WK. The Supreme Court's limitation of managed-care liability. New
179 England Journal of Medicine. 2004;351(13):1347-1352.
180 doi:10.1056/nejmlim042143

181 14. Stern JB. Will the tort of bad faith breach of contract be extended to health maintenance organizations? Law, Medicine and Health Care. 1983;11(1):12-21. doi:10.1111/j.1748-720x.1983.tb00804.x
184 15. Bad faith insurance claims: are punitive damages available? Lee Cossell & Feagley, LLP. June 24, 2021. Accessed August 27, 2023. https://www.nleelaw.com/bad-faith-insurance-and-punitive-damages/
187 16. Valentini v. Grp. Health, 20 Civ. 9526 (JPC) (S.D.N.Y. Dec. 27, 2021)
188 17. Sachs S. The jury is out: mandating pre-treatment arbitration clauses in patient intake. Journal of Dispute Resolution. 2018;2018(2):116-131. https://scholarship.law.missouri.edu/cgi/viewcontent.cgi?article=1813&context=jdr
192 18. Szali IS. The prevalence of consumer arbitration agreements by America's top companies. UC Davis Law Review. 2019;52:233-259. https://lawreview.law.ucdavis.edu/online/vol52/52-online-Szalai.pdf
195 19. Dafny LS. Evaluating the impact of health insurance industry consolidation: learning from experience. November 20, 2015. Accessed August 26, 2023. https://www.commonwealthfund.org/publications/issue-briefs/2015/nov/evaluating-impact-health-insurance-industry-consolidation
199 20. Cogan JA. Readability, contracts of recurring use, and the problem of ex post judicial governance of health insurance policies. Roger Williams University Law Review. 2010;15(1):93-127. https://ssrn.com/abstract=1991348
202 21. Arbitration clauses in insurance contracts: the urgent need for reform. Public Citizen [web]. Accessed August 26, 2023. https://www.citizen.org/article/arbitration-clauses-in-insurance-contractsthe-urgent-need-for-reform/
206 22. H.R.3173 - 117th Congress (2021-2022): Improving Seniors' Timely Access to Care Act of 2021. Updated September 15, 2022. Accessed August 27, 2023. https://www.congress.gov/bill/117th-congress/house-bill/3173
209 23. O'Reilly KB. Bills in 30 states show momentum to fix prior authorization. AMA [web]. Published May 10, 2023. Accessed August 27, 2023. https://www.ama-assn.org/practice-management/prior-authorization/bills-30-states-show-momentum-fix-prior-authorization
213 24. H.R.3947 - 117th Congress (2021-2022): Justice for Patients Act. Updated June 17, 2021. Accessed August 27, 2023. https://www.congress.gov/bill/117th-congress/house-bill/3947
216 25. H.R.7780 - 117th Congress (2021-2022): Mental Health Matters Act. Updated October 11, 2022. Accessed August 27, 2023. https://www.congress.gov/bill/117th-congress/house-bill/7780/
219 26. S.1376 - 118th Congress (2023-2024): Forced Arbitration Injustice Repeal Act. Updated April 27, 2023. Accessed August 27, 2023. https://www.congress.gov/bill/118th-congress/senate-bill/1376
222 27. Policy Compendium. Ohio State Medical Association. (See relevant OSMA policy below).
224 28. Insurance Reform. Ohio State Medical Association. Accessed November 30, 2023. https://www.osma.org/aws/OSMA/pt/sp/insurance-reform
226
227

OSMA Policy:

Policy 09 – 2016 – Prior Authorization for Patients Injured at Work

1. The OSMA shall survey physician members who are treating patients with work related conditions to determine the problems associated with obtaining prior authorization for treatment including procedures and medications.
2. The OSMA shall request that the Bureau of Workers Compensation and self-insured employers address the problems associated with obtaining prior authorization for patients injured at work to allow treatment of patients to occur in a timely and appropriate manner.

Policy 19 – 2018 – Prior Authorization for Durable Medical Equipment (DME)

1. Denials of prior authorization for durable medical equipment (DME) must be based on true medical necessity not arbitrary time limits or other paperwork issues.
2. The OSMA continue to work to improve the prior authorization process including working with our Ohio Congressional Delegation and our American Medical Association to improve the process for Medicare Managed Care plans.
3. The OSMA Delegation take this policy to the American Medical Association Annual Meeting.

Policy 14 – 2019 – Compensation for Prior Authorization Services

1. The OSMA opposes pre-authorization as a requirement for patient care.
2. The OSMA shall seek legislation that provides for appropriate compensation to physician offices for expenses incurred in obtaining prior authorizations for patient care.

Policy 23 – 2022 – Prohibit Reversal of Prior Authorization

1. The Ohio State Medical Association (OSMA) supports legislation to prohibit retroactive denial of a previously approved medication, procedure, or test unless the patient is no longer insured by that company at the time of service.
2. The OSMA delegation to the AMA will take this topic regarding reversal of prior authorization to the AMA House of Delegates to advocate for this change as a part of their greater effort to eliminate prior authorization all together.

Policy 10 – 2023 – Supporting Increased Access to HIV Prevention Medication

1. The OSMA opposes prior authorization requirements for HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medications.
2. The OSMA supports requiring state-regulated payers to cover full costs of HIV prevention medications and related services, including screenings, diagnostic procedures, administrative fees, and clinical follow-ups in-person or via telemedicine, without any cost-sharing obligation for the plan holder.
3. The OSMA supports legislation requiring all payers in Ohio to add long-acting injectable variations of PrEP to their formularies to ensure that they are accessible to eligible patients.

Policy 25 – 2023 – Codifying Efforts for Legislative Action on Prior Authorization

1. The OSMA will seek legislative solutions to reduce the burden of prior authorization requirements.

273 2. The OSMA advocacy team will report back annually to the House of Delegates on the status
274 of prior authorization advocacy efforts unless deemed unnecessary by Council.
275