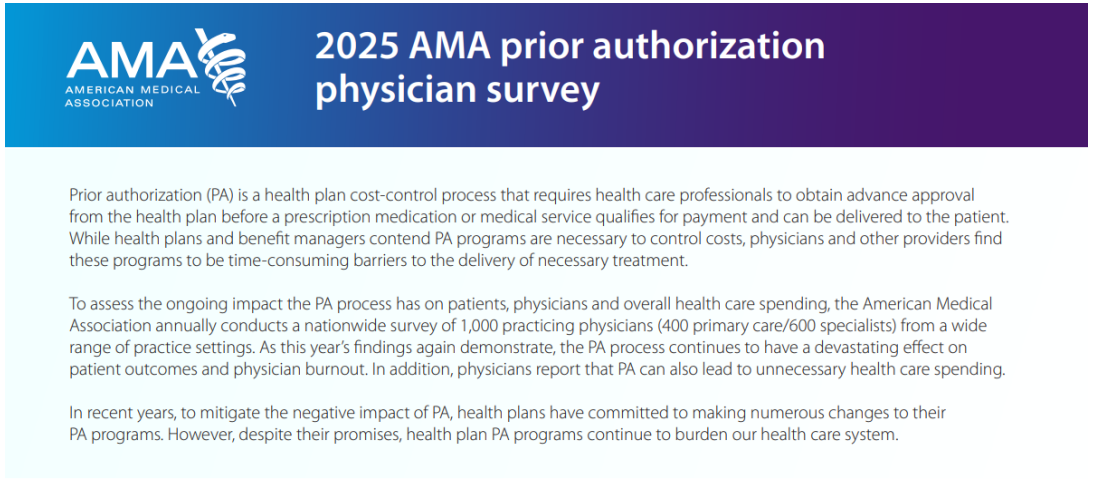
Prior Authorization: Physicians' experience and opportunities for meaningful reform

National Association of Insurance Commissioners Regulatory Framework (B) Task Force

August 31, 2026

AMA Prior Authorization Physician Survey

- Fielded in **December 2025**
- 1000 practicing physicians
  - 400 Primary care physicians
  - 600 Specialists
- Respondents screened to ensure:
  - Currently practice in United States
  - Provide 20+ hours of patient care a week
  - Complete PAs during a typical week of practice



AMA AMERICAN MEDICAL ASSOCIATION

2025 AMA prior authorization physician survey

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. While health plans and benefit managers contend PA programs are necessary to control costs, physicians and other providers find these programs to be time-consuming barriers to the delivery of necessary treatment.

To assess the ongoing impact the PA process has on patients, physicians and overall health care spending, the American Medical Association annually conducts a nationwide survey of 1,000 practicing physicians (400 primary care/600 specialists) from a wide range of practice settings. As this year's findings again demonstrate, the PA process continues to have a devastating effect on patient outcomes and physician burnout. In addition, physicians report that PA can also lead to unnecessary health care spending.

In recent years, to mitigate the negative impact of PA, health plans have committed to making numerous changes to their PA programs. However, despite their promises, health plan PA programs continue to burden our health care system.

fixpriorauth.org/sites/default/files/2026-05/2025-prior-authorization-survey.pdf

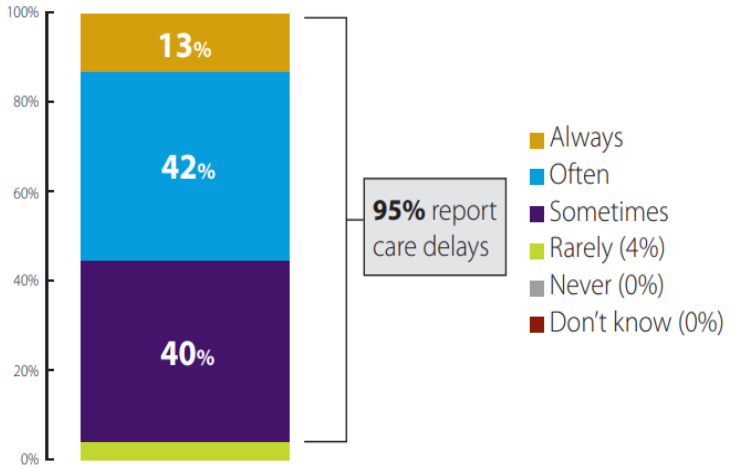
Prior authorization harms patients

26% of physicians report that PA has led to a serious adverse event for a patient in their care.

20% report that PA has led to a patient's hospitalization
22% report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage
8% report that PA has led to a patient's disability, permanent bodily damage, congenital abnormality/birth defect or death

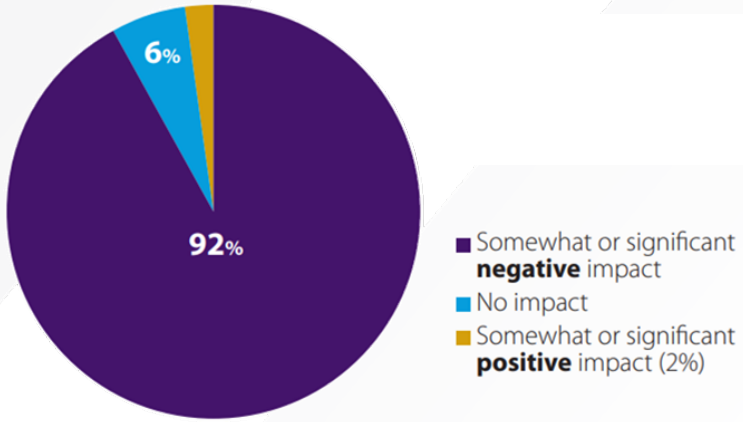
Care delays associated with PA

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



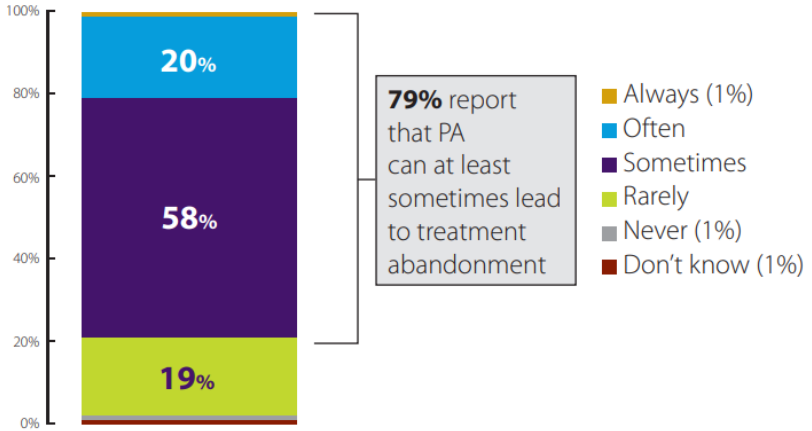
Impact of PA on clinical outcomes

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



Treatment abandonment due to PA

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



The Pattern is Getting Worse

74% of physicians report denials have increased over the past five years

32% say requests are often or always denied outright

"I've been denied a treatment that worked for 11 years."

Gina F.,
New York

"I am constantly receiving automatic [prior authorization] denials for necessary medicines for my multiple sclerosis (MS) patients."

Ted R., MD,
District of Columbia

Prior Authorization Burdens Practices and Physicians

On average, practices complete

40

PAs per physician, per week

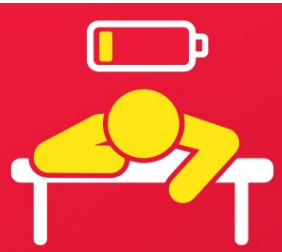
Physicians and their staff spend

13 HOURS

each week completing PAs

40%

of physicians have staff who work exclusively on PA

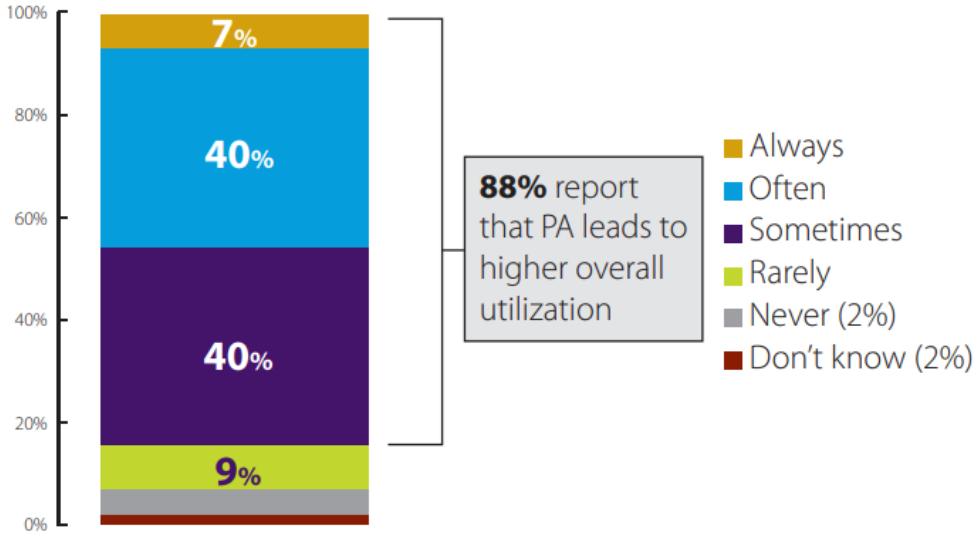


94%

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

Prior Authorization Wastes Health Care Resources

Q: Please consider how your patients' utilization of health care resources is impacted by the PA process. In your experience, how often does the PA process lead to higher overall utilization of health care resources?



Percentages do not sum to 88% due to rounding.

Q: In which of the following ways has the PA process led to higher overall utilization of health care resources for patients in your care?

75% report ineffective initial treatment (e.g., due to step therapy requirements)

73% report additional office visits

47% report immediate care/ER visits

32% report hospitalizations

Policy solutions: Opportunities for state policymakers

Faster response times

24 hours for urgent care and 48 for nonurgent.

Use of APIs and ePA w/ standard transactions (must be paired with other solutions since, by itself, ePA could increase use of prior authorization and automation doesn't fix faulty criteria).

Reducing prior authorizations

A prior authorization should be good for the course of treatment.

Eliminate prior authorization for care with high approval rates.

Ensuring clinical integrity

Denials made by physician of same specialty, licensed in the state, experience treating condition.

Clinical criteria based on nationally recognized standards of care developed by medical specialty societies.

Data collection and reporting

Rates of approval, denials, appeals, response times, more.

Available to patients, providers, and policymakers.

Summary reports by regulators.

Continuity of care

90+ day grace period when patient is switching plans.

Prevent repeat prior authorizations.

Transparency and more

Decisions are binding (no retroactive denials).

Public clinical criteria and prior authorization requirements.

Reason for adverse determination.

Appeal processes.

Reforms should apply to medical services *and* prescription drugs, devices.

Rightsizing the volume of prior authorization

Reducing the volume of prior authorization on drugs and services prevents delays and waste.

Meaningful volume reductions:

- Easy to identify what requires PA and what does not.
- Streamline notification to patients and physicians when service or drug PA is removed.
- Treat effort not as an exercise in shortening a list, but meaningful changes that patients and physicians will feel.

To inform these efforts, public and regulatory **reporting of PA data** at the individual service and drug level and at the individual product level.

- Too often the data are not granular enough and the service lines are invisible, providing limited insight in the PA programs and outcomes.
- Often only report percentages (rather than number of PA requests), which limits the ability to understand the scale of requests, denials, and approvals behind the percentages.
- Data can identify problem areas and target reforms where they can protect patients most.
- Use the evidence to remove, narrow, or exempt drugs and services.

Evidence-based criteria must power automation

Automation simply accelerates whatever criteria sits underneath it.

The clinical criteria used for prior authorization should:

- Be accurate and up-to-date clinical criteria aligned with and reflective of national medical specialty society guidelines and peer-reviewed clinical literature. Not enough to reference such criteria or have it “based-on” the criteria but with plan deviations.
- Allow for appropriate flexibility for individual patient circumstances, as appropriate treatment depends on the patient’s unique clinical circumstances.

Both the clinical criteria and the referenced clinical information should be readily available to the treating physicians and the public.

Over one-third

of physicians report that clinical criteria are rarely or never evidence-based.

Without evidence-based criteria, automation only reaches the wrong decision faster.

Qualified physician review prevents avoidable denials

Unqualified reviewers make erroneous adverse determinations that reduce access, increase financial stress on patients, and are infrequently appealed

- KFF survey: among patients who report denials, delays, or alterations, about a third say it had a "major negative impact" on their mental health and emotional well-being (34%) and finances (33%), and a quarter say it had a "major negative impact" on their physical health (26%).
  - Insurers denied between 12% and 18% of standard prior authorization requests in 2025 (KFF)
  - When appealed, regularly overturned
- 74% of physicians say denials have increased in the last 5 years, but only 1 in 5 say they always appeal—reasons being perceived outcome, lack of resources, urgency of care.

Only 1 in 4 (24%) of physicians agree that health plan denials are based on medical necessity are being reviewed by a licensed and qualified physician.

Only 16% of physicians participating in peer-to-peer reviews report that the health plan's "peer" often or always has the appropriate qualifications.

To make an adverse determination:

Licensed in the state

A physician accountable to professional standards

Same specialty

Aligned with the treating physician's specialty

Clinically current

Trained and experienced in the service under review

Departments of Insurance could consider:

- Data calls, targeted investigations, market analysis programs, and market conduct exams to evaluate compliance.
- Engaging with local consumer and physician organizations to garner insight into implementation and areas in need of regulator attention.
- Developing educational materials for patients, physicians and providers to increase awareness about existing protections.
- Coordinating across impacted departments, including sharing of information, to help ensure consistent enforcement and identify noncompliance.
- Increasing data reporting from plans, including data on conformity with reform pledge.
- Forcing corrective action when health plans are out of compliance.

Regulatory Framework Task Force could consider:

- Aggregating states' experiences with implementation, including challenges with enforcement and identify best practices for addressing challenges.
- Developing templates for states to use in their prior authorization data collection efforts so that data can easily be analyzed across payers and across markets.
- Establishing a working group to focus on enforcement opportunities and regulator interventions.

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Thank you!

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