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AHA Report on Commercial Insurer Practices: "Clinicians Should be Able to Focus on Caring Without Burdensome Obstacles"

A new report issued from the American Hospital Association (AHA) says patient access to the health care system is eroding as some concerning and burdensome commercial health care practices are growing. Such practices contribute to clinician burnout, patient care delays for necessary treatments, and billions of wasted dollars in the health care system.

"Patients should be able rely on their health insurance plan to facilitate covered, medically necessary health care services when they need it without delays or inappropriate denials, and clinicians should be able to focus on caring without burdensome obstacles," the report states.

The report points out that some insurers work with providers in a collaborative way to improve value to patients. However, concerning practices by some are growing, with 78% of hospital and health system respondents to an AHA survey indicating their experience working with some commercial insurers is getting worse.

The report focuses on prior authorization as one of the most widely used insurer utilization management practices. Its intent is to ensure providers are ordering care consistent with clinical guidelines and protocols and to ensure the care is covered by the patient's plan. But inappropriate use of prior authorization has detrimental effects on patients, providers and overall health care costs.

AHA has gathered several examples of the inappropriate use of prior authorization, including one patient that was denied care for a psychotic episode simply because they did not have a prior history of psychotic episodes. Such practices have resulted in bloated administrative costs—one 355-bed psychiatric facility, for example, needs 24 full-time equivalent staff just to deal with prior authorizations. And in Wisconsin, UW Health has estimated that it spent $18.2 million in 2019 managing prior authorizations, with 65 FTE dedicated to handling these processes.

The report points to many reasons why this administrative burden is often unnecessary, including that insurers may broadly require prior authorizations for services or treatment protocols that are well-established or have little variation. For example, one respondent to a 2019 AHA survey indicated that a prior authorization review that could take up to 24 hours was required just to give insulin, a well-established treatment protocol, to a patient that presented with a blood glucose level at five times the acceptable range.

Insurer practices around prior authorization vary, with some insurers requiring significant, duplicative or even unnecessary documentation. And insurers themselves may not have the staff to handle the volume of requests. In 2018, 98 hospitals reported nearly 865,000 prior authorization requests that received no response from insurers requiring additional follow-up from providers.

AHA points out that 68% of prior authorization denials are overturned after providers appeal the initial decision, calling into question the need for many of the prior authorization requests in the first place. With the incredible burden imposed on both patients and providers, AHA calls for regulators to increase oversight to ensure that patients have access to covered services and to prevent inappropriate prior authorization and payment delays. This includes improving data collection and public reporting, setting thresholds for appropriate levels of prior authorizations, applying financial penalties for inappropriate denials of care or reimbursement, and ensuring that inadequate provider networks aren't contributing to prior authorization delays.

AHA also calls for action to standardize prior authorization processes and improve the timeliness of responses including requiring insurers to have staff available at all hours. Hospitals care for patients 24 hours per day, 7 days a week, 365 days per year, and responses to prior authorization requests are needed 24/7 as well.

AHA says these actions will help improve care, make the health system more navigable, reduce clinician burnout and decrease unnecessary costs and burdens in the system.

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