AAOS
American Association of Orthopaedic Surgeons

Prior Authorization: Physician Burnout, Worse Health Outcomes, and Greater Expense

Issue Introduction:

Prior authorization is one example of the administrative rules that payers use to manage healthcare utilization and determine what they will reimburse. From a state policy perspective, it is important to understand how legislators and organizations are addressing healthcare utilization, review processes, and adverse determinations.

Different Names, Same Purpose*:** While most physicians are aware of the prior authorization model in practice, the systems and rules used by payers to administer plans and coverage are constantly changing and evolving. Terms and practices like ***prior authorization, step therapy, fail-first, quantity limit, and others all refer to different frameworks of healthcare utilization, but generally can be thought of as having the same end goal; administrative rules for controlling costs associated with medical care by requiring approval for procedures — with determinations made by outside physicians, or even non-medical entities — based by what is covered by a plan rather than what would provide the best outcome for any given patient.

Utilization reform must then take many different forms to address the new and emerging reform efforts from payers. The terms or practice may change, but the issue remains the same: ensuring that treatments are controlled by healthcare providers and not by payers.

The Facts: Prior Authorization continues to lead to delays in care and ultimately worse health outcomes for the patient body. Research and physician surveys have time and again shown that reform is needed around prior authorization to ensure that physicians can treat their patients without high administrative burden and burnout.

- Young Physicians are likely to experience burnout and trouble with adjusting from the traditional focus of medical school to the reality of a highly regulated, more business and administration focused reality of medicine.[1]
- This is especially difficult for Physicians who work with underserved and marginalized communities, that may already struggle with burnout to a higher degree due to feelings of powerlessness.[2]
- More than one in four physicians (29%) report that prior authorization has led to a serious adverse event for a patient in their care, according to a 2024 physician survey by the AMA.
  - This same survey found that more than four in five physicians (82%) reported that patients abandon treatment due to authorization struggles with health insurers.[3]

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[1] Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med. 2014;89(3):443-451. doi:10.1097/ACM.0000000000000134

[2] Eisenstein L. To Fight Burnout, Organize. N Engl J Med. 2018;379(6):509-511. doi:10.1056/NEJMp1803771

[3] American Medical Association, American Medical Association. Physicians concerned AI increases prior authorization denials. American Medical Association. https://www.ama-assn.org/press-center/ama-press-releases/physicians-concerned-ai-increases-prior-authorization-denials. Published February 24, 2025.

Policy Position:

Prior Authorization Reform is a Tier One (Active Pursuit) AAOS priority. The current structure and relationship that exists between payers, physicians, and patients is not conducive to long term positive health outcomes or healthcare administration.

AAOS believes that broad reforms are necessary to ensure speedy and effective treatment for patients that can be delivered by unimpeded physicians. **AAOS supports both federal and state-level legislative and advocacy solutions to reform the system and ensure orthopedic surgeons can continue to safely provide patient care, with minimal delays in a review process administered by physicians.**

Per the AMA, Policymakers should consider the following prior authorization reforms:

- Establish quick response times (24 hours for urgent care, 48 hours for non-urgent care).
- Adverse determinations should be made only by a physician licensed in the state and of the same specialty that typically manages the patient's condition.
- Prohibit retroactive denials if care is preauthorized.
- Authorization should be valid for at least 1 year, regardless of dosage changes, and for those with chronic conditions, the prior authorization should be valid for the length of treatment.
- Require public release of prior authorization data by drug and service as it relates to approvals, denials, appeals, wait times and more.
- A new health plan should honor the patient's prior authorization for at least 90 days.
- Target volume reduction through the use of solutions such as exception or gold-carding program.

Ways to Engage:

AAOS encourages physicians and state societies to collaborate by supporting national legislative efforts through sign on letters and communication with legislators. At the state level, we encourage physicians to work with their state societies to advocate to legislators to pass common sense reforms for utilization review and prior authorization.

For more information or ways to engage, please reach out to AAOS VP of Government Relations:

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2025 State Wins

State	Bill Number	Descriptor	Notes
Montana	HB 398	Generally, revise insurance laws related to prior authorization of chronic conditions.	Changes to prior authorization rules pertaining to chronic conditions, exemptions for continuity of care, and qualifications of individuals making or reviewing adverse determinations. **Signed into law March 28th, 2025.**
Washington	HB 1706	API modernization and broad Prior Authorization Reform	Aligns API in the state of Washington with CMS guidelines, modernizing and ensuring timely responses for electronic PA requests. Reduces administrative burden and improves systems for physician use. **Signed into law April 7th, 2025**.
North Dakota	SB 2280	API modernization and broad Prior Authorization Reform	Modernizing and ensuring timely responses for electronic PA requests, along with regulation for who serves on review boards and how policy changes are displayed on coverage entity webpages. Reduces administrative burden and improves systems for physician use. **Signed into law April 23rd, 2025.**
Oklahoma	HB 1810	API modernization and broad Prior Authorization Reform	Modernizing and ensuring timely responses for electronic PA requests, along with regulation for who serves on review boards and how policy changes are displayed on coverage entity webpages. Reduces administrative burden and improves systems for physician use. **Became law May 25th, 2025**
Iowa	HF 303	Prior Authorization Reform	Measure creates a timeline for responses by a utilization review organization; requires a utilization review organization to annually review all health care services for which the health benefit plan requires PA and eliminates PA requirements for health care services for which prior PA are routinely approved. **Signed into law May 27th, 2025.**

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2026 State Wins

State	Bill Number	Descriptor	Notes
Iowa	HF 2635	Prior Authorization Reform .	Significant reforms to PA which require that only clinical peers or qualified reviewers may deny or downgrade PA requests. The bill also exempts cancer screenings and emergency conditions requiring immediate inpatient treatment from PA requirements across private insurance plans and Medicaid-managed care plans. The law also requires: • Human review required before AI-based denials • Written explanation for denials/downcoding • Same-specialty peer-to-peer reviews • Protection for out-of-network referrals The bill also includes certificate of need reforms to give the legislation broader appeal and ensure its passage. **Signed into law May 13th, 2026.**

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2026 Federal Action

AAOS Comments on CMS Electronic Prior Authorization for Drugs Rule

AAOS highlighted broad concerns with PA processes, our support for a streamlined electronic PA process for medications, and detailed recommendations on step therapy guardrails. We recommend:

- Standardized electronic PA process
- Faster payer response times (48 hours)
- Automatic approval when deadlines are missed
- Transparency and public reporting

Technology should reduce burden, not create new barriers. AAOS continues to support efforts to modernize prior authorization through electronic processes.

We recently submitted comments supporting a more standardized electronic prior authorization system across payers.

- We also recommended shorter response timelines and stronger accountability measures when plans fail to meet required deadlines.
- In addition, AAOS continues to advocate for meaningful guardrails around step therapy, including standardized exception processes and greater transparency.
- The goal is to ensure technology improves efficiency without creating new obstacles to patient care.

AAOS Recommendations on Step Therapy

Treatment decisions should be driven by patient needs and physician expertise—not rigid utilization management protocols. Step therapy is often viewed separately from prior authorization, but from a physician and patient perspective it creates many of the same barriers to timely care. We recommend:

- Require a step therapy exception process
- Standardize exceptions across payers
- Leverage technology to streamline requests
- Publicly report step therapy metrics
- Preserve physician clinical judgment

AAOS Legislation to Combat "Clawbacks"

AAOS is currently working to draft legislation that combats retroactive denials of services and procedures already rendered:

- Based on current statute in Connecticut
- Developed through a prior authorization workgroup of AAOS surgeon volunteers

Legislation would:

- Require plans to honor approved prior authorizations
- Prohibit retroactive medical necessity denials
- Limit downcoding
- Restrict claim reopening except for fraud or good cause

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Prior Authorization Reform

Prior authorization (PA) requirements are used by Medicare Advantage (MA) plans to help ensure high-quality, cost-effective care while preventing unnecessary utilization.

In reality, the current prior authorization system imposes excessive administrative burdens on medical practices through complex requirements and electronic health record maintenance, reducing physicians' time with patients and increasing operational costs. It also regularly delays or completely prevents patients from receiving necessary care and negatively interferes with the doctor-patient relationship that is at the center of quality care.

WISeR (Wasteful and Inappropriate Service Reduction Model): CMMI launched this model on January 1 to test technology-enabled approaches to streamline and expedite prior authorization for services identified as low-value or at risk of fraud, waste, and abuse in original Medicare. It impacts providers in six states who perform included services such as arthroscopic knee procedures, epidural steroid injections, spinal fusion, and vertebral augmentation. AAOS is working with CMMI to make constructive changes that will improve the model for physicians, including consideration of gold carding protections.

The Improving Seniors' Timely Access to Care Act

The Improving Seniors' Timely Access to Care Act (H.R. 3514/S.1816) prioritizes patient care over paperwork by modernizing and streamlining the prior authorization process in Medicare Advantage. This legislation would mandate electronic prior authorization for MA plans, standardize transactions and clinical documentation requirements, increase transparency around MA prior authorization practices. and empower CMS to establish clear timeframes for prior authorization decisions. Since the bill codifies several key provisions of CMS's January 2024 final Interoperability and Prior Authorization rule (CMS-0057-F) it has received a zero-cost score from the Congressional Budget Office.

Most recently, the bill reached a critical threshold of 290 House cosponsors, an overwhelming bipartisan majority. This number is the threshold required for placement on the House Consensus Calendar and we are hopeful that this achievement will build momentum to bring the bill forward for markup.

WHAT AAOS MEMBERS CAN DO

Share your prior authorization story with our team!