AMA
AMERICAN MEDICAL ASSOCIATION

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September 19, 2025

Michael E. Chernew, PhD
Chair
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Re: American Medical Association Comments on September 2025 Meeting

Dear Dr. Chernew:

On behalf of the physician and medical student members of the American Medical Association (AMA), we are pleased to provide resources to the Medicare Payment Advisory Commission (MedPAC) regarding prior authorization and consolidation, two topics discussed during the September 2025 meeting. We appreciate your consideration of these findings and would welcome the opportunity to meet with you to discuss them further.

Prior Authorization

In its deliberations on Medicare payment operations and improving payment accuracy, MedPAC discussed prior authorization as one of CMS' efforts to ensure proper payments in Medicare. We were pleased that Commissioners raised concerns about its negative impact on patients and physicians. Our resources lend support to these concerns.

In a December 2024 survey of 1,000 practicing physicians, an overwhelming majority (93 percent) reported that prior authorization delays patient care, with 82 percent stating that the process can lead to treatment abandonment and 94 percent linking it to negative patient clinical outcomes. More than one in four (29 percent) surveyed physicians said that prior authorization has led to a serious adverse event for a patient in their care, such as hospitalization, disability, or even death.

Beyond this troubling human cost, the survey results reinforce the significant practice burdens and expenses associated with this process: 40 percent of physicians indicated that they have staff who work exclusively on prior authorization. Finally, this data raises serious doubts that prior authorization reduces health care costs: 88 percent of physicians reported that prior authorization leads to higher overall utilization of health care resources due to factors such as additional office visits, ineffective initial therapies, and emergency department visits.

Health plans' use of unregulated artificial intelligence (AI) automation and predictive tools in prior authorization is increasingly overriding clinical judgment and generating coverage denials with little or no human review. Our survey found that three in five physicians (61 percent) are concerned AI is increasing prior authorization denials. According to the AMA's *Physician Sentiments Around the Use of AI in Heath Care: Motivations, Opportunities, Risks, and Use Cases* report, based on a survey of more than 1,000 physicians conducted in November 2024, nearly half of physicians (49 percent) ranked oversight of

payers' AI use in medical-necessity determinations among their top three regulatory priorities. AI should augment decision-making rather than replace physician-led determinations; robust oversight is needed to prevent automated, systematic batch denials from undermining access to necessary care.

The AMA led the development of the 2018 Consensus Statement on Improving the Prior Authorization Process, which outlines key areas of prior authorization policy change agreed upon by national health care professional organizations and insurer trade associations. To reduce administrative burden and promote access to safe, timely care, the consensus statement covered five topics:

1. Selective application of prior authorization.
2. Prior authorization program review and volume adjustment.
3. Transparency and communication regarding prior authorization.
4. Continuity of patient care.
5. Automation to improve transparency and efficiency.

Unfortunately, despite being released nearly seven years before the 2024 survey was fielded, physicians report that health plans have made little progress honoring their commitments as outlined in the consensus statement. For instance, 58 percent of physicians report that the number of generic medications that require prior authorization has increased over the last five years, and 61 percent of physicians report that prior authorization at least sometimes destabilizes a patient whose condition was previously stabilized on a specific treatment plan.

In June 2025, AHIP and Blue Cross Blue Shield Association announced commitments to improve prior authorization, with the outlined changes echoing those agreed to in the 2018 Consensus Statement. While the AMA appreciates the gesture; we will be closely monitoring the implementation and impact of these pledges. In addition, we continue to advocate for the critical improvements outlined in our Prior Authorization and Utilization Management Reform Principles to ensure patients' timely access to care and reduction of administrative burdens for physician practices.

Finally, the Commissioners briefly discussed the Center for Medicare and Medicaid Innovation (CMMI) Wasteful and Inappropriate Service Reduction (WISeR) Model. The AMA sent a letter to CMMI outlining several recommendations to ensure that efforts to reduce low-value care are implemented in a way that supports high-quality, patient-centered medical practice and includes robust guardrails to protect patients and physicians. We continue to meet with CMMI about opportunities to improve the WISeR model.

Consolidation

During its September 2025 meeting, MedPAC discussed consolidation across health care sectors as part of its Medicare payment context chapter. The AMA has done extensive work in this space, particularly focused on competition in the pharmacy benefit manager (PBM) and health insurance markets, and we share our findings to help inform your discussions on this topic.

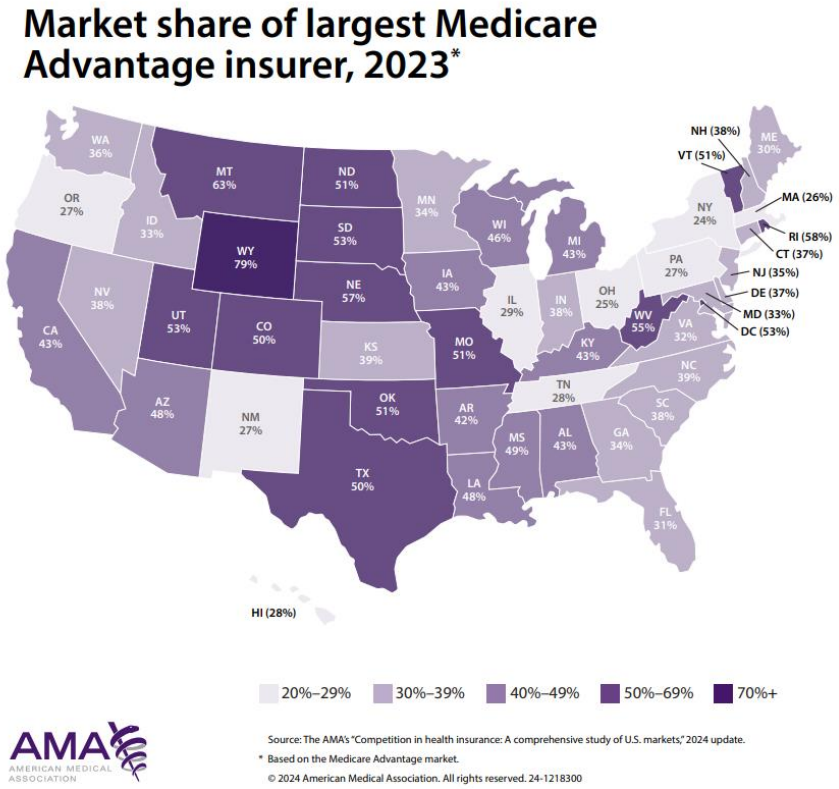
First, the AMA analyzed whether PBM markets are competitive, an important question of public policy because less competition can lead to consumer harm. Using 2022 and 2023 data on prescription drug plan (PDP) lives and the PBM used by insurers to perform five PBM functions, this paper titled *Competition in PBM Markets and Vertical Integration of Insurers with PBMs: 2025 Update* presents a descriptive analysis of PBM markets and the provision of PBM products to insurers. It reports the ten largest PBMs and drug insurers in the U.S. at the national level. The paper also summarizes concentration levels (HHIs) in those PDP region-level PBM markets.

In 2023, the four largest PBMs at the national level (i.e., OptumRx, CVS Health, Express Scripts, and Prime Therapeutics) provided rebate negotiation services for a collective 67 percent of drug lives. With regard to local competition among PBMs providing rebate negotiation, retail network management and claims adjudication, the average HHI across PDP regions is around 2300. Seventy-four percent to 82 percent of PDP region-level PBM markets are highly concentrated (HHI>1800) across those three PBM functions. Finally, PDP insurance markets are highly concentrated on average as well. The average PDP-region HHI was 2605 in commercial PDP insurer markets, 2389 in Medicare Advantage PDP insurer markets, and 2076 in standalone PDP insurer markets.

The PBM report also estimated the extent of vertical integration between PDP insurers and PBMs. When looking at just Part D prescription drug plan lives, 88 percent were in a plan where the insurer and PBM were vertically integrated. In addition, nine of the 10 largest PBMs share ownership with health insurers. This analysis is intended to provide insight to help policymakers understand the anticompetitive conditions in the PBM market that can result in competitive harm to patients.

Second, each year, the AMA conducts a Competition in Health Insurance study to help lawmakers and others understand whether health insurance markets are competitive or whether insurers have market power, which can harm consumers, physicians, and qualified health care professionals. It is the only publication of its kind and is based on an analysis of unique enrollment data from a single data source for health insurers in all states and metropolitan statistical areas (MSAs) of the U.S.

The 2024 CHI study presents 2023 data on the degree of competition in commercial and Medicare Advantage (MA) health insurance markets. Specific to MA markets, 97 percent of MSA-level markets were highly concentrated in 2023. The average MSA-level HHI was 3129. In 91 percent of MSAs, at least one insurer held a market share of 30 percent or greater, and in 30 percent of MSAs, one insurer's share was at least 50 percent. Below is a map showing the market share of the largest MA insurer in each state in 2023.



We appreciate the opportunity to provide comments about MedPAC's September 2025 meeting and your attention to these important topics. The AMA stands ready to assist you as you explore them in more detail in the future. Please reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org if you have questions or need further information.

Sincerely,

John Whyte, MD, MPH