HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

April 2, 2025

Hon. Mark Green
2446 Rayburn House Office Building
Washington, DC 20515

Dear Representative Mark Green:

The Healthcare Business Management Association (HBMA) is pleased to share this letter with you expressing our support for the Reducing Medically Unnecessary Delays in Care Act of 2025. Administrative burdens like prior authorizations take valuable time away from patient care and contribute to physician burnout. This bill is an important step in reducing these burdens and will enable medical practices to focus on providing timely, high-quality care.

HBMA, a non-profit professional trade association, is a major voice in the revenue cycle management industry in the United States. HBMA is a recognized revenue cycle management (RCM) authority by both the commercial insurance industry and the governmental agencies that regulate or otherwise affect the U.S. healthcare system.

RCM companies play an essential role in the operational and financial aspects of the healthcare system. The RCM process involves everything from the lifecycle of a claim to credentialing, coding, and managing participation in value-based payment programs. Our work on behalf of medical practices allows physicians to focus their attention and resources on patient care—where it should be directed—instead of on the many administrative burdens they currently face, such as prior authorization.

Medical practices face daily care disruptions and denials due to overburdening and excessive prior authorization requirements. Medical practices must dedicate a large portion of staff and financial resources to complying with these requirements. If passed, this bill would require board-certified clinicians with relevant medical backgrounds adjudicate prior authorization requests.

This approach ensures qualified medical experts assess these requests, not algorithms. We strongly support how the bill would ban artificial intelligence (AI) from deciding prior authorization requests. Three of the largest Medicare Advantage Organizations (MAO), UnitedHealth Group, Humana and Cigna, are each involved in class action litigation regarding their use of AI in prior authorization. The UnitedHealth Group litigation cites the “illegal deployment of artificial intelligence in place of real medical professionals to wrongfully deny elderly patients care owed to them under Medicare Advantage Plans by overriding their treating physicians’ determinations as to medically necessary care based on an AI model that Defendants know has a 90% error rate."

HBMA supports this bill’s approach to standardizing prior authorization processes and criteria across Medicare Advantage plans. Currently, most plans rely on differing and inconsistent prior

authorization processes. This creates additional, unnecessary work for medical practice staff. This approach will help streamline the prior authorization process so doctors can instead direct their attention to caring for patients.

We believe there are opportunities for the bill to go further. For example, it is important to understand that prior authorization does not guarantee payment. In many cases, a health plan will approve a prior authorization only to deny payment after an RCM company submits the claim. This creates additional layers of preventable burdens.

We also believe that Congress needs to create greater oversight for how health plans use AI in prior authorization reviews. Under current law, it is too easy for a medical reviewer to rubber stamp an AI algorithm's recommendation. Congress should require more transparency in how health plans use AI in the prior authorization process and place stricter limits on how MA plans use AI to review prior authorization requests.

Additionally, we encourage Congress to support "gold card" programs that exempt clinicians with high rates of prior authorization approvals from prior authorization requirements.

Commercial plans should align their approach to prior authorization with that of traditional Medicare, which uses prior authorization in a highly targeted way for specific items or services that evidence demonstrates are susceptible to improper billing. Currently, traditional Medicare does not have any prior authorization requirements for items or services furnished in non-hospital settings.

While we believe there is a greater need for consistency across Medicare Administrative Contractors (MACs), Local Coverage Determinations (LCDs) provide upfront transparency on how Medicare will cover a service. This transparency prevents the need for prior authorization.

Thank you for your leadership on this important issue. We greatly appreciate the work you are doing to help medical physicians and our patients. Please do not hesitate to contact Matt Reiter (reiterm@capitolassociates.com) or Brad Lund (brad@hbma.org) if you wish to discuss our recommendations further.

Sincerely,

Krik Reinitz
President
Healthcare Business Management Association