AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Michael Sarge Pollock
Chair
Health Insurance & Long-Term Care Issues Committee
National Council of Insurance Legislators
616 5th Avenue, Suite 106
Belmar, NJ 07719

RE: AMA comments draft NCOIL Prior Authorization Reform Model Act

Dear Chairman Pollock:

On behalf of the physician and student members of the American Medical Association (AMA), thank you for the opportunities to engage with the National Council of Insurance Legislators' (NCOIL) Health Insurance & Long-Term Care Committee (the Committee) on the draft Prior Authorization Reform Model Act (draft model act).

We appreciate many of the meaningful changes adopted as part of the most recent draft including shortening the response times for health plan decisions and extending the length of approvals to 12 months. The most current version of this drat model act (October 14, 2025) is a strong and balanced reform bill that will improve patients' access to care.

As you move toward consideration of the bill at the NCOIL November meeting, however, we urge the Committee to make a few final changes to ensure that medical necessity decisions are made by qualified physicians, data collected by regulators is robust and usable, and prior authorization automation standards are aligned with new federal requirements. These suggestions are detailed below.

Section 10: Include strong qualifications of the reviewer for adverse determinations

The AMA recommends that Section 10 of the draft model act be revised to require that only a physician licensed in the state, of the same specialty as the treating physician, and with the training, knowledge, and experience of providing the health care services under review is able to make an adverse determination and a denial on appeal. These changes will help reduce inappropriate initial denials and increase access to timely, medically necessary care.

Too often unqualified reviewers make erroneous adverse determinations that are infrequently appealed, reducing access to needed care and increasing financial stress on patients. Seventy-five percent of physicians report that denials have increased in the last five years, but only one in five says they always appeal due to the perceived outcome of the appeal, lack of resources to complete the appeal, or the urgency of care that necessitates timely treatment.

Similarly, data from the Kaiser Family Foundation (KFF) show that only 11.7 percent of prior authorization denials in Medicare Advantage are appealed but 81.7 percent of appeals were overturned. KFF survey data also show that of patients who experienced claim denials, 26 percent experienced significant treatment delays, 24 percent were unable to receive recommended care, 24 percent experienced a decline in health, and 55 percent ended up paying more for care than they had expected.

Because it is critically important to get it right at the initial review, the draft model act should ensure that both adverse determinations and denials of appeals are being made by qualified physician reviewers.

Section 6: Standardized electronic prior authorization for medical services

When combined with judicious use of the process and guardrails to protect patients, automation of prior authorization has the potential to help relieve burden and harm. It is important, however, to require standardized automation rather than the development of individual payer portals or electronic forms which increase burdens and delays by requiring physicians to leave their electronic health records, locate separate websites, and keep multiple passwords. Much progress has been made at the federal level to promote automation, and the AMA believes that NCOIL now has an important role to play in helping states standardize and align prior authorization programs in their jurisdictions with these federal standards.

The AMA very much appreciates the Committee's recent addition to the draft model act of the requirement to use the National Council for Prescriptive Drug Programs SCRIPT standard for ePA transactions under the pharmacy benefit. This change will help ensure state alignment with federal automation requirements for prescription drugs and takes important steps toward streamlining the prior authorization process.

To do the same under the medical services benefit, **we urge the Committee to align with federal requirements under the Centers for Medicare & Medicaid Services Prior Authorization and Interoperability final rule and require that health insurers offer a Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interface (API)** that allows the physician to determine if a service being ordered requires prior authorization, the documentation requirements necessary for approval, and whether the request is approved, denied, or requires additional information before a determination can be made. Progress has been made in Colorado, Minnesota, Virginia, and Washington, where they are working to mirror federal requirements in their state laws. We ask that the Committee help lead other states looking to do the same by adopting the following language under Section 6:

> *No later than January 1, 20XX, a health insurer must have and maintain a prior authorization application programming interface (API) that automates the prior authorization process for providers to determine whether a prior authorization is required for health care services, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determination from its electronic health records or practice management systems. The API must use the Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) standard in accordance with 45 CFR 170.215(a)(1) and the most recent standards and guidance adopted by the United States Department of Health and Human Services to implement 45 CFR 170.215(a)(1).*

Sections 18 and 5(G): Ensuring usable and meaningful data collection

Sections 5(G) and 18 of the draft model act have the potential to take meaningful steps toward increasing the transparency of prior authorization requirements by requiring reporting of data both at the individual health plan level and to regulators. This type of data reporting has become increasingly important in state reform efforts across the country, as little data is available to patients, physicians, and policymakers about what services are most targeted for prior authorization requirements, how quickly decisions are made, how frequently services are approved versus denied, etc. Increased access to meaningful data will help patients make informed decisions about their health plans. Additionally, this information can inform more targeted policies that protect patients and increase efficiency.

To ensure the useability of the data to be collected under this model act for all the purposes mentioned above, the **AMA urges the Committee to require health plans to report prior authorization data at the individual service/medication level**. When data are collected and reported at the individual service or medication level, patients who are evaluating plans for enrollment will be able to make decisions about which health plans place prior authorization on services or prescriptions they need to manage their chronic conditions, or which plans will likely provide more timely care for specific treatments. Stakeholders will be able to evaluate the impact of specific prior authorization requirements, as well as determine the patients and physician specialists that are most impacted. Finally, policymakers will be able to make targeted reforms that best serve their constituents.

In conclusion, the AMA is extremely grateful to the Committee for its efforts in creating a prior authorization reform model bill that will improve patient's access to timely care and reduce administrative waste in the health care system. We hope the Committee will consider these final recommendations.

We thank you for allowing the AMA to be part of these important discussions over the last year and look forward to our continued work together. 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