June 20, 2025

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

Dear Chairman Pollock,

On behalf of the Arthritis Foundation and American Medical Association, thank you for the multiple opportunities to engage with the National Council of Insurance Legislators' (NCOIL) Health Insurance & Long Term Care Issues Committee ("Committee") on the issue of prior authorization reform. Reducing the burden of the prior authorization process on patients and physicians would improve access to medically necessary care and save significant health care resources, and we are grateful that your Committee is considering the draft Prior Authorization Reform Model Act ("draft Model Act").

As we stated before the Committee in April, the draft Model Act takes reasonable, meaningful steps to right-size ballooning prior authorization programs and would help ensure that patients have access to timely and medically necessary care. As the Committee considers this draft Model Act, we offer the attached enhancements, several of which are described below, to better reflect best practices in prior authorization reform and ensure relief for patients and physicians.

Shorter response times for prior authorization decisions

Patient harm often comes from the delays associated with prior authorization. The AMA publishes an annual survey of practicing physicians and their experiences with prior authorization. Unfortunately, this year 93 percent of physicians reported care delays, 82 percent reported treatment abandonment, and 29 percent reported a serious adverse event because of prior authorization delays. Similarly, a survey by the American Society of Clinical Oncology reported prior authorization caused delays in treatment 96 percent of the time and delays had real adverse effects, including disease progression (80 percent) and death of a patient (36 percent).

To help reduce these harmful delays in care, **we recommend that the response time requirement under Section 7 of the draft Model Act be changed to 2 calendar days and the response time requirement under Section 8 be changed to 24 hours**. Additionally, we recommend that states do not defer to *longer* response times that may be established by the federal government.

Reducing repeat authorizations

Forcing patients to obtain prior authorization for care that has already been previously authorized threatens patient outcomes, reduces patient stability, and wastes resources. AMA survey data show that 89 percent of physicians report that prior authorization interferes with continuity of care and 61 percent report that prior authorization at least sometimes destabilizes a patient previously stabilized on a specific treatment plan. Additionally, a report from the Council for Affordable Quality Healthcare (CAQH) found that administrative processes, including prior authorization, resulted in $89 billion of national healthcare expenditures.

Therefore, to protect patients and health care resources, **we recommend that under Sections 13 and 14, a prior authorization should be valid for at least a year or the length of treatment, and that there should never be repeated prior authorization requirements for the treatment of chronic or long-term conditions**. Precedent exists as Medicare Advantage plans are required to provide approval of a prior authorization requests for a course of treatment for as long as medically necessary to avoid disruptions in care, and several states have taken steps to reduce or prevent repeat prior authorizations.

Stronger qualifications of the reviewer at the initial review level

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 say 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, **we recommend that Section 10 be edited to require that only a physician licensed in the state, of the same specialty as the treating physician, and with experience treating the patient's condition be able to make an initial adverse determination and a denial on appeal.** This will help reduce inappropriate initial denials and increase access to timely, medically necessary care.

Data reporting on the individual service level

Sections 5(G) and 18 of the draft Model Act take meaningful steps to increase the transparency of prior authorization requirements by requiring reporting of data both at the individual health plan level and to the Department of Insurance. This type of data reporting has become

increasingly important in state reform efforts across the country, as little data are available to patients, physicians, and, importantly 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 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 guarantee that the most usable data are available for these purposes, **we recommend that the data are reported at the individual service/medication level**, rather than using all services/medications as the denominator.

Electronic prior authorization

Automation of prior authorization, when combined with judicious use of the process and guardrails to protect patients, could help relieve prior authorization burden and harm. However, it is important 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 (EHR), locate separate websites, and keep multiple passwords. Fortunately, significant progress has been made at the federal level to promote automation in the prior authorization process, and states such as Colorado, Minnesota, Virginia, Washington, and others are working to mirror federal requirements in their state laws.

Therefore, **we recommend that Section 6 of the draft Model Act align with federal automated processes, including mandating standard transactions for electronic prior authorization**. Specifically, for medical services, policy should align with federal requirements under the Centers for Medicare & Medicaid Services (CMS) 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. To automate the prescription drug prior authorization process, health insurers should support the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard for electronic prior authorization transactions, as currently required under Medicare Part D.

Next Steps

We appreciate your consideration of our recommended changes to the draft Model Act. Our organizations are committed to right-sizing the prior authorization process to promote timely access to medically necessary care for patients and reduce administrative burdens and resource waste in the health care system. We look forward to future opportunities to engage with your Committee on this important issue and are grateful for the work you have undertaken already to help reform the prior authorization process.

Sincerely,

Arthritis Foundation
American Medical Association