AMA
AMERICAN MEDICAL ASSOCIATION

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May 23, 2022

The Honorable Herb Conaway, Jr., MD
Chairman
Health Committee
New Jersey Assembly
Delran Professional Building
8008 Route 130 North, Building C, Suite 450
Delran, NJ 08075

Re: AMA Support for Assembly Bill 1255

Dear Dr. Conaway:

On behalf of the American Medical Association (AMA) and our physician and student members, we write to state our strong support for Assembly Bill (A.B.) 1255, the "Ensuring Transparency in Prior Authorization Act" and urge your committee to advance this important bill to reform the prior authorization process, protecting patients and health care resources.

The AMA has long been concerned about the prior authorization process and its negative impact on patients, as we frequently hear from physicians and patients about delays in care that result from these insurer protocols. In fact, recently, the AMA released survey data showing that 93 percent of physicians report care delays because of prior authorizations. AMA data also show that 34 percent of physicians report that prior authorization has led to a serious adverse event for a patient in their care, such as hospitalization, permanent impairment, or death. Not surprisingly, the same survey found that 91 percent of physicians see prior authorization as having a negative effect on their patients' clinical outcomes and 82 percent of the physicians surveyed indicated that patients abandon treatment due to authorization struggles with health insurers.

In addition to the harmful individual patient impact, there is no economic rationale for prior authorization. Costs to the health care system due to prior authorization are playing out in physician practices all over New Jersey. For example, physician offices find themselves using inordinate amounts of staff time and resources submitting prior authorization paperwork to justify medically necessary care for their patients to health plans. In fact, AMA survey data show that, on average, physician practices complete 41 prior authorizations per physician per week and that 40 percent of physicians report that there are staff members in their offices that exclusively work on prior authorizations. This adds up to nearly two business days, or 13 hours, each week – dedicated to completing prior authorizations.

It is also important to recognize that these prior authorization burdens continue to place administrative pressure on physician practices – as they face staff shortages and attempt to regain their footing following the COVID-19 pandemic. Notably, a September 2021 *Stat* poll, from the Medical Group Management Association (MGMA), showed that 73 percent of medical practices ranked staffing as their biggest pandemic challenge heading into 2022, and another MGMA December poll revealed continued staffing concerns. Now more than ever, administrative burdens, such as prior authorization, weigh down physician practices and consume resources – leading to fewer resources being allocated to direct patient care.

Moreover, by delaying care, undercutting recovery, and reducing the stability of patients' health, prior authorization increases workforce costs as patients miss work or may not be as productive in their jobs. For example, AMA survey data show that of physicians who treat patients between the ages of 18 and 65 currently in the workforce, more than half report that prior authorization has interfered with a patient's ability to perform their job responsibilities. While health plans undoubtedly see prior authorization as a cost-saving tool used to reduce spending on medically necessary care, the costs to patients, physician practices, employers, and the health care system is unjustifiable.

In 2018, in what looked like progress, health plans recognized the need to reduce the burden of prior authorization and agreed to make a series of improvements to the prior authorization process. Despite increasing evidence of harm, however, most health plans have made no meaningful progress on reforms. This means that passage of A.B. 1255 is necessary to improve access to care for patients in New Jersey.

A.B. 1255 is a well-balanced approach to streamlining and right-sizing the prior authorization process. It brings New Jersey in line with many states that have enacted similar reforms and sets an example for other policymakers to follow. A.B. 1255 would reduce care delays from prior authorization requirements by mandating timely authorizations or denials from health plans. It also increases transparency in the process by requiring health plans to post the items and services subject to prior authorization restriction – allowing patients to make informed decisions about their health insurance and providers to access requirements easily. Additionally, it would ensure that when physician practices invest resources into automation and the standardized electronic prior authorization (ePA) process, plans support those efforts by responding to prior authorization requests using the ePA standard transaction.

The legislation will also provide stakeholders the opportunity to better understand and improve the prior authorization process though the reporting of prior authorization statistics by health plans, including rates of approvals and denials. To strengthen this provision, the AMA encourages you to consider adding additional statistics that have been included in other state laws such as whether an adverse determination was appealed; whether that appeal was approved or denied; and the time elapsed between submission and determination.

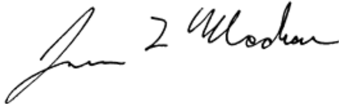
Additionally, as prior authorization policy evolves, we want to bring to your attention provisions that have been enacted in other states and encourage amendments to A.B. 1255 that include these meaningful reforms:

- **Ensuring prior authorization response times are measured in calendar days rather than business days.** In situations where deadlines are measured using calendar days, physicians may request a prior authorization on a Thursday afternoon and end up waiting 5 or 6 days (or longer potentially over a holiday weekend) to receive a response. These delays have negative impacts on patients, including the worsening of a patient's condition without access to treatment.
- **Reducing repeated prior authorizations, especially for those with chronic conditions**. It is critical that when a patient with a chronic condition is stable on a medication or treatment that repeated prior authorizations not continually cause delays that could result, for example, in a loss of function or destabilization of the patient's condition.
- **Requiring that only physicians licensed in the state of New Jersey and specializing in the care being sought through the prior authorization be allowed to make an adverse determination**. If we are to believe there is clinical justification for prior authorization requirements, then we must also believe that determinations of medical necessity that are contrary to the treating physician's determination should be made by an equally qualified and experienced physician.

The AMA, in collaboration with the Medical Society of New Jersey, strongly supports enactment of A.B. 1255, and we look forward to working with you toward that goal. Most importantly, this legislation will improve the clinical outcomes of patients in New Jersey, while also reducing wasted health care resources that are inherent in prior authorization programs.

Thank you again for your leadership. Please contact Emily Carroll, Senior Legislative Attorney, AMA Advocacy Resource Center, at emily.carroll@ama-assn.org, with any questions.

Sincerely,



James L. Madara, MD

cc: The Honorable Sterley S. Stanley
The Honorable Daniel R. Benson
Medical Society of New Jersey