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Prior Authorization and Health Plan Accountability

National Association of Insurance Commissioners

August 31, 2026

Current Problems with Prior Authorization

(1) Patient Impact:

- Disruption and delays in patient care
- Denials of appropriate and necessary care
- Care Abandonment

(2) Administrative burdens:

- Inefficient submission methods
- Lack of transparency on required documentation and medical necessity criteria

(3) Clinician Burnout

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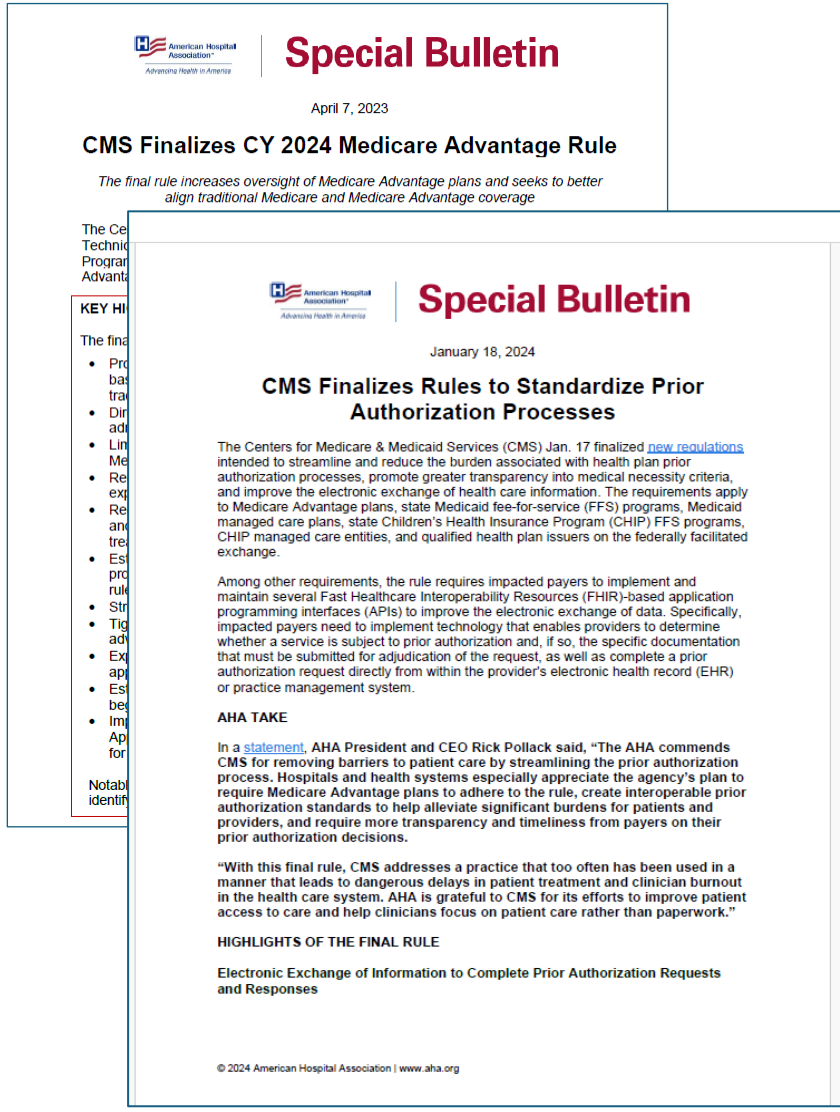
Prior Auth: Previous Rulemaking

CMS Implements Substantive Reforms

- CY 2024 Medicare Advantage Final Rule
  - ➢Clinical (medical necessity) criteria
  - ➢Reviewer credentials
- Interoperability and Prior Authorization Final Rule
  - ➢Standard transaction
  - ➢Shorter timeframes
  - ➢Reporting metrics



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Special Bulletin

April 7, 2023

CMS Finalizes CY 2024 Medicare Advantage Rule

The final rule increases oversight of Medicare Advantage plans and seeks to better align traditional Medicare and Medicare Advantage coverage

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Special Bulletin

January 18, 2024

CMS Finalizes Rules to Standardize Prior Authorization Processes

The Centers for Medicare & Medicaid Services (CMS) Jan. 17 finalized new regulations intended to streamline and reduce the burden associated with health plan prior authorization processes, promote greater transparency into medical necessity criteria, and improve the electronic exchange of health care information. The requirements apply to Medicare Advantage plans, state Medicaid fee-for-service (FFS) programs, Medicaid managed care plans, state Children's Health Insurance Program (CHIP) FFS programs, CHIP managed care entities, and qualified health plan issuers on the federally facilitated exchange.

Among other requirements, the rule requires impacted payers to implement and maintain several Fast Healthcare Interoperability Resources (FHIR)-based application programming interfaces (APIs) to improve the electronic exchange of data. Specifically, impacted payers need to implement technology that enables providers to determine whether a service is subject to prior authorization and, if so, the specific documentation that must be submitted for adjudication of the request, as well as complete a prior authorization request directly from within the provider's electronic health record (EHR) or practice management system.

AHA TAKE

In a statement, **AHA President and CEO Rick Pollack said, "The AHA commends CMS for removing barriers to patient care by streamlining the prior authorization process. Hospitals and health systems especially appreciate the agency's plan to require Medicare Advantage plans to adhere to the rule, create interoperable prior authorization standards to help alleviate significant burdens for patients and providers, and require more transparency and timeliness from payers on their prior authorization decisions.**

"With this final rule, CMS addresses a practice that too often has been used in a manner that leads to dangerous delays in patient treatment and clinician burnout in the health care system. AHA is grateful to CMS for its efforts to improve patient access to care and help clinicians focus on patient care rather than paperwork."

HIGHLIGHTS OF THE FINAL RULE

Electronic Exchange of Information to Complete Prior Authorization Requests and Responses

Electronic Standard Transaction: Procedural Improvements

PA STAGE	CURRENT PROCESS	STANDARDIZED PROCESS (FINAL RULE)
1 **Determine PA Requirement**	Manual website review or insurer calls; often after visit	→ Real-time EHR-to-plan check during patient visit
2 **Collect Clinical Information**	Provider estimates criteria; manual EHR extraction	→ EHR auto-identifies required data and flags gaps
3 **Submit Request**	Plan-specific paper or portal forms; fax or mail; variance = inefficiencies	→ EHR-generated electronic submission within workflow
4 **Receive Decision**	**Up to 14 days** (non-urgent); phone, fax, mail; unclear denials	→ Electronic decision in system; **7 days** non-urgent, **72 hours** urgent; clear rationale

HHS/Insurer Pledge (6/23/2025)

PAYERS AGREE TO DELIVER THESE COMMITMENTS ACROSS ALL PLAN TYPES

1. Reduced scope of services subject to prior authorization
2. Electronic standards
3. Transparency & communication
4. Continuity of care
5. Physician reviewers

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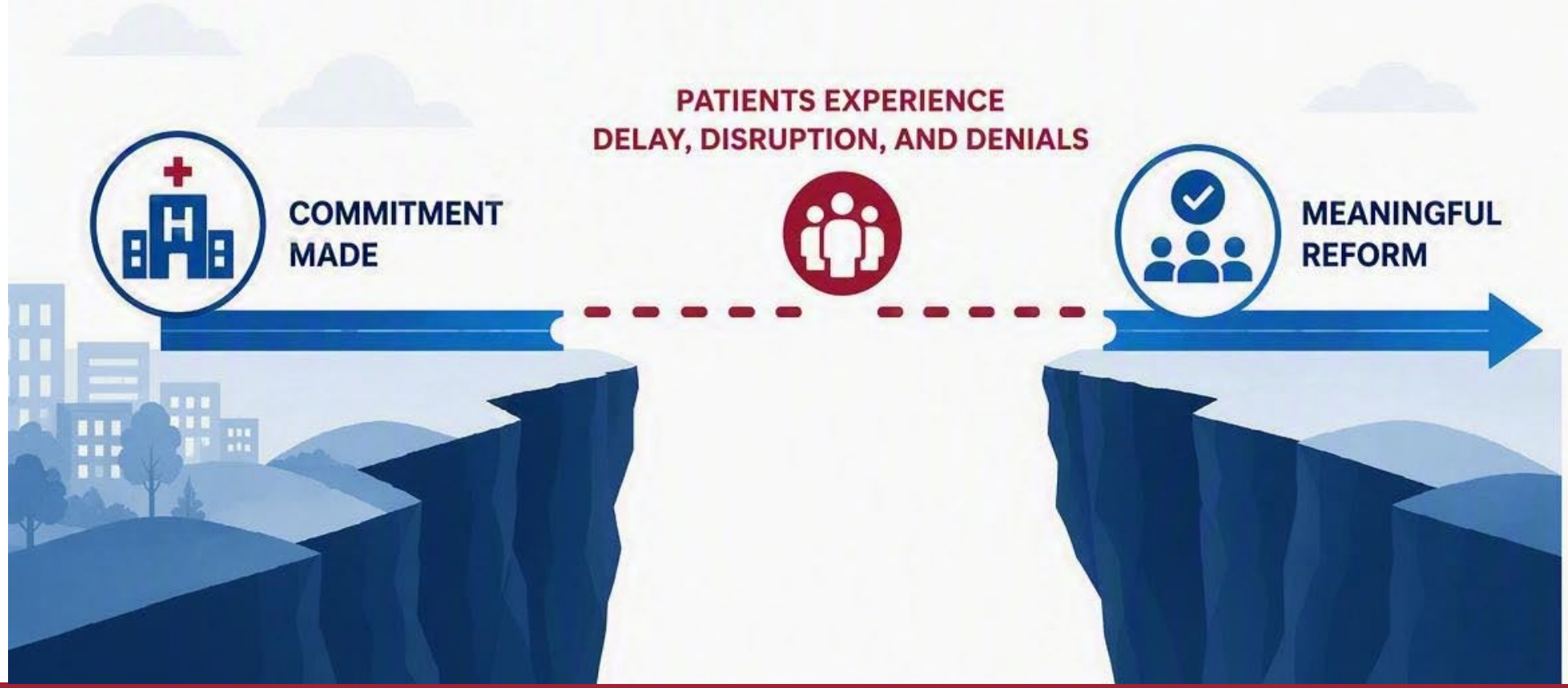
REFORM:
ROOM FOR IMPROVEMENT

The Prior Authorization Pledge is a step forward—now we must close the gap.



- Faster decisions
- Greater transparency
- Stronger partnership
- Better care, better outcomes

Reform: Compliance vs Commitment

- **Physician Review**
  - Physicians with experti:se should review all potential denials, with independence to overturn based on independent medical judgment
  - Identification on Denials
    - NPI
    - Taxonomy code

- **Code Reduction ≠ Volume Reduction**
  - Plan reductions should be measured based on comparison of total prior authorization requests, rather than total

- **Increase in post-service utilization management?**
  - Regulators should monitor other forms to ensure legitimacy of administrative burden reduction claims

- **Electronic Standard: Automation or status quo?**

Recommendations

1. Clinician reviewer identification
2. Standardization of clinical criteria
3. Ensuring that volume reductions are based on total prior authorizations submitted by providers
4. Monitoring use of other forms of utilization management
5. Tracking reduction in processing times
6. Granular, service-specific metric reporting

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