Consumers' Perspective: The Need for Greater Transparency and Accountability for Prior Authorization

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Health care consumers are facing continuing harm from overuse and misuse of prior authorization and other utilization management

- We welcome insurers' recognition that prior authorization is creating serious challenges for consumers
- Voluntary measures are helpful but fall short and are no substitute for enforceable consumer protections
- Consumer reps urge NAIC and state regulators to move forward with measures to curb harmful prior authorization/UM practices and require greater transparency and accountability from insurers

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Recent KFF Public Opinion & Data

- After cost, 34% of insured people identify PA as the biggest hurdle to healthcare
- 18% of PA's were denied in the ACA marketplace, range 3%-25%
- Denials are rarely appealed but 43% were overturned in federal facilitated exchange, range 16%-54%

https://www.kff.org/public-opinion/kff-health-tracking-poll-prior-authorizations-rank-as-publics-biggest-burden-when-getting-health-care/
https://www.kff.org/patient-consumer-protections/prior-authorization-metrics-provide-new-insights-into-insurer-practices-but-gaps-remain/?utm_medium=email&_hsenc=p2ANqtz-8rIfOcoCHVvwEBAhz3X_xvF6UPQW7QBlafOBwlwix8BUygRvb1rumOEMXqj5KD2q4wH0gELC63P8h8kKIbm6qa4dab9Q&_hsmi=433028420&utm_content=433028420&utm_source=hs_email#df80f072-9652-4c30-8220-5c145faf9d16

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1. Voluntary measures are helpful but fall short

Carl Schmid, HIV+Hepatitis Policy Institute

Perspective on Voluntary Commitments

- Some are useful
- There is no enforcement or penalties
- No standard reporting requirements
- Many voluntary commitments are in current law
- Does not include prescription drugs
- Ignores many components of PA problems

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2. Making prior authorization data more accessible to consumers

Harry Ting

Inform Consumers & Hold Plans Accountable

- Require plans to report key PA stats publicly
  - PA stats for the prior year, using state template
  - Links to find - on each plan home page
  - For consistent reporting across carriers, require stats to be calculated using industry standard codes (e.g CMS codes for denial, rejection errors)
- Include following metrics
  - Avg number of PA's required/member
  - Initial denial rates, including partial denials & step therapy, excluding cases not covered or with incomplete info
  - Appeal reversal rates
  - Percent meeting state turnaround time requirements

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Provide Metrics for Following Categories*

- Medical surgical procedures
- Mental health & substance use disorder treatment
- Diagnostic testing & imaging
- Prescription drugs
- Durable medical equipment, prosthetics, orthotics, and supplies

* Many of these are required for insured plans in Colorado. For example, see: *https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/healthcare-professionals/documents-forms/prior-authorizations/CO-medical-prior-authorization-reports-2025-and-exemptions-2026.pdf*

3. DoI opportunities to reign in prior authorization abuses

Wayne Turner, National Health Law Program

Clinical criteria for PA and other UM

State regulators can require insurers to:

- Use evidence-based clinical criteria that reflect up-to-date, generally-accepted standards of care
- Ensure that plans and AI tools properly apply criteria
- Require insurers contracting with third parties provide access to PA criteria
  - NAIC FAQ – “if the proprietary information was used in the business of insurance by the insurer, then it would have been subject to [state] regulatory authority”
- Make criteria available to enrollees, potential enrollees, and providers

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Providing consumers with the information they need on PA denials

- Individualized written notice that explains the reason for the adverse benefit determination, including clinical basis and criteria used
- Any additional information required (e.g., medical records, diagnostic tests)
- Explanation of appeal rights and processes, including grievances, independent medical review, and expedited consideration
- Notices should be consumer-tested and in plain language

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Is prior authorization appropriate?

- Require insurers to periodically:
  - review services subject to PA/UM
  - clinical criteria used
  - remove services from PA/UM (See, e.g., CA SB-306)
- Monitor exempting select providers from PA (aka “gold carding”) for potential harm (e.g., adverse selection)
- Pre-launch and ongoing testing of AI tools used for PA
- Meaningful human in the loop (see Pro Publica: Doctor at Cigna Said Her Bosses Pressured Her to Review Patients’ Cases Too Quickly. Cigna Threatened to Fire Her

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States/NAIC are in the best position to protect consumers from PA harms

- Federal interoperability standards helpful but CMS monitoring and compliance lacking
  - ➔ Example: CMS PA metrics reporting template issued five months after March 31, 2026 effective date
- No standardized way for consumers to access PA information at time of plan selection
  - See Look Up Your Health Plan's Denial Rate: Report Card | AuthDenied
- State compliance monitoring
  - Plan certification process
  - Market conduct exams/data calls

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Ensure that Consumers Can Easily Access Prior Auth Information

- Ensure that information for all services is published in one place
  - Currently prior auth criteria are often split across different websites/documents for different services (e.g. prescription drugs vs medical services vs behavioral health services)
  - Services for different market segments may be published in different documents
- Publish prior auth information, including clinical criteria, in consumer-friendly search tools (see e.g. Nebraska LB77)
  - Ensure that search tools accept consumer-friendly search terms
  - Avoid login requirements, as these block caregivers and potential plan enrollees from accessing
  - Allow consumers to easily find rules that apply to their own health plan
- Ensure that information in published documents is the consistent with the rules as applied in internal prior auth systems, process, and other regulated documents.

https://www.osi.state.nm.us/wp-content/uploads/2026/08/NM-Prior-Auth-Assessment-Summary-of-Findings-FINAL.pdf

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4. Next steps

Carl Schmid, HIV+Hepatitis Policy Institute

Recommendations for NAIC

- Establish Prior Authorization Working Group
  - Continue to add state Prior Authorization laws to the White Paper
  - Showcase individual state implementation & enforcement, challenges & results
  - Draft Model Law/regulatory models
- Conduct Individual State Market Conduct Exams
- Increase Data Transparency (e.g., state MCAS data)
- Partner with D Committee to develop new working group, market standards
- Partner with H Committee on best practices on AI and prior authorization
  - See: NAIC Consumer Health Representative report
- Monitor federal actions & industry voluntary commitments

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Resources

NAIC Consumer Representatives Report: Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management

Consumers' Checkbook: New Mexico Prior Authorization Transparency Assessment

NHeLP: Prior Authorization Issue Brief 2 – Federal Oversight of Prior Authorization

Health Affairs: Drug Coverage Policies And Clinical Guidelines Alignment: Most Coverage Decisions Include Additional Restrictions

Thank you!

Contact us:

https://content.naic.org/sites/default/files/consumer-participation-representative-contact-list.pdf

See more of our work:

https://consumeradvocacyforhealth.org/

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