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August 27, 2025

Commissioner Grace Arnold
Regulatory Framework (B) Task Force, Chair
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 700
Washington, DC 20001-1512

Forwarded via email: Jolie H. Matthews

RE: AHIP Redlines on draft NAIC Prior Authorization White Paper

Dear Commissioner Arnold,

AHIP appreciates the opportunity to comment on the proposed prior authorization white paper. We have provided our feedback through redlines and comments in the actual draft for your review and consideration.

Generally, AHIP redlines:

- Increase the section addressing federal government requirements.
- Introduce content covering accreditation requirements.
- Expand details about appeals processes, clinical guidelines, electronic information, and related sections.
- Supply industry data to support analysis.
- Add clarifications to ensure objectivity.

AHIP appreciates the inclusion of the Prior Authorization Industry Initiative and we are grateful for the opportunity to present alongside BCBSA on these important industry commitments during the NAIC 2025 Summer National Meeting. As discussed during that meeting, these voluntary industry commitments will result in faster, more direct access to appropriate treatments and medical services for patients and allow for a more efficient and transparent process overall for providers.

AHIP welcomes further collaboration with the NAIC Regulatory Framework (B) Task Force on prior authorization and we look forward to continued discussion. Should you have any questions, please contact me at khathaway@ahip.org or 202.870.4468.

Sincerely,

Kris Hathaway

Kris Hathaway
Vice President, State Affairs

Draft: 7/18/25

Comments are being requested on this draft by Aug. 29, 2025. Comments should be sent only by email to Jolie Matthews at jmatthews@naic.org.

Prior Authorization White Paper

Contents

What is prior authorization?

Prior authorization (PA) is a mechanism used to check that a service, treatment, or medication is medically necessary and covered by a health plan. This ~~is~~was initially intended to ensure safety (e.g., prevent negative drug interactions) and reduce utilization of medically unnecessary treatments, with the overall aim of containing health care costs and improving quality. Depending on the plan and characteristics of the market, ~~Now,~~ PA can be ~~is~~ used for a range of services,~~broad swath of~~ treatments, and medications. ~~both prescriptions and procedures, though not all services require PA.~~ PA can achieve a favorable balance between costs and benefits for both insurers and their members. By formalizing in advance, in writing, the insurer's commitment to covering a health care service, it can also provide needed assurance for consumers and providers prior to the provision of services. While PA can benefit insurers, providers, and consumers, the process has been criticized for ~~a reputation of~~ burdening providers and delaying care for consumers.

Commented [AHIP1]: Redlines in this paragraph keep the report current and objective.

Commented [A2]: Redlines parallel comments made later in the paper to AHIP's survey results in Footnote 16: https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf

How this document can help regulators

In recent years, state legislatures have introduced and updated PA statutes to reduce administrative burdens and negative health outcomes. Most proposed legislation focuses on the method by which PA must be requested (e.g., by phone, fax, or electronic means such as through an EHR or an online portal), timeframes for plan responses, and "provider gold-carding," a system in which providers can bypass the PA process given their previous record of consistently providing evidence based ~~necessary~~ medical care. This reference is meant to be a source of information and a roadmap of legislative options related to PA.

Commented [AHIP3]: Redlines in this paragraph provide technical clarifications.

Commented [AHIP4]: We reference this issue which is in a later section of the paper on 'Solutions and examples'.

Please note that this document will not elaborate on the use of artificial intelligence (AI) in the PA space. The topic would more appropriately be addressed in detail by the NAIC Innovation, Cybersecurity, and

Technology (H) Committee, though we would be comfortable assisting the H Committee in any endeavors to better understand the use of AI in prior authorizations in any forthcoming materials.

The prior authorization process

The PA process typically involves several steps, requiring coordination between health care providers, the patient, and the insurance company.[1] Those steps typically are:

- ***Submission:*** The health care provider submits a PA request to the insurer, detailing the medication or treatment recommended for the patient.
- ***Review:*** The insurance company reviews the request, confirming the patient is currently covered with the insurer and whether PA applies to the requested service and then evaluates~~ing~~ it against its clinical guidelines and policies.
- ***Approval or Denial:*** Based on the review, the insurer either approves, partially approves, or denies the request, often providing an explanation. Insurers may also offer a peer-to-peer consultation prior to rendering a decision.
- ***Appeals:*** If the request is denied, the patient or provider may appeal the decision and provide additional information to support the necessity of the treatment. Two levels of appeals processes are typically available – internal and external review.

Common medical services subject to prior authorization

Certain types of medical services are more likely to require PA. Examples include:

- ***High-Cost and Specialty Drugs:*** Medications that are expensive or require careful monitoring, such as biologics or high-dose chemotherapy drugs.
- ***Advanced Imaging:*** Tests like MRI, CT scans, or PET scans that can jeopardize patient safety if used inappropriately.
- ***Surgical Procedures:*** Surgeries that are elective or involve the use of experimental techniques.
- ***Durable Medical Equipment:*** Items like wheelchairs or hospital beds to ensure appropriate use.

Commented [A5]: Providing additional context that is often asked about by policymakers.

Commented [AHIP6]: Redlines in this section provide additional context to align with the other bullets.

[1] https://www.health.harvard.edu/staying-healthy/prior-authorization-what-is-it-when-might-you-need-it-and-how-do-you-get-it.

Prior authorization issue perspectives

The provider perspective

Administrative burden and expense

Prior authorization can create substantial administrative burdens, costs, and inefficiencies. According to a recent American Medical Association (AMA) survey[2], physicians spend 13 hours per week requesting PAs. To mitigate this, health care providers must also employ and maintain knowledgeable staff who can help monitor the PA process. According to the same AMA survey[3], 40% of participating physicians have staff who work exclusively on PAs. Providers' electronic health records generally do not integrate with insurer systems, so staff must manually enter data into these systems. Furthermore, incorrect or missing patient demographic and insurance information can delay PA or result in unexplained denials.

In many cases, health insurers require PA to be completed at certain intervals during a course of treatment. This may take the form of step therapy (the process by which an insurer requires the use of certain comparable treatments first, and only upon failure will a preferred or prescribed treatment be approved) or requirements for regular authorizations to monitor treatment progress and efficacy. Navigating these PA requirements during ongoing treatment of a patient burdens a provider with additional administrative tasks – time that could be spent treating the patient.

Despite the burdens of the PA process, some providers prefer the administrative burden of obtaining a PA over the risk of not being paid. Some providers want insurers to require PAs for certain services so the provider will know a service will be covered by the insurer with PA approval. For example, this concern led Arkansas to pass legislation in April 2025 mandating that an insurer require PA for breast reconstructive surgery.[4]

Lack of consistency and transparency

Definitions of medical necessity for a particular service differ between insurers, and some insurers define medical necessity without providing the clinical criteria for a provider to determine if the health care service being requested meets the medical necessity threshold. This forces providers to spend more time determining what will be approved for each patient's plan and potentially research alternative treatments that may not be as effective as the preferred treatment. Furthermore, navigating differences in medical necessity criteria during an ongoing course of treatment highlights the disruption that can be caused due to PA processes.

Denial letters ~~often~~ may lack transparency and provide ~~no~~minimal information on how the denial was determined. It may not be clear~~Health care providers are forced to guess~~ why the denial occurred and how to appeal the decision. Some health care providers completely avoid the PA process by not accepting insurance.

Commented [AHIP7]: Redlines provide clarification.

[2] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[3] Id.
[4] https://arkleg.state.ar.us/Bills/Detail?id=sb83&ddBienniumSession=2025%2F2025R

~~Outdated and~~ Differing and/or inefficient technology

~~Oftentimes,~~ Depending on the technologies (including software, web portals, fax machines, and ~~even communication by~~ phone) ~~used by insurer~~ PA systems can differ across insurers and be costly to providers to implement~~are outdated and cumbersome~~. Moreover, t~~T~~he PA process can be significantly delayed or result in denials if an insurer has not updated its utilization management processes or has not communicated changes to processes or codes. Though some insurer portals make it easy to look up required PA information by simply inputting a procedure's current procedural terminology code, other insurers will not provide information until a provider contacts them. When medical offices are required to contact a health benefit plan by phone, staff experience long hold times. Providers often need to create documentation of their communications by phone or fax in case such information is later needed to prove contact was made.

Commented [AHIP8]: We have not heard from providers that health plans' systems are outdated, but we know that plans and provider systems are not always interoperable which does cause challenges.

Misalignment with clinical standards of care

In addition to determining whether a requested service is recommended according to research-based evidence, insurers may also consider whether the service is the most cost-effective way to treat a patient. Clinical standards used by providers do not necessarily consider cost and are intended to provide the most efficient and effective care depending on a patient's particular needs. Rather than treating a patient with what the health care provider considers to be the most appropriate treatment using their knowledge of clinical standards of care, a PA request denial may force a health care provider to prescribe a different therapy, ~~not considered to be in the patient's best interests, but~~ that is covered by the patient's insurer. The provider must choose whether to pursue a lengthy and possibly ~~futile~~unsuccessful appeal process related to their preferred therapy that will further delay treatment or choose a different therapy that may be less likely to provide optimal results.

Commented [A9]: Redlines provide clarification.

The consumer perspective

While PA processes can help patients avoid unnecessary costs and keep premiums low and ~~are well-meaning for the health care system,~~ ideally take place between the provider and the health plan without requiring patient involvement, the consumer experience can be ~~is often~~ marred by inefficiency, care disruption, and adverse outcomes.

Disruptions in care

According to a KFF survey, approximately six in 10 insured adults are not able to use their insurance without experiencing a problem.[5] Of those insured adults that report having an issue with using their insurance, 16% reported experiencing problems specifically with PA processes.[6] ~~Additionally, a KFF analysis of CMS' 2023 Transparency in Coverage data demonstrated that prior authorization accounted for 9% – more than six million - of in-network claim denials.~~ Separately, a physician survey conducted by the AMA in 2023, found that 94% of the patients of participant physicians experienced delays in care that they would not

Commented [A10]: Citation correction - this study is not showing that 9% of claims were denied because of a PA denial - the 9% represents the percent of claims that were denied because a referral or PA was not obtained when it was required.

[5] https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/
[6] Id.

have otherwise experienced.[7] Moreover, the same survey found that 78% of responding physicians said PA can sometimes lead to treatment abandonment. ~~the patients abandoned treatment because of the PA processes~~.[8]

Beyond driving individuals away from engaging with their providers, onerous PA processes may also discourage individuals from seeking long-term treatment that may require multiple interactions with PA processes with different health care providers, different health insurers, or both. When health insurers require PA to be completed at certain intervals during ongoing treatment, patients can experience undue stress and disruptions to their treatment and recovery.

Higher costs in the long run

Delays or disruption in care can lead patients to seek more expensive forms of care, including emergency room visits, and can lead to preventable hospitalization. One provider survey found that 42% of providers reported the PA process led to immediate care or ER visits and 29% reported it led to hospitalizations. ~~Federal law prohibits plans from requiring PA for coverage of emergency services. As a result, some individuals seek care directly from an emergency room rather than engaging with their health insurer to help coordinate care prior to a medical issue becoming emergent. According to a survey from the AMA, insured adults who received health care in an emergency room would have been twice as likely to encounter PA problems when trying to seek care in a non-emergency setting when compared to those who did not otherwise use the emergency room~~.[9]

For those consumers who ~~do~~ must seek care in an emergency room setting, they will incur significant out-of-pocket costs that may otherwise be avoided by seeking care in non-emergency room settings.[10] For example, one study found that an insured spends $646 out-of-pocket on average for an emergency room visit.[11]

Adverse and inequitable outcomes

Within the overall insured population, certain groups of people experience a disproportionate share of PA problems. For example, 31% of adults who use more health care services (defined as having more than 10 doctor visits a year) experience difficulties navigating PA processes.[12] About a quarter (26%) of individuals with mental health conditions who sought treatment or a prescription experienced problems or delays as a result of their difficulties navigating PA processes.[13] Seeking medical care can be stressful, complicated, and expensive, and adding the burden of PA processes can be harmful. Among individuals who reported

Commented [A11]: Citation correction - The survey asked physicians how often do issues relating to the PA process lead to patients abandoning recommendations, 22% reported often / 56% sometimes.

Commented [A12]: Redlines better reflect the citation. As drafted, the paragraph seems to say individuals seek ER care to avoid PA, whereas the survey results are showing PA delays or disruptions can lead to higher ER utilization.

[7] https://web.archive.org/web/20240819003745/https:/www.ama-assn.org/system/files/prior-authorization-survey.pdf
[8] Id.
[9] ~~Id.~~
[10] https://www.healthsystemtracker.org/brief/emergency-department-visits-exceed-affordability-thresholds-for-many-consumers-with-private-insurance/#Total%20and%20Out-Of-Pocket%20Costs%20for%20Emergency%20Department%20Visits,%202019
[11] Id.
[12] ~~https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/~~
[13] Id.

problems with PA processes, they were twice as likely (than individuals who did not report experiencing issues with PA processes) to report that their health declined as a result.[14]

The appeals process

It is important to note that most PA requests are approved. For example, for Medicare Advantage plans in 2023, 90% of PA determinations were fully favorable.[15] AHIP's survey of their members reported similar numbers in the commercial market with approval rates for prescription medications at 90% and 97% for medical services[16]. In the event of a PA denial, there are mechanisms to appeal. ~~-~~ Under federal and state law, health plans are required to provide internal appeal processes and in most cases independent external reviews. ~~These processes are often byzantine and difficult to access and discourage consumers who receive a denial from appealing. In Pennsylvania, for example, of the 2,135,041 claims denied by Qualified Health Plans in the state's individual health insurance market, just 3,156 internal appeals were filed. Of those internal appeals, nearly half (48%) were overturned in favor of providing coverage for the requested service.[17] The pattern is repeated at the national level. Qualified Health Plans offering individual health insurance coverage through the Federally Facilitated Exchange in 2022 denied 69,315,868 claims. Less than one percent of those denials was appealed, and 42% of the appeals filed were overturned.[18] Staking the availability of coverage for medical services on the ability to navigate administrative processes can have negative impacts on health outcomes.~~

The insurer perspective

From the insurer perspective, the primary goals of PA include:

- Directing patients toward ~~Flagging~~ newer and better treatments for patients to improve the quality of care;
- Preventing excessive, unnecessary, harmful or fraudulent health care utilization; and
- Ensuring health care dollars are used as effectively as possible. ~~Containing claims costs.~~

Patient Safety

Health insurers often cite examples of clearly harmful activity by providers, such as providing inappropriate cancer treatments to patients who may not even suffer from cancer, to demonstrate how PA supports patient safety.[19] Other examples include overuse of opioids, antipsychotic medications in children, and high-risk medications for elderly patients. PA also ensures patients receive the safest level of care. For example, performing unnecessary imaging tests can have serious negative impacts, including false

Commented [A13]: Providing an additional source for context.

Commented [AHIP14]: From our review of the materials, this data seems to be referencing claims data and not prior auth data.

Commented [AHIP15]: Common examples as forwarded to us from our CMOs and footnoted.

[14] Id.
[15] https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/#:~:text=Of%20the%2049.8%20million%20prior,of%2014%20requested%20therapy%20sessions.
[16] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf
[17] ~~https://www.pa.gov/content/dam/copapwp-pagov/en/insurance/documents/posted-filings-reports-orders/posted-reports/aca-plan-transparency-reports/transparency-coverage-report-aca-health-plans-2024.pdf~~
[18] ~~Id.~~
[19] Examples: https://www.propublica.org/article/anthony-olson-thomas-weiner-montana-st-peters-hospital-leukemia; https://www.thelundreport.org/content/tenth-lawsuit-claims-oregon-labs-testing-caused-women-harm-unneeded-chemotherapy

positives,[20] exposure to unnecessary radiation, and higher out-of-pocket costs.[21]

Additionally, studies show that too many patients get care that isn't aligned with the latest evidence. For example, nearly 4 in 10 patients don't receive care that meets the latest medical evidence, which can negatively impact their outcomes and even potentially be dangerous.[22]

It is difficult to determine how frequently these forms of consumer harm are prevented by PA, but there is no reason to doubt that such harms are a legitimate concern.

Cost containment

~~Insurers claim that~~ PA prevents the use of low-value health care services, saving insurers, plan sponsors, and members dollars without adverse health consequences.[23] While the research on the value proposition of health care services may be clear in some cases, it is disputed in others, e. ~~E~~especially for newer modes of treatment that may lack a large evidence base. This can lead to disputes, appeals and complaints to regulators.

~~for insurers. However, insurer representatives consistently articulate the centrality of PA for their efforts to contain costs and improve quality of care.~~Milliman conducted an analysis of claims data to determine the impact to commercial premiums nationally if prior authorization was eliminated across all medical and pharmacy services. The study determined that eliminating PA for all services would result in a premium increase of almost $30 PMPM; even eliminating PA for a narrow scope of services would lead to a premium increase of over $20 PMPM. Across the entire commercial market, Milliman calculates that premium increases could total between $43B and $63B annually.[24] Milliman also notes cost-sharing would increase with the elimination of PA.

In that same Milliman study, they found that PA creates a sentinel effect whereby performance improvement occurs because providers in a program know they are being evaluated against evidence based clinical criteria. In an independent study, Milliman estimated that eliminating the sentinel effect by restricting the use of PA may result in premium increases of 5.6% - 16.7% for plans in Massachusetts.[25]

In addition, it should be noted that the Medicare fee-for-service program has expanded its use of PA for select items and services to preserve access to medically necessary care while reducing improper Medicare billing and payments[26]. State Medicaid programs may also choose to use PA for certain items and services.

The potential cost containment benefits of PA may be particularly important in the context of the Affordable Care Act's (ACA) insurance reforms. Core ACA provisions such as guaranteed issue, community

[20] Ganguli I, Simpkin AL, Lupo C, et al. Cascades of Care After Incidental Findings in a US National Survey of Physicians. *JAMA Netw Open.* 2019;2(10):e1913325. doi:10.1001/jamanetworkopen.2019.13325

[21] Rosenkrantz AB, Sadigh G, Carlos RC, Silva E 3rd, Duszak R Jr. Out-of-Pocket Costs for Advanced Imaging Across the US Private Insurance Marketplace. *J Am Coll Radiol.* 2018 Apr;15(4):607-614.e1. doi: 10.1016/j.jacr.2017.12.010. Epub 2018 Feb 22. PMID: 29477290.

[22] Duff, J., Cullen, L., Hanrahan, K. *et al.* Determinants of an evidence-based practice environment: an interpretive description. *Implement Sci Commun* **1**, 85 (2020). https://implementationsciencecomms.biomedcentral.com/articles/10.1186/s43058-020-00070-0

[23] One often-cited source is the Low-Value Care Task Force at VBID Health: https://vbidhealth.com/low-value-care-task-force/

Commented [A16]: Redlines provide additional cited context.

Commented [AHIP17]: Deleted to align with the other sections, which do not use phrases like "providers claim" or "patients claim."

Commented [A18]: Redlines include a citation on the economic/cost value of prior authorization.

Commented [AHIP19]: Redlines provide additional context on the use of PA in government programs.

rating and prohibitions on pre-existing condition exclusions provide important consumer protections but also leave insurers on the hook for higher health care costs. In this context, it may be unsurprising that PA requirements appear to be on rise in recent years, as they may represent one of the few tools remaining for insurers to contain costs, which in turn can help keep premiums and out-of-pocket costs in check. It is important to note however, that an industry survey reported that insurers across all lines of business never based their PA programs on cost alone[27].

~~Friction with providers and members~~

~~For insurers, the benefits of PA must be weighed against the administrative costs and burdens of administering a PA program and the potential for friction and conflict with health care providers and members. This friction may result from issues including potential reductions in provider time available for patient care, provider resentment, patient frustration, and poorer quality outcomes due to delayed or abandoned care.~~

Commented [A20]: Redlines eliminate this section because the complexities and 'friction' are woven into and discussed elsewhere in this paper. Should further context be needed, that would more appropriately be added under the patient and/or provider sections.

Electronic prior authorization (ePA)

Health insurance carriers have been broadly supportive of moving away from manual and "paper" processes for PA and toward more uniform electronic submission standards. For example, carriers supported federal adoption of a rule on PA interoperability in 2024.[28] Carrier advocates have typically ~~argued~~ recommended that state activity in this area should focus on aligning state requirements for insurers with these federal rules, and that states should consider more proactively implementing requirements for health care providers to use electronic processes.[29] An initiative by insurers covering more than 50 million Americans found that implementing ePA led to faster time to patient care, faster times to decisions, and improved information for providers[30]. ~~Carriers have suggested that m~~More rapid adoption and effective implementation of e~~lectronic~~ PA on the part of health care providers can resolve some of their concerns about administrative burdens. Despite this, AHIP's survey of member plans report that manually submitted PA requests still account for nearly half of all PA requests[31].

Commented [AHIP21]: Redlines provide additional data support for ePA.

Selective use and other streamlining initiatives

Health plans have implemented a number of targeted modifications to streamline the PA process and reduce the burden of PA for certain subsets of providers and patients. ~~Selective use, also called g~~Gold carding~~,~~ is one such initiative that involves a process by which a high performing health care provider may qualify for an exemption from a carrier's PA requirements. ~~means applying different PA processes and expectations based on provider performance~~.[32]

Commented [AHIP22]: Redlines provide additional context.

[28] https://www.ahip.org/news/press-releases/ahip-statement-on-the-cms-interoperability-and-prior-authorization-final-rule
[29] https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states
[30] https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care
[31] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf
[32] See e.g., https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf

Other approaches to streamlining the PA process include removing some services and drugs from PA requirements, reducing or waiving PA for patients undergoing active treatment, and reducing or waiving PA requirements for providers in value-based contracts[33]. Many health insurers apply selective use policies as part of their PA programs. Health insurers have typically opposed statutory or regulatory mandates in the area of selective use, preferring to be permitted the flexibility to explore a range of options to strike a favorable balance between administrative simplification, patient protection and cost containment. ~~However, many health insurers voluntarily apply selective use policies as part of their PA programs.~~

~~Questions regarding the e~~Evidence~~ base~~based criteria

One of the key purposes of PA ~~cited by insurers~~ is to ensure that covered services are evidence-based and effective. ~~Some insurers have expressed concerns about the evidence base behind PA and have pushed for stricter requirements in this area.[34]~~ Health plans collect and assess the best available medical evidence for the specific populations they serve. PA programs are typically based on guidelines from medical societies like the American College of Cardiology and the American College of Radiology, as well as scientific evidence from recently published, peer-reviewed medical literature. Practicing community physicians and subject matter experts at leading academic institutions may also contribute to the development of clinical guidelines.

There are rigorous reviews of insurers' clinical guidelines as part of accreditation. In addition, guidelines must also meet state and federal laws and Center for Medicare & Medicaid Services (CMS) requirements where applicable. Many state laws require guidelines to be evidenced-based and updated annually. In addition, ~~Insurers are unlikely to be supportive of restricting their flexibility in this area for a variety of reasons. For example:~~ PA denials are typically subject to appeal and external review requirements that provide the opportunity for an independent check on practices not aligned with clinical evidence.

It is important to note, questions about the value proposition of particular health care services may not be entirely resolvable by clinical evidence. For example, there may be cases where two therapies with significant cost differences have similar effectiveness in treating a health condition but may have differential effects on the patient experience in other respects, such as comfort or aesthetic considerations.[35]

Accreditation Standards for PA

The majority of states utilize NCQA or URAC to ascertain insurers are meeting a state's regulatory requirements. Both of these accreditation bodies require intensive review of an insurer's utilization management program, including prior authorization requirements. Accreditation standards typically address areas such as the clinical criteria used for decisions, regular review and availability of the criteria, practitioner involvement, qualifications of health professionals making PA decisions, and timeframes for decisions, among other areas. Accreditation standards are updated regularly. For example, many of these

Commented [AHIP23]: Deleted this sentence as we included it earlier in the paragraph with additional context.

Commented [A24]: Aligning the paper with other sections. The paper does not use phrases like 'cited by consumers' or 'cited by providers' in those sections.

Commented [A25]: Redlines delete this sentence, as this would not be the insurers perspective. This could be moved to the consumer perspective section.

Commented [A26]: Redlines provide additional context and background on clinical guidelines within the insurer perspective section.

Commented [AHIP27]: We recommend including a section on accreditation standards on PA as they are substantial and part of many states' oversight procedures.

[33] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf

~~[34] For example, Congress has considered legislation that would push Medicare Advantage issuers to consult with health care providers on evidence-based best practices for prior authorization: https://delbene.house.gov/news/documentsingle.aspx?DocumentID=3221~~

[35] Potential examples could include proton beam therapy for cancer treatment or autologous breast reconstruction following mastectomy.

standards are in the process of being updated to align with the new federal requirements mentioned in this paper.

~~Solutions and~~Reform examples

Commented [A28]: Redlines provide a more targeted title for the section.

States

Gold carding

"Gold carding" describes a process by which a high performing health care provider may qualify for an exemption from a health insurer's PA requirements. A provider who has qualified for a gold card for a particular health care service will not be required to obtain PA before performing that service. Once implemented, these programs are intended to simplify health care for consumers, providers, and insurers.

Under state mandated gold carding programs, a health insurer is required ~~by the state~~ to evaluate a health care provider's history of requesting PA for a particular health care service to determine whether the provider qualifies for an exemption from PA for that particular service. The insurer examines medical records to determine the number of times a health care provider requested PA for a particular service and compares that number to the number of times the provider's request for that service was approved. If the percentage of approved requests meets the threshold rate~~number~~ mandated by the state legislature, the insurer will be required to issue the provider a gold card exemption for that service.

A gold card is insurer-specific such that a health care provider may meet the standard for obtaining a gold card from some insurers but not others. A gold card can also be service-specific: an insurer may examine PA requests by a health care provider and make a separate calculation for each service to determine whether the provider should receive a gold card exemption for each of these services. However, even if a provider has been granted a gold card for a particular service, if an insurer determines that a service provided by a provider who holds a gold card exemption for that service was not medically necessary or otherwise fails to meet plan eligibility standards, the insurer may still decline to cover the service.

Many gold carding programs are new and results are still unknown on their effectiveness in reducing administrative burden and implications to cost and quality.

Commented [A29]: Redlines provide additional context on gold carding programs.

Arkansas

Arkansas has extended its gold card programs to PAs for prescription drugs. Insurers in Arkansas examine the health care provider's history of all PAs requested for all health care services, which Arkansas defines to include prescription drugs.[36] A health care provider's gold card exemption privilege extends to any health care service for which they received approval of the PA request at least 90%) of the time within a six-month evaluation period.[37] An insurer may rescind a health care provider's exemption if the provider performs five or fewer of the health care service for which they obtained an exemption.[38]

[36] Ark. Code Ann. § 23-99-1103(10)(A).
[37] Ark. Code Ann. § 23-99-1120(a).
[38] Ark. Code Ann. § 23-99-1122(a)(3).

Arkansas has also established a process that allows an insurer to continue requiring PA for a particular drug if the insurer obtains approval from the state's boards of pharmacy and medicine to continue requiring PA.[39] When an insurer receives approval to continue requiring PA for a particular drug, the approval is good for two years, and the insurer may continue requiring PAs for that drug from all health care providers, regardless of any gold card exemption privilege a health care provider would have otherwise had.

Texas

In 2022, Texas implemented House Bill 3459, also known as the Texas Gold Law. This legislation exempts physicians and providers from needing PA for certain health care services if they maintain ~~a consistently high~~an approval rate of ~~–~~ at least 90% over a recent six-month period ~~–~~ for those services. However, the law does not apply to patients insured by Medicaid or Children's Health Insurance Program (CHIP). Its intent is to reduce delays in patient care and allow physicians to dedicate more time to their patients. The Texas Department of Insurance (TDI) is responsible for overseeing the implementation of this law.

A provider or physician in Texas qualifies for an exemption once they have:

1. Submitted five or more eligible PA requests for the particular health care service in the most recent evaluation period; and
2. At least 90% of the eligible PA requests for a particular service were approved. [40]

The physician or provider is not required to request an exemption to qualify for an exemption. It is the responsibility of the insurer to notify physicians and providers that they have been granted or denied a PA exemption for those health care services for which the minimum threshold has been satisfied.

According to the legislation, the notice granting exemptions must contain a plain language explanation of the effect of the PA exemption and any claim coding guidance to properly document the exemption. Exemptions must remain in place for at least six months before being rescinded.

In 2025, Texas amended their gold carding law by passing House Bill 3812 which extended the length of gold cards from 6 months to one year, included claims not regulated by TDI for evaluation, narrowed administrative licenses, etc.

Commented [A30]: Redlines reflect recent legislative changes.

West Virginia

Updated West Virginia statute lowered the requirements to qualify for a gold card program. This allows a health care provider to earn exemption from PA requirements based on the provider's track record of previous PA approvals and the frequency with which the provider performs the procedure. If a health care provider has performed an average of 30 procedures per year and in a six-month period has received a 90% final prior approval rating, the health insurer may not require a PA for at least the next six-month period, or longer if the insurer allows. The state legislature clarified in 2025 that prescription drugs and related authorizations are exempted from the gold card program.

[39] Ark. Code Ann. § 23-99-1128(b).
[40] Texas Administrative Code https://texas-sos.appianportalsgov.com/rules-and-meetings?$locale=en_US&interface=VIEW_TAC_SUMMARY&recordId=209986 and Texas Insurance Code Title 14, Ch. 4201 https://statutes.capitol.texas.gov/Docs/IN/htm/IN.4201.htm#4201.653

Wyoming

The Wyoming legislature passed legislation regarding provider exemptions from PA requirements (Gold Carding).[41] The law will go into effect January 2026. The legislation establishes guidelines for a provider to be exempted from completing PAs for health care services that have been authorized 90% of the time in the proceeding twelve months. The provider must have submitted no fewer than five PAs for the procedure during that time. The insurer can review the exemption every twelve months, but they may establish a longer exemption period. In addition, an exemption cannot be revoked before twelve months have passed.

Providers are not required to apply for an exemption. The insurer or contacted utilization review entity shall provide a health care provider with a statement that notifies them they qualify for the exemption; a list of services for which the exemption applies; and a statement of the 12-month duration. A health care provider may appeal a health insurer or contract utilization review entity's decision to deny an exemption.

Addressing continuity concerns

District of Columbia

The District of Columbia requires a PA to be valid for at least one year or for the course of the treatment, including any dosage changes.[42]

Illinois

Illinois also requires health insurers to honor an approved PA for the first 90 days of a health insurance consumer's coverage under a new health insurance policy.

Oklahoma

House Bill 3190 specifies that PAs are valid for at least 45 days, or for six months in the case of chronic conditions, creating a more predictable and less disruptive process for patients. A health ~~benefit~~ plan cannot revoke, limit, condition, or restrict PA if care is provided within 45 business days from when the health care provider received the PA, unless the enrollee was no longer eligible for care on that day. ~~These extended validity periods for PAs, particularly for chronic conditions, are more generous than in many other states, providing patients with greater stability in their care.~~

Commented [AHIP31]: Most state examples did not provide commentary, therefore deleted to keep aligned with the other descriptions.

Tennessee

Tennessee passed a law that took effect in 2025 that requires health insurers to honor an approved PA for the first 90 days of a health insurance consumer's coverage under a new health insurance policy.

Texas

In Texas, a health insurer is not permitted to require more than one annual PA for a prescription drug for certain conditions.

[41] Wyo. Stat. Ann. § 26-55-112

[42] https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-we-must-ensure-continuity-care#:~:text=Georgia%2C%20Kentucky%2C%20Louisiana%2C%20Michigan,hemophilia%20or%20Von%20Willebrand%20disease.

Wyoming

The Wyoming Insurance Code, titled *Ensuring Transparency in PA Act* was passed in 2024[43] and addresses continuity of care and step therapy. If an individual changes health care coverage and has an approved PA with their prior insurer, and the health care service is a covered benefit under the new plan, the new insurer must honor the PA for at least 90 days.

In addition, insurers cannot require a consumer to repeat a step therapy protocol if that enrollee, while under their current or previous health benefit plan, used the prescription drug required by the step therapy protocol, or another prescription drug in the same pharmacologic class.

Reducing response times

Oklahoma

House Bill 3190[44], which took effect on January 1, 2025, requires utilization review entities to respond more promptly to PA requests. After a utilization review entity has obtained all necessary information to make a decision, the entity must respond within 72 hours for urgent requests and within seven days for non-urgent requests. ~~These expedited timelines are intended to facilitate timely care for patients.~~

Commented [AHIP32]: Most state examples did not provide commentary, therefore deleted to keep aligned with the other descriptions.

Texas

According to TDI, commercial insurers have two business days to approve a PA request after receiving all necessary information. Life-threatening conditions require a response within one hour and concurrent care within 24 hours.

Washington

The Evergreen State has implemented shorter turnaround times for PA approvals[45], ranging from one to five calendar days, aiming for timely patient access to care. The required turnaround times differ depending on how the request is submitted to the carrier (non-electronic versus electronic) and whether the request is urgent. For e~~lectronic~~ PA requests, carriers must make a decision and notify the provider and facility of the decision within three calendar days for a standard request and within one calendar day for an urgent request. The turnaround times are a little longer for non-electronic requests - within five calendar days for a standard request and two calendar days for an urgent request.

West Virginia

West Virginia statute allows for a bundled request per episode of care. An episode of care is defined as a medical condition or specific illness. For non-life threatening or routine medical conditions, the health insurer must respond within five business days from the date the PA was received. For life threatening or non-routine medical conditions, the insurer must respond within two business days. Incomplete PAs must be corrected within two business days by the provider from the date of receipt of the insurer. The health care provider shall provide the requested information within three business days from the date of the returned request and the health insurer shall render a determination within two business days after the receipt of the requested information.

[43] Wyo. Stat. Ann. §§ 26-55-101 through -113
[44] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400
[45] Washington RCW 48.43.830 https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.830

Wyoming

The *Ensuring Transparency in PA Act* relied heavily on the American Medical Association model and established response times for PA requests.[46] PA response times for non-emergent responses are to be within five calendar days of obtaining all necessary information to complete the review. Urgent authorizations are to be completed within 72 hours of obtaining all necessary information. Health insurers and contracted utilization review entities shall not require PA for medications used for opioid use disorder. In addition, a health insurer or contracted utilization review entity shall not require PA for rehabilitative or habilitative services including, but not limited to, physical therapy service or occupations therapy services for the first twelve visits for each new episode of care.

Updating technology and systems

Texas

In 2014, Texas mandated standardized PA request forms for health care services and prescription drug benefits.[47] The code, which took effect on September 1, 2015, established an advisory committee tasked with updating the forms every two years. Its primary goal was to streamline the PA process, making it more efficient and transparent for both providers and patients. ~~By standardizing the forms and ensuring their accessibility, the code aimed to reduce confusion and facilitate a smoother authorization process for necessary health care services.~~ The forms must be provided in both paper and electronic formats and made accessible on health plan websites. Medicaid and CHIP are required to accept these forms.

Commented [AHIP33]: Most state examples did not provide commentary, therefore deleted to keep aligned with the other descriptions.

Washington

Washington state's PA legislation differs from other states by prioritizing the use of Electronic Health Records (EHR) and interoperable systems, requiring automatic decisioning of some requests, and setting faster turnaround times for PA approvals. It also requires carriers to include PA data in their annual report to the Office of the Insurance Commissioner (OIC). ~~Washington was the first state to mandate that carriers receive PA requests through physician practice EHRs.~~

Commented [AHIP34]: Most state examples did not provide commentary, therefore deleted to keep aligned with the other descriptions.

With the passage of Engrossed Second Substitute House Bill (ESSHB)1357[48] in 2023, each carrier is required to build and maintain a PA application programming interface (API) that automates the process for in-network providers to determine whether a PA is required for health care services, identify PA information and documentation requirements, and facilitate the exchange of PA requests and determinations from its EHR or practice management system by January 1, 2025. Carriers would also be required to automate the process to determine whether a PA is required for durable medical equipment or a health care service, streamlining the process. The API requirements were modified by Substitute House Bill (SHB) 1706[49] in

[46] Wyo. Stat. Ann. §§ 26-55-101 through -113

[47] see 28 Tex. Admin. Code § 19.1810

[48] Washington ESSHB 1357 https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/1357-S2.SL.pdf?cite=2023%20c%20382%20s%201

[49] Washington SHB 1706 https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/House/1706-S.SL.pdf

2025 to align the API requirements codified in Washington's RCW with the guidance and timelines in the CMS Interoperability and PA Final Rule[50].

West Virginia

During the 2024 Legislative Session, WV updated PA laws[51] to require a health insurer to submit requests with any related communication via an electronic portal.

Improving transparency

Oklahoma

House Bill 3190[52] requires health insurers to publish their PA requirements online, ensuring they are accessible to patients and providers. If a utilization review entity—defined as an individual or organization that performs PA for a health benefit plan—plans to implement a new requirement or change an existing one, they cannot do so until their website reflects the updated information.

Furthermore, utilization review entities are required to enhance communication opportunities during the PA process. They must have staff available for phone calls regarding PA issues at least eight hours a day during normal business hours. In addition, they must allow staff to address communications about PA concerns after regular business hours and provide treating providers with the opportunity to discuss a PA denial with an appropriate reviewer.

All adverse determinations and appeal decisions must be made by a physician or licensed mental health professional to ensure that qualified professionals are involved in medical decisions. For adverse determinations, the physician or licensed mental health professional must:

- possess a current and valid unrestricted license in the United States;
- have the appropriate training, knowledge, or expertise to apply relevant clinical guidelines to the requested health care service; and
- make the determination under the clinical direction of a licensed physician who serves as a medical director for the utilization review entity.

For appeals, the requirements are more strict~~er to ensure a fair process~~. The physician or licensed mental health professional must share the same or a similar specialty as the health care professional who typically manages the medical condition in question. This means they should either maintain board certification in the same specialty or have training and experience relevant to treating the condition and any related complications. All appeal decisions must consider all known clinical aspects of the health care service under review, including any pertinent medical records provided by the enrollee's health care provider.

Commented [AHIP35]: Most state examples did not provide commentary, therefore deleted to keep aligned with the other descriptions.

Pennsylvania

Pennsylvania passed Act 146 in 2022 to overhaul its PA rules. Specifically, health insurers are now required to post their medical policies and the medical services that are subject to PA on public-facing websites. Additionally, health care providers and health insurers will need to use electronic portals to streamline

[50] CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) https://www.cms.gov/priorities/burden-reduction/overview/interoperability/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

[51] W. Va. Code Ann. §33-15-4s et.seq.

[52] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400

document and information exchange. ~~Adjustments to individual states' PA rules along these lines may alleviate the administrative tangles that often result from a health care provider's unfamiliarity with a health insurer's policies.~~

Commented [AHIP36]: Most state examples did not provide commentary, therefore deleted to keep aligned with the other descriptions.

Texas

If a PA exemption is denied, the insurer is required to provide a notice to the provider describing why the exemption was denied, directions on how to appeal the denial and information on how to file a complaint with TDI.[53] Determinations must be made by an individual licensed to practice medicine in Texas who has the same or similar specialty as that physician. The physician or provider has the right to a review regarding a PA exemption to be conducted by an independent review organization.[54]

Washington

Starting October 1, 2020, and annually thereafter, carriers in Washington must include in their annual report to the OIC aggregated and deidentified data related to their PA practices and experience for the prior plan year.[55] For each category (inpatient medical or surgical, outpatient medical or surgical, mental health and substance use disorder, durable medical equipment, diabetes, and prescription), carriers must list the ten codes with the:

- highest total number of PA requests during the previous plan year, including the total number of PA requests for each code and the percentage of approved requests for each code;
- highest percentage of approved PA requests during the previous plan year, including the total number of prior requests for each code and the percentage of approved requests for each code; and
- highest percentage of PA requests that were initially denied and then subsequently approved on appeal, including the total number of PA requests for each code and the percentage of requests that were initially denied and then subsequently approved.

West Virginia

In West Virginia, if a PA request is rejected by the health insurer and the health care provider asks for an appeal by peer review, the peer review shall be with a health care provider similar in specialty, education, and background. The time frame for a peer-to-peer appeal process shall take no longer than five days from the date of request of the peer-to-peer consultation. The time frame regarding an appeal of the decision on a PA shall take no longer than 10 business days from the date of the appeal submission.

Wyoming

The *Ensuring Transparency in PA Act* ~~and~~ established guidelines for review of adverse determinations.[56] Individuals qualified to make adverse determinations need sufficient knowledge in the applicable practice area or specialty, knowledge of coverage criteria, have an unrestricted license to practice within the scope of their profession recognized in the United States or District of Columbia, and knowledge of the person's medical history and diagnosis. The health insurer or contracted utilization review entity shall provide the

[53] see 28 Tex. Admin. Code §19.1732(b)

[55] Washington RCW 48.43.0161 https://app.leg.wa.gov/RCW/default.aspx?cite=48.43.0161
[56] Wyo. Stat. Ann. § 26-55-101 through -106

opportunity for the provider to discuss the medical necessity of the service. An attempt to schedule the discussion should take place within five days of the provider's request.

Finally, the insurer or contracted utilization review entity shall make any PA requirements and restrictions easily accessible on their website to enrollees, health providers and the public. Should a provider ask for the PA requirements or restrictions from an insurer, the insurer must provide the list to the requesting party within 24 hours. [57] Furthermore, any changes to the requirements must be posted 60 days in advance of the change's enactment. [58] These deadlines have to do with the disclosure and review of prior authorization requirements, not a specific patient PA.

The federal government

In addition to state legislative action, the Centers for Medicaid and Medicare Services (CMS) within the federal Department of Health and Human Services (HHS), issued a CMS Interoperability and PA Final Rule[59] in 2024 ~~in an effort~~ to set uniform national PA standards for the federal health coverage programs under its jurisdiction, as well as for Qualified Health Plans offering ACA compliant coverage through Federally Facilitated Exchanges. The rule created uniform timeframes for PA decisions, data exchange requirements, transparency requirements, and other digitization efforts. ~~While this~~The rule requires impacted payers to build ePA systems to communicate prior authorization information and efficiently and transparently process PA requests. ~~does not reach health insurers operating in states with State-Based Exchanges, having a federal baseline may help encourage national uniformity as states continue to grapple with the issue.~~

These new ePA systems will enable:

- Electronic access to information for patients on PA requests and decisions;
- Electronic access to information for providers on when PA is required and what information is required to accompany a PA request;
- Electronic exchange of PA requests and decisions between providers and payers; and
- Electronic exchange of PA information across payers.

In addition, the federal standards set PA response timeframes, generally requiring impacted payers to send a PA decision within 72 hours for expedited or urgent requests and 7 calendar days for standard or non-urgent requests.

The federal rule also requires impacted payers to specify a reason when they deny a PA request, regardless of the method used to send the PA request. The reason for denial must be of sufficient detail to enable the provider to know what action to take as follow-up – that is, whether to appeal, submit additional documentation, or identify alternative treatment options.

The federal rule includes an extensive list of PA-related information that impact payers must publicly report, including:

Commented [AHIP37]: Pulled from the end of the paper to above the trade association section and expanded to provide additional context.

[57] Wyo. Stat. Ann. § 26-55-103
[58] Wyo. Stat. Ann. § 26-55-103
[59] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

- A list of all items and services that require PA;
- The percentage of standard PA requests approved, aggregated for all items and services;
- The percentage of standard PA requests denied, aggregated for all items and services;
- The percentage of standard PA requests approved after appeal, aggregated for all items and services;
- The percentage of PA requests for which the timeframe for review was extended and the request was approved, aggregated for all items and services;
- The percentage of expedited PA requests approved, aggregated for all items and services;
- The percentage of expedited PA requests denied, aggregated for all items and services;
- The average and median timeframe between submission of a standard PA request and a decision, aggregated for all items and services; and
- The average and median timeframe between submission of an expedited PA request and a decision, aggregated for all items and services.

While this rule does not reach health insurers operating in states with State-Based Exchanges, having federal standards may help encourage national uniformity as states continue to grapple with the issue. Additionally, as mentioned below, an industry PA initiative includes a voluntary commitment across more than 45 plans to support the new technical standards for ePA beyond the federal programs impacted by the rule to all lines of business.

~~Provider~~ Trade Associations

American Medical Association Model Legislation

The goal of the AMA model legislation[60] is to improve transparency and limit interruptions to patient care. The following states have taken language directly from the model legislation: Delaware, Georgia, Illinois, Mississippi, New Jersey, Oklahoma, and Wyoming.

The legislation recommends:

- Establishing quick response times (24 hours for urgent, 48 hours for non-urgent care).
- Requiring adverse determinations to be made only by a physician licensed in the state and of the same specialty that typically manages the patient's condition.
- Prohibiting retroactive denials if care is preauthorized.
- Requiring authorizations to be valid for at least 1 year, regardless of dose changes, and for those with chronic conditions, to be valid for the length of treatment.
- Requiring the public release of insurers' PA data by drug and service as it relates to approvals, denials, appeals, wait times and more.

[60] American Medical Association's Ensuring Transparency in Prior Authorization Act https://www.ama-assn.org/system/files/model-bill-ensuring-transparency-in-prior-authorization.pdf

- Requiring new plans to honor a patient's PA for at least 60 days; and
- Reducing volume using PA exemptions or gold-carding programs.

It also defines several terms including clinical criteria, medically necessary health care services, PA, urgent health care service, and utilization review entity.

A utilization review entity is any individual or entity that performs PA on behalf of certain other entities, including but not limited to, insurers that write health insurance policies, a preferred provider organization or health maintenance organization, or an employer with employees who are covered under a health benefit plan or health insurance policy. Under the bill, a utilization review entity is required to make PA requirements and restrictions readily accessible on its website in detailed but easily understandable language. This should also include written clinical criteria.

Utilization review entities are also required to submit an annual report to a given state's Department of Insurance that contains specific information about PA requests from the previous calendar year.

The bill defines medically necessary health services as those that a prudent physician would provide to diagnose or treat an illness, are clinically appropriate, in accordance with generally accepted standards of medical practice, and not primarily for economic benefit. If a utilization review entity is questioning whether a health care service is medically necessary, it must notify the enrollee's physician. Before issuing an adverse determination, the enrollee's physician must be given the opportunity to discuss the medical necessity of the service with the physician determining authorization of the service under review.

Furthermore, a utilization review entity issuing an adverse determination must explain its reasoning using its own PA requirements as a basis, provide the clinical criteria used, inform the enrollee of their right to appeal and the process to file an appeal, and provide all information necessary to support a successful appeal.

When issuing a denial of an appeal, the utilization review entity must provide the enrollee and requesting health care provider with the reasons for denying the appeal, the clinical criteria used in determining the denial of the appeal, the process for challenging the determination, and all information necessary to support a successful second level appeal (when the next level is not an external review process).

The model legislation also outlines a gold-card system. A utilization review entity may not require a health care provider to complete a PA for a health care service if in the most recent 12-month period, the utilization review entity has approved or would have approved not less than 80% of the PA requests submitted by the health care provider for that service, including any approval granted after an appeal.

Finally, the bill establishes PA exemptions for emergency services and medications for opioid use disorder (MOUD) and outlines electronic standards for PA. By a given date, an insurer must accept and respond to PA requests under the pharmacy benefit through a secure electronic transmission using the NCPDP SCRIPT Standard ePA transactions. Any technology not directly integrated with a physician's electronic health record/electronic prescribing system must not be considered secure electronic transmission.

American Psychiatric Association Model Legislation

In 2022, the American Psychiatric Association (APA) developed model legislation[61] aimed at reforming the PA process to reduce unnecessary administrative burdens and improve patient access to care. This legislation focuses on streamlining the authorization process, increasing transparency, and ensuring timely decision-making. ~~It protects the rights of patients with mental health conditions, preventing unfair denial of coverage or excessive delays in accessing necessary care~~.

Commented [AHIP38]: Redlines in the paragraph keep the paper objective.

The proposal identifies specific scenarios that would be exempt from PA, including:

1) Generic prescription drugs that are not classified as controlled substances under 21 CFR 1308.11 through 21 CFR 1308.15 or under any state criminal law.
2) Any prescription drug, whether generic or brand-name, that is not classified as a controlled substance in federal or state law, after the insured or enrollee has been prescribed the drug without interruption for six months.
3) Any prescription drug, whether generic or brand-name, where the insured or enrollee has already undergone PA for the same dosage and received approval for coverage, on the grounds of therapeutic duplication.
4) Any prescription drug, whether generic or brand-name, when the dosage has been adjusted by the prescriber.
5) Any long-acting injectable prescription drug.

The APA's model legislation also aims to eliminate unnecessary paperwork and ensure that any denial of coverage is made by a physician with the appropriate expertise. Denials during the PA process must be made by a physician who specializes in the same field as the prescriber or who focuses on the diagnosis and treatment of the condition for which the drug was prescribed.

The legislation outlines expedited internal appeal processes with quick response times for denials. It requires decisions to be made within 48 hours for expedited appeals. If the prescriber believes that the insured or enrollee will suffer serious harm without access to the prescribed drug, the denial becomes eligible for an expedited internal appeal. Once the expedited appeal process is initiated, the insurance carrier must render a decision within 48 hours and provide written notice. If a decision is not made within this timeframe, the initial denial is automatically overturned, and the insured or enrollee receives immediate coverage approval for the prescription drug.

Additionally, the model legislation proposes eliminating PA requirements through the implementation of gold-carding programs. Under these programs, a physician or provider would not need PA for a specific health benefit if, during the most recent six-month evaluation period, the carrier approved or would have approved at least 90% of the PA requests submitted by that physician or provider for that health benefit. Physicians or providers will be reevaluated every six months to determine their eligibility for this exemption.

[61] APA Prior Authorization Model Legislation https://votervoice.s3.amazonaws.com/groups/americanpsych/attachments/SAC/2022%20APA%20Prior%20Authorization%20Reform%20Model%20Legislation.pdf

~~The federal government~~

~~In addition to state legislative action, the Centers for Medicaid and Medicare Services (CMS) within the federal Department of Health and Human Services (HHS), issued a CMS Interoperability and PA Final Rule[62] in 2024 in an effort to set uniform national PA standards for the federal health coverage programs under its jurisdiction, as well as for Qualified Health Plans offering ACA compliant coverage through Federally Facilitated Exchanges. The rule created uniform timeframes for PA decisions, data exchange requirements, transparency requirements, and other digitization efforts. While this rule does not reach health insurers operating in states with State-Based Exchanges, having a federal baseline may help encourage national uniformity as states continue to grapple with the issue.~~

Private PA Voluntary Iindustry Initiative

In June 2025, AHIP and BCBSA announced a voluntary initiative ~~efforts~~ by ~~its member~~ health insurance providers to simplify prior authorization, with a focus on "connecting patients more quickly to the care they need while minimizing administrative burdens on providers."[63] The initiative ~~pledge is the outcome of a survey of AHIP's members[64] and~~ applies to insurance markets including Commercial coverage, Medicare Advantage, and Medicaid managed care. The participating member health plans voluntarily commit to:

- **Standardize electronic PA** by January 1, 2027. Participating health plans will work toward implementing common, transparent submissions for e~~lectronic~~ PA.
- **Reduce the scope of claims subject to prior authorization**, with demonstrated reductions by January 1, 2026. Individual plans will commit to specific reductions to medical PA as appropriate for their particular market.
- ~~**Guarantee**~~ **Ensuring continuity of care when patients change plans**, beginning January 1, 2026. When a patient changes insurance companies during a course of treatment, the new plan will honor existing PAs for benefit-equivalent in-network services as part of a 90-day transition period.
- **Enhance communication and transparency on determinations,** operational for fully insured and commercial coverage by January 1, 2026, with a focus on supporting regulatory changes for expansion to additional coverage types.
- **Expand real-time responses.** In 2027, at least 80% of approvals of electronically submitted complete PA ~~electronic prior authorization~~ requests will be answered ~~-~~in real-time and carriers will support federally-required technical standards for ePA requirements beyond federal programs across all markets.
- **Ensure medical review of denied requests based on medical necessity / clinical factors**, a standard that is already in place

Commented [A39]: Redlines include clarifications to the Initiative.

[62] ~~https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability~~

[63] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization

[64] ~~https://ahiporg-production.s3.amazonaws.com/documents/202506_AHIP_Report_Prior_Authorization-final.pdf~~

Given the immense use of resources consumed by the PA process, some entrepreneurs have created businesses that exist solely to facilitate PA electronic communication between health care providers and health benefit plans.

Takeaways

States should work within the broader NAIC to develop Prior Authorization Standards and align with federal requirements.

Take advantage of data calls

Make use of targeted data calls while in the legislative process to understand your market. This data will prove invaluable to mold future legislation that will benefit your consumers as well as your providers and insurers.

Incorporat~~eing~~ flexibility in legislation

Any new processes in legislation, while well-intentioned, may cause unintended consequences to consumers. New processes, such as e~~lectronic~~ PA, can cause unneeded delays if systems crash unless there are alternate methods permitted or sufficient time allowed for implementation.

Build relationships with state partners

In all conversations with providers, regulators, insurers, and consumer organizations, stay patient focused. The ultimate goal is to get patients the necessary, evidence-based care they need in the shortest amount of time at an affordable cost.

Implementation processes

As with any health care legislation, prior authorization changes to law can require significant effort to implement. It is important for state agencies to understand their roles with any changes, and to have mechanisms in law or processes in place to communicate how actions or decisions by one agency may impact the work of other agencies. In addition, many of the changes to facilitate faster processing time require IT updates at both the insurer and provider levels, taking both time and a financial commitment to achieve.

Develop provider and consumer education

States may pursue public awareness campaigns so that health insurance consumers and their physicians become familiar with PA processes and the attendant appeal rights. States may also highlight rules currently in effect designed to significantly increase transparency of health insurer processes. Bringing more focus to the health insurance consumer experience with PA will greatly benefit those depending on the coverage they purchased to help navigate and address complex health concerns.

Create structure for enforcement

New PA requirements can have complicated enforcement mechanisms, and some may require additional staff expertise or investment in training. The Regulatory Framework (B) Task Force will evaluate the need for an ad hoc or other group to support regulators newly embarking on PA enforcement.

APPENDIX—CHART ON STATE PA LAWS AND TYPE PRIOR AUTHORIZATION LAW

