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Comments are being requested on this draft by Wednesday, Nov. 19, 2025. Comments should be sent only by email to Jolie Matthews at jmatthews@naic.org.

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Prior Authorization White Paper

Contents

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What is prior authorization?

Prior authorization (PA) is a mechanism used to check that a service, treatment, or medication is covered by the health plan and is appropriate, medically necessary, safe, and cost effective. It is intended to ensure safety (e.g., prevent negative drug interactions), reduce utilization of medically unnecessary or ineffective treatments or services, and contain health care costs. PA is used for a broad range of services, treatments, and medications. By formalizing in advance, in writing, the insurer's commitment to covering a health care service, PA can achieve a favorable balance between costs and benefits for both insurers and their members. 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 burdening providers and delaying care for consumers.

How this document can help regulators

In recent years, state legislatures have enacted and updated PA statutes to streamline PA processes to reduce administrative burdens, support improved patient outcomes, and promote greater transparency in the PA process . 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 electronic health record (EHR) or an online portal), timeframes for plan responses, and "provider gold-carding," which is a system in which providers can

bypass the PA process given their previous record of consistently providing evidence-based medical care. This white paper is meant to be a source of information and a roadmap of legislative options related to PA.

This white paper will not elaborate on the growing use of artificial intelligence (AI) in the PA process. The Innovation, Cybersecurity, and Technology (H) Committee (H Committee) is the more appropriate forum for a detailed discussion of this topic. The Regulatory Framework (B) Task Force, however, would be comfortable assisting the H Committee in any of its work to better understand the use of AI in the PA process in any forthcoming materials.

The prior authorization process

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

- ***Submission:*** The health care provider determines whether a PA is required, verifies the process for submitting, and submits a PA request and the required supporting clinical documentation to the insurer, detailing the medication, treatment, or service recommended for the patient.
- ***Review:*** The insurer reviews the request, verifies the patient is currently covered with the insurer, determines if PA applies to the requested medication, treatment, or service, and then evaluates it against its clinical guidelines and policies.
- ***Decision:*** Based on its review, the insurer either approves ~~or partially approves~~ the ~~coverage~~ authorization request or makes an adverse determination by denying the ~~coverage~~ request, often providing an explanation.
- ***Appeals:*** If the request is denied, the patient or provider may appeal the adverse determination through the insurer's appeal process and provide additional information to support the necessity of the treatment. Two levels of appeals processes are typically available—internal and external review.

Commented [EC1]: A partial approval should be considered an adverse determination to access appeal opportunities and for data reporting.

Commented [EC2]: For the Task Force to consider, the use of the term "coverage" may not be the most appropriate term here and throughout the document. A prior authorization, unfortunately, does not always determine coverage. We hear from physicians frequently that care may still be denied even though a prior authorization may have been approved.

Common treatments and medical services subject to prior authorization

Although prior authorization is regularly applied to all types of ~~S~~services and treatments, some that may be more likely subject to PA are those that are high-risk, high-cost, or subject to clinical variation. Examples include:

- ***High-Cost and Specialty Drugs:*** Medications that are expensive or require careful monitoring, such as biologics or oncology drugs.
- ***Advanced Imaging:*** Services such as magnetic resonance imaging (MRI), computed tomography (CT) scans, or positron emission tomography (PET) scans.

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

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- ***Surgical Procedures:*** Surgeries that are elective or involve the use of experimental techniques.
- ***Durable Medical Equipment:*** Items like wheelchairs or hospital beds.
- ***Mental Health and Substance Use Disorder Services:*** More intensive services and some medications for treating these conditions.

Prior authorization issue perspectives

To completely understand the PA process, one must contemplate three perspectives: the consumer, the provider, and the insurer. The three perspectives presented in this section reflect the information the Task Force heard in presentations, documents, and surveys as it was drafting this white paper. The Task Force's intent in including these perspectives is to capture the conversations state regulators may be called upon to engage in as they work to reform the PA process.

The provider perspective

Administrative burden and expense

Prior authorization seemingly imposes substantial administrative burdens, costs, and inefficiencies on providers. According to a recent American Medical Association (AMA) online survey of one thousand (1,000) physicians[2], physicians or their staff spend 13 hours per week requesting PAs. Health care providers must 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' EHRs do not always integrate with insurer systems, requiring provider staff to manually enter data into these systems or use antiquated technology, such as fax machines, and phones to transmit sensitive information. Furthermore, incorrect or missing patient demographic and insurance information can delay PA or result in unexplained denials.

In some cases, health insurers require PA to be completed at defined intervals during a course of treatment. This may take the form of step therapy, which is the process by which an insurer requires the use of a particular treatment 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 and can negatively impact patient outcomes.

Some pharmacists have expressed concern over the added burden and processing time that can result when the PA determination is not completed by the prescriber or their staff before the prescription order is transmitted to the pharmacy (prospective) but is instead completed after it has been received at the pharmacy from the provider, submitted to the carrier for coverage and then returned to the provider for the authorization process to be completed (retrospective). The acceleration in the availability and use of

[2] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[3] Id.

electronic PA systems by prescribers could result in more prospective and fewer retrospective prior authorization determinations.

Additionally, treating physicians sometimes encounter health plan reviewers who have no experience treating the patient's condition, who are not in the same specialty, or who are not physicians at all. This results in significant and unnecessary time spent attempting to justify a course of treatment to an inexperienced health plan representative and the potential for an inappropriate denial due to reviewer's lack of experience.

Lack of consistency and transparency

Definitions of medical necessity for a particular service differ among insurers, and some insurers define medical necessity without providing the clinical criteria necessary for a provider to determine if the health care service being requested meets the medical necessity threshold. Providers have to spend a great deal of time~~may need to work more closely with insurers to~~ determining~~e~~ what will be approved for each patient's plan and potentially researching alternative treatments that may not be as effective as the provider's preferred treatment. Furthermore, requiring a provider to navigate differences in medical necessity criteria during an ongoing course of treatment highlights the disruption that can be caused due to PA processes.

~~Some providers report that d~~Denial letters do not always include detailed clinical reasoning for an adverse determination or guidance on how to successfully submit an appeal. This can create confusion for providers who are trying to understand the rationale behind the determination and decide on next steps. Some health care providers completely avoid the PA process by not accepting insurance.

Technology and communication limitations

Health care providers ~~sometimes~~ often find the technologies (including software, web portals, fax machines, and phone) used to facilitate the PA process between the insurer and the provider are cumbersome and costly to implement.

Moreover, some providers report significant delays or denials resulting from an insurer not updating its utilization management processes or communicating 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 use manual processes that create inefficiencies when a provider is required to contact them. Many provider organizations, particularly smaller or independent practices, face challenges in adopting or maintaining EHR systems that are fully interoperable with insurer platforms. As a result, even where modern digital PA tools are available, provider staff may still need to manually enter information, make phone calls, or document communications via fax to complete the PA process.

Health care providers report that when they are required to contact a health benefit plan by phone, staff experience long hold times and need to create documentation of their communications by phone or fax in case such information is later needed to prove contact was made.

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Clinical variation and alignment with coverage criteria

In addition to determining whether a requested service is recommended according to research-based evidence, insurers also consider whether the service is the most cost-effective way to treat a patient. Clinical standards used by providers focus on delivering efficient and effective care depending on a patient's particular needs but may not always align with a plan's criteria ~~coverages~~ or account for cost considerations. As a result, there may be times that a provider's preferred treatment differs from what is initially approved for coverage. 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 health care provider denied a PA request must choose whether to appeal and possibly further delay treatment or prescribe a different, and potentially less effective, therapy that will be approved ~~is covered~~ by the patient's insurer.

The consumer perspective

While PA processes are intended ~~well-meaning for the health care system and designed~~ to help control costs and avoid unnecessary utilization of health care services, the consumer experience can be affected 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.[4] Of those insured adults that report having an issue with using their insurance, 16% reported experiencing problems specifically with PA processes.[5] Additionally, a KFF analysis of CMS' 2023 Transparency in Coverage data demonstrated that lack of prior authorization or appropriate referral accounted for 9% – more than six million - of in-network claim denials. Separately, a self-reporting physician survey conducted by the AMA in 2024~~3~~, found that 9~~4~~3% of ~~the patients of participant~~ participating physicians reported that prior authorization leads to patients experiencing delays in care that they would not have otherwise experienced.[6] Moreover, ~~78~~82% of the physicians in the same survey reported that PA processes can lead patients to abandon treatment.[7]

Beyond driving individuals away from engaging with their providers, 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 defined intervals during ongoing treatment, patients can experience undue stress and disruptions to their treatment and recovery.

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

[5] Id.

[6] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf~~https://web.archive.org/web/20240819003745/https://www.ama-assn.org/system/files/prior-authorization-survey.pdf~~

[7] Id.

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Effect on Costs

Studies have shown that commercial premiums could significantly increase if PA were to be eliminated.[8] However, PA processes may lead to delays or disruptions in care, which can lead patients to seek more expensive forms of care or forego treatment. Both options may lead to increased overall costs. For example, rather than scheduled treatment, there may be an increase in emergency room visits and otherwise preventable healthcare utilization.

For those consumers who do 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.[9] For example, one study found that an insured spends $646 out-of-pocket on average for an emergency room visit.[10]

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.[11] 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.[12] Seeking medical care can be stressful, complicated, and expensive, and adding the burden of PA processes can be harmful. Among individuals who reported 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 (26% v. 11%, respectively).[13]

The appeals process

It is important to note that most PA requests are approved. Additionally, AHIP's survey of their members reported similar numbers in the commercial market with approval rates for prescription medications at 90% and medical services at 97%.[14]

Despite the large percentage of coverage authorizations, many requests are still denied. In the event of a PA denial, there are mechanisms to appeal. The appeal process allows for the exchange of additional clinical information and further evaluation of the appropriateness of the requested treatment. These processes are often complicated, burdensome, difficult to access, and may discourage consumers who receive a denial from appealing.

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[8] For example: https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/8-18-23_BCBSA-Prior-Authorization-Impact.pdf.
[9] 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
[10] Id.
[11] https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/
[12] Id.
[13] Id.
[14] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf

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The following statistics are not specific to coverage denials related to prior authorization, but they illustrate the relatively low number of appeals in relation to denied claims. In Pennsylvania, for example, of the 2,135,041 claims denied by qualified health plans (QHPs) 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.[15] The pattern is repeated at the national level. QHPs offering individual health insurance coverage through the Federally Facilitated Exchange (FFE) in 2022 denied 69,315,868 claims. While the total number of denied claims does not account for claims that were, for example, ultimately paid before an appeal was filed, the numbers still demonstrate that a very small percentage of denials are appealed, and 42% of the appeals filed were overturned.[16] Increased transparency and streamlined functionality of the appeals process will help ensure fair and comprehensive claim adjudication.

The insurer perspective

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

- Directing patients toward medically necessary and appropriate treatments for patients to improve the quality of care;
- Preventing excessive, unnecessary, harmful or fraudulent health care utilization; and
- Containing costs and ensuring health care dollars are used effectively.

Patient Safety

Prior authorization can support patient safety by helping ensure that care decisions are based on clinical evidence~~, and tailored to individual needs. PA can prevent harmful activity by providers in some instances, such as providing inappropriate cancer treatments to patients who may not even suffer from cancer.[17]~~ Other examples cited may include overuse of opioids, antipsychotic medications in children, and high-risk medications for elderly patients.

PA can also help ensure patients receive a safe and appropriate level of care. For example, performing unnecessary imaging tests can have negative impacts, including false positives,[18] exposure to unnecessary radiation, and higher out-of-pocket costs. [19]

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[15] 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

[16] Id.

~~[17] 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~~

[18] 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

[19] 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.

Additionally, PA can help ensure that patients get care that is aligned with the latest evidence. For example, one study suggests that nearly 4 in 10 patients do not receive care that meets the latest medical evidence, which can negatively impact outcomes and may endanger patient safety.[20]

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

One purpose of PA is to prevent the use of low-value health care services, generating savings for insurers, plan sponsors and members~~ without compromising quality of care~~.[21] While the research on the value proposition of health care services may be clear in some cases, it may be evolving or disputed in others, especially for newer modes of treatment that may lack a large evidence base. This can lead to disputes, appeals and complaints to regulators.

On behalf of the Blue Cross Blue Shield Association (BCBSA), the actuarial firm 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.[22] 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. Milliman also notes cost-sharing would increase with the elimination of PA.

Commented [EC3]: It is unclear what policy change would result in this premium increase. Additionally, important to note, that few if any proposals being considered anywhere are geared toward elimination of PA entirely, so the data in this paragraph may not be particularly relevant to the discussion.

The same Milliman study found that PA encourages ~~performance improvement~~greater adherence to health plans' criteria, because providers in a program know they are being evaluated against ~~evidence based~~health plan's clinical criteria. In an independent study, Milliman estimated that eliminating this effect by restricting the use of PA may result in premium increases of 5.6% - 16.7% for plans in Massachusetts.[23] This highlights why it is critical that health plan's clinical criteria are evidence-based and consistent with nationally recognized standards of care developed by medical specialty societies.

Suggestive evidence of the cost containment impact of PA is also available through a variety of public sector programs.

When South Carolina's Medicaid program eliminated PA for rehabilitative behavioral health services in 2014, costs for those services reportedly jumped from $300,000 to $2 million per week, leading to a $54

[20] 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

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

[22] "Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements," March 30, 2023. Available at https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/8-18-23_BCBSA-Prior-Authorization-Impact.pdf

[23] "Potential impacts on costs and premiums related to the elimination of prior authorization requirements in Massachusetts," October 10, 2023. Available at https://www.milliman.com/en/insight/potential-impacts-costs-premiums-elimination-prior-authorization-massachusetts

million budget shortfall and an eventual reinstatement of PA requirements.[24] Similarly, researchers have found that in Medicare Part D, PA restrictions reduced spending on drugs by $96 per beneficiary-year (3.6% of drug spending), while only generating about $10 in paperwork costs.[25]

The Centers for Medicare & Medicaid Services (CMS) recently announced an Innovation Center model, the Wasteful and Inappropriate Service Reduction (WISeR) Model, for patients and providers in Original Medicare.[26] The model will test technology-enabled PA and pre-payment review to expedite and improve the review process for a pre-selected set of services that are vulnerable to fraud, waste and abuse. CMS describes the goals as helping patients avoid unnecessary or inappropriate care, lowering costs and easing administrative burden on providers.

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

For context, however, it is important to note that an industry survey reported that insurers across all lines of business do not base 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 friction and conflict that can arise with health care providers and members. This friction results from issues including administrative burden on providers and members, potential reductions in provider time available for patient care, provider frustration with being unable to provide the care that is best for their patients given their clinical training and knowledge of patient's individual health situation,~~resentment at being second-guessed~~, patient frustration with delays, and poorer quality outcomes due to delayed or abandoned care. These frictions are explored in detail in other sections of the white paper, but it is important to note that they may generate costs and burdens for insurers as well as other PA stakeholders.

Electronic prior authorization (ePA)

Health insurers and providers have been broadly supportive of moving away from manual and "paper" processes for PA and toward more uniform electronic submission standards. For example, insurers supported federal adoption of the CMS Interoperability and PA final rule in 2024, which is discussed in more detail in the Federal Government section.[28] This rule was followed by a complementary health

[24] https://kffhealthnews.org/news/article/prior-authorization-insurer-denials-patients-run-out-of-options/
[25] Zarek C. Brot-Goldberg, Samantha Burn, Timothy Layton & Boris Vabson, "Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare," January 2023. Available at https://www.nber.org/papers/w30878
[26] https://www.cms.gov/priorities/innovation/innovation-models/wiser
[27] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf
[28] https://www.ahip.org/news/press-releases/ahip-statement-on-the-cms-interoperability-and-prior-authorization-final-rule

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information technology certification rule published on Aug. 4, 2025. Insurer advocates have typically recommended that state activity in this area should focus on aligning state requirements for insurers with these federal rules, and that states should consider 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] Despite this, an AHIP survey of member plans reports that manually submitted PA requests still account for nearly half of all PA requests.[31]

Many physician and consumer organizations are also strong proponents of automation and have engaged at the federal and state levels to advance the use of a standard electronic prior authorization process that will both reduce costly administrative burdens and speed time to patient care. Organizations like the AMA have highlighted PA automation as an important part of PA reform efforts, as this technology holds promise in improving the transparency of what drugs and services require prior authorization and insurers' clinical documentation requirements, as well as increasing the efficiency of data exchange between providers and insurers. However, they are careful to point out that alignment with federal standards is key, and adoption of this automation through a physician's EHR using Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) Burden Reduction Implementation Guides and National Council for Prescription Drug Programs (NCPDP) SCRIPT electronic PA transactions is critical. Importantly, without both insurer and EHR support of HL7 FHIR and NCPDP PA standard transactions, physicians and other providers will not be able to leverage the efficiency of these new technologies. In a 2024 AMA survey, fewer than one-quarter (23%) of physicians reported that their EHR system offered electronic PA for prescription medications, indicating that an automated PA workflow is not available to the large majority of physicians.[32] Other electronic methods, such as individual payer portals, only place additional burdens on practices, as physicians and staff must leave the EHR workflow, enter unique logins and passwords for all the payers and plans with which they contract, navigate highly variable portal designs, and re-key clinical data into the insurer's proprietary online format.

In June 2025, nearly 60 national and regional health plans, representing 257 million lives, announced a series of new voluntary commitments aimed at simplifying and improving the PA process.[33] Through these commitments, participating health plans support increasing the use of ePA through the development of standardized data and submission requirements that will support faster turn-around times. Participating health plans committed that as of Jan. 1, 2027, 80% of medical PA requests with complete information will be processed in near real-time.

[29] https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states
[30] https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states
[31] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf
[32] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[33] https://www.bcbs.com/news-and-insights/article/right-care-right-place-right-time

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Many health plans are already moving towards a one-system solution across all product lines both public and private because it is expected to be easier to update their systems simultaneously and use for all product lines instead of managing multiple integrations and processes.

Several states are moving forward with implementation of a unified approach across both public and private commercial health insurance markets by extending the federal electronic PA requirements and standards for medical items and services to the private commercial market. Examples include Virginia, Alaska[34], California, Tennessee, Utah, and Washington[35].

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.

While a standardized electronic workflow can streamline the PA process and reduce delays in care delivery, automation is not a magic bullet to solving the complex PA issue. For instance, electronic PA processes that are based on faulty clinical criteria will deliver fast—yet inappropriate—denials. Accurate, up-to-date clinical criteria aligned with national medical specialty society guidelines and evidence-based literature must form the foundation of any successful electronic PA tool.

Selective use, gold carding, and other streamlining initiatives

Health plans have implemented a number of modifications to streamline the PA process and reduce the burden of PA for certain subsets of providers and patients. Gold carding is one such initiative that involves a process by which a high performing health care provider may qualify for an exemption from an insurer's PA requirements.[36] 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.[37]

Some health insurers have opposed statutory or regulatory mandates in this area, 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.

Evidence base

~~One of the key purposes of PA is to ensure that covered services are evidence-based and effective. In light of concerns from some physicians, advocates and policymakers about the evidence base used in PA,[38] it is important to clarify the current practices and requirements in this area~~.

[34] Alaska Statute 21.07.150 Prior authorization programming interface.
[35] https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.830.
[36] See e.g., https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf
[37] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf
[38] ~~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~~

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Health plans collect and assess medical evidence for the specific populations they serve. According to health plans, 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.

Health plans subject to accreditation typically undergo rigorous reviews of insurers' clinical guidelines. 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, 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~~.

Commented [EC4]: Internal appeals processes are not typically an independent check on the health plan's clinical criteria.

It is also important to note that 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 offer comparable clinical outcomes but differ significantly in cost or other factors relevant to patient experience, such as comfort, convenience or aesthetic considerations.[39]

Accreditation Standards for PA

The majority of states utilize accreditation entities such as the National Committee on Quality Assurance (NCQA) or URAC to ascertain that insurers are meeting a state's regulatory requirements. These accreditation bodies review 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 standards are in the process of being updated to align with the new federal requirements mentioned in this white paper.

Reform examples

States

Gold carding

There are several ways state laws have sought to reduce the level of PA, including limitations or exemptions for PA for certain services and gold carding.

"Gold carding" describes a process by which a health care provider may qualify for an exemption from some or all 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.

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

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Under state-mandated gold carding programs, a health insurer is required 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~~plan data to determine the number of times the provider's request for a particular service was approved. If the percentage of approved requests meets the threshold rate mandated by the state, the insurer will be required to issue the provider a gold card exemption for that service. State-level gold carding laws are relatively new, and their long-term impacts remain uncertain. ~~While these laws are intended to reduce administrative burden by exempting providers from certain PA requirements, research has shown that they may also increase service utilization and place upward pressure on health care costs.[40] In some cases, the thresholds for exemption are set low, which can pose risks to patient safety.~~ Additionally, some laws limit an insurer's ability to review or revoke a provider's gold card status ~~except on an infrequent basis~~, such as once every 12 months. ~~This restricted oversight can delay timely intervention when concerns arise.~~ At the same time, some insurers have begun developing their own gold carding initiatives, which may allow for more flexibility and~~,~~ service-specific targeting~~, and closer monitoring~~..

Commented [EC5]: We suggest these are minimal data (and coming out of the pandemic) to conclude that utilization increases.

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, excepting instances where a state has mandated broad-based gold-carding requirements. Even if a provider has been granted a gold card for a particular service, if an insurer determines that a service provided by the provider holding 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.

Arkansas

Arkansas includes PA for prescription drugs its gold card program requirement. Insurers in Arkansas examine a health care provider's history of all PAs requested for all health care services, which Arkansas defines to include prescription drugs.[41] 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.[42] 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.[43]

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.[44] 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.

~~[40] https://legislature.vermont.gov/assets/Legislative-Reports/Blue-Cross-VT-Provider-Passport-Program-Report-01-15-2023.pdf.~~

[41] Ark. Code Ann. § 23-99-1103(10)(A).

[42] Ark. Code Ann. § 23-99-1120(a).

[43] Ark. Code Ann. § 23-99-1122(a)(3).

[44] Ark. Code Ann. § 23-99-1128(b).

AMA COMMENTS

Texas

In 2022, Texas enacted House Bill 3459, known as the Texas Gold Act[45]. This Act was amended in 2025 with the passage of House Bill 3812.[46] House Bill 3812: 1) extended the length of gold cards from six months to one year; 2) included claims from products not regulated by the Texas Department of Insurance (TDI) in gold card evaluations; and 3) placed restrictions on administrative licenses only for the physician in charge of all utilization management for a health plan and physicians making recissions. The law is effective beginning Sept. 1, 2025.

Under these laws, physicians and providers can be exempted from ~~requiring~~ PA requirements for certain health care services if they maintain an approval rate of at least 90% over a recent one year period – for those services. When evaluating a physician or provider for this exemption, an insurer must consider all PA requests submitted by that physician or provider across all health insurance policies and health benefit plans issued by the insurer, not just those that allow for gold carding.

It is important to note that these laws do not apply to patients insured by Medicaid or Children's Health Insurance Program (CHIP). The TDI oversees 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. [47]

The physician or provider is not required to request 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.

Under the law, 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 12 months before being rescinded.

West Virginia

An updated West Virginia statute lowered the requirements to qualify for a gold card program[48]. 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 has received a 90% final prior approval rating in a six-month period, 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.

[45] https://legiscan.com/TX/text/HB3459/2021.
[46] Texas House Bill 3812 https://legiscan.com/TX/text/HB3812/id/3247239
[47] 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
[48] https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/IB%2021-08%20Electronic%20PA%20(1).pdf.

AMA COMMENTS

Wyoming

The Wyoming legislature passed legislation regarding provider exemptions from PA requirements (gold carding).[49] 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 preceding 12 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: 1) a statement that notifies the health care provider that the provider qualifies for the exemption; 2) a list of services for which the exemption applies; and 3) a statement of the 12-month duration. A health care provider may appeal a health insurer's or contract utilization review entity's decision to deny an exemption.

Addressing continuity concerns

District of Columbia

The District of Columbia[50] requires a PA to be valid for at least one year or for the course of the treatment, including any dosage changes.[51]

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. Illinois also prohibits concurrent review and post-service utilization review for certain services for which PA has been prohibited, which is important to ensure PA is not shifted to another manner of utilization management or cost-shifting to patients.[52]

New Hampshire

Starting Jan. 1, 2025, under New Hampshire's PA law, an approved PA cannot be revoked, limited, conditioned, or restricted for 60 business days.[53]

Oklahoma

House Bill 3190[54] 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 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.

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[49] Wyo. Stat. Ann. § 26-55-112

[50] https://code.dccouncil.gov/us/dc/council/laws/25-100.

[51] 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.

[52] https://www.ilga.gov/documents/legislation/103/HB/10300HB5395enr.htm

[53] RSA 420-J:6.

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

AMA COMMENTS

Tennessee

Tennessee passed a law[55] 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.

Wyoming

The Wyoming Insurance Code, titled *Ensuring Transparency in PA Act* was passed in 2024[56] 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

Michigan

Michigan's PA law[57] requires a review period of 72 hours for urgent PA requests, or within 72 hours of receiving additional information, if necessary. For non-urgent requests, insurers must act within 7 calendar days of submission or within 7 calendar days of receiving additional information. If an insurer fails to act within these timeframes, the prior authorization is automatically granted. Approved prior authorizations are valid for a minimum of 60 days or for the clinically appropriate duration, whichever is longer.

New Hampshire

Beginning Jan. 1, 2025, New Hampshire's PA law requires all PA requests to be processed within 7 calendar days if submitted electronically and 14 calendar days if submitted non-electronically. Urgent requests must be processed within 72 hours. If the health insurer does not notify the covered person and their provider within these time limits, the PA request will be considered approved.[58]

Oklahoma

House Bill 3190[59], which took effect on Jan. 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.

[55] https://legiscan.com/TN/text/HB0885/2023.
[56] Wyo. Stat. Ann. §§ 26-55-101 through -113
[57] Michigan PA 60 of 2022 (MCL 500.2212e)
[58] NH RSA 420-J:6.
[59] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400

AMA COMMENTS

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

Washington has implemented shorter turnaround times for PA approvals[60], 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 ePA 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. 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[61]. 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.

Wyoming

Wyoming's *Ensuring Transparency in PA Act* relied heavily on the American Medical Association (AMA) model legislation and established response times for PA requests.[62] 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 must 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 12 visits for each new episode of care.

[60] Washington RCW 48.43.830 https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.830
[61] https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/IB%2021-08%20Electronic%20PA%20(1).pdf
[62] Wyo. Stat. Ann. §§ 26-55-101 through -113

AMA COMMENTS

Updating technology and systems

Commented [EC6]: Colorado has also recently aligned automation standards with federal requirements.

New Hampshire

Starting Jan. 1, 2025, New Hampshire's PA laws incentivize electronic submissions by applying shorter processing timeframes for requests submitted electronically. Additionally, it permits providers to initiate peer-to-peer review before a determination is made.[63]

Texas

In 2014, Texas mandated standardized PA request forms for health care services and prescription drug benefits.[64] The regulation, which took effect on Sept. 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. 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.

Washington

Washington state's PA legislation differs from other states by prioritizing the use of EHR and interoperable systems, requiring automatic decisioning of some requests, and setting faster turnaround times for PA approvals. It also requires insurers to include PA data in their annual report to the Office of the Insurance Commissioner (OIC).

With the passage of Engrossed Second Substitute House Bill (ESSHB)1357[65] 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[66] in 2025 to align the API requirements codified in Washington's RCW with the guidance and timelines in the CMS Interoperability and PA Final Rule[67].

West Virginia

During the 2024 Legislative Session, West Virginia updated its PA laws[68] to require a health insurer to submit requests with any related communication via an electronic portal.

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[63] RSA 420-J:6.
[64] see 28 Tex. Admin. Code § 19.1810
[65] 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
[66] Washington SHB 1706 https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/House/1706-S.SL.pdf
[67] 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
[68] W. Va. Code Ann. §33-15-4s *et.seq*.

AMA COMMENTS

Ensuring qualifications of health benefit plan reviewers

Oklahoma

Oklahoma's House Bill 3190[69] requires all adverse determinations and appeal decisions to 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 stringent. 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.

Texas

Texas' regulations require PA determinations to 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.[70]

Improving transparency

New Hampshire

Beginning March 31, 2026, New Hampshire's PA law requires health insurers to report PA as specified in 45 CFR 156.223 to the commissioner and requires the New Hampshire DOI to post insurer-specific data online.[71]

Oklahoma

House Bill 3190[72] 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

[69] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400.
[70] see 28 Tex. Admin. Code §19.1732(b)
[71] RSA 420-J:6.
[72] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400.

concerns after regular business hours and provide treating providers with the opportunity to discuss a PA denial with an appropriate reviewer.

Pennsylvania

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

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.[73]

Virginia

Virginia requires each health insurer to make available by posting on its website no later than March 31 of each year the PA data for health care services for the previous calendar year for all metrics required for compliance with federal law and CMS regulations.[74] These specifically include those promulgated under 42 C.F.R. §§ 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c).[75] It also requires carriers to make available through one central location on the carrier's publicly accessible website or other electronic application, the list of services and codes for which prior authorization is required."[76]

Washington

Starting Oct. 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.[77] For each category (inpatient medical or surgical, outpatient medical or surgical, mental health and substance use disorder, durable medical equipment, diabetes, and prescription), insurers 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;

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

[74] Subsection F of § 38.2-3407.15:8 of the Code of Virginia.

[75] These include a list of all items and services that require prior authorization; the percentage of standard and expedited prior authorization requests that were approved, aggregated for all items and services; the percentage of standard and expedited prior authorization requests that were denied, aggregated for all items and services; the percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services; the percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services; the average and median time that elapsed between the submission of a request and a determination by the ... plan, for standard prior authorizations, aggregated for all items and services; the average and median time that elapsed between the submission of a request and a decision by the ... plan for expedited prior authorizations, aggregated for all items and services.

[76] Subsection C of § 38.2-3407.15:8 of the Code of Virginia.

[77] Washington RCW 48.43.0161 https://app.leg.wa.gov/RCW/default.aspx?cite=48.43.0161

AMA COMMENTS

- 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

Wyoming's *Ensuring Transparency in PA Act* establishes guidelines for review of adverse determinations.[78] 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 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, under the Act, the insurer or contracted utilization review entity shall make any PA requirements and restrictions easily accessible to enrollees, health providers, and the public on their website. If a provider requests the PA requirements or restrictions from an insurer, the insurer must provide the list to the requesting party within 24 hours.[79] Furthermore, any changes to the requirements must be posted 60 days in advance of the change's enactment.[80] These deadlines relate to the disclosure and review of PA requirements, not a specific patient PA request.

The Federal Government

In addition to state legislative action, the CMS issued the CMS Interoperability and PA Final Rule[81] in 2024 to set uniform national PA standards for the federal health coverage programs under its jurisdiction, as well as for QHPs offering ACA compliant coverage through FFEs. The rule created uniform timeframes for PA decisions, data exchange requirements, transparency requirements, and other digitization efforts.

Specifically, the rule sets federal standards for 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 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

[78] Wyo. Stat. Ann. § 26-55-101 through -106
[79] Wyo. Stat. Ann. § 26-55-103
[80] Wyo. Stat. Ann. § 26-55-103
[81] https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

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 impacted payers must publicly report, including: 1) a list of all items and services that require PA; 2) the percentage of standard PA requests approved, aggregated for all items and services; 3) the percentage of standard PA requests denied, aggregated for all items and services; 4) the percentage of standard PA requests approved after appeal, aggregated for all items and services; 5) the percentage of PA requests for which the timeframe for review was extended and the request was approved, aggregated for all items and services; 6) the percentage of expedited PA requests approved, aggregated for all items and services; 7) the percentage of expedited PA requests denied, aggregated for all items and services; 8) the average and median timeframe between submission of a standard PA request and a decision, aggregated for all items and services; and 9) the average and median timeframe between submission of an expedited PA request and a decision, aggregated for all items and services.

In addition to these requirements, the rule requires impacted payers to build ePA systems to communicate PA information and to efficiently and transparently process PA requests. Under the rule, 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.

Although this rule does not reach health insurers operating in states with State-Based Exchanges (SBEs), having federal standards may help encourage national uniformity as states continue to grapple with the issue. Additionally, as discussed in the Industry Trade Associations section, 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.

The CMS Interoperability and PA Final Rule does not apply to prescription drugs. The rule explicitly excludes drugs from its requirements for PA, including the new API standards and process changes, because the CMS determined that the standards and timeframes for drugs differ significantly from those for medical items and services. While the rule excludes drugs, the CMS has noted comments regarding this exclusion and has indicated that specific rulemaking for drug PA may be forthcoming.

AMA COMMENTS

Provider Trade Associations

American Medical Association (AMA)

AMA PA and Utilization Management Reform Principles

To address its concerns with utilization management programs, such as PA, in 2017~~4~~, the AMA published its Prior Authorization and Utilization Management Reform Principles.[82] This proposal received endorsement from over 100 medical and physician associations. The goal was to ensure that patients have timely access to necessary treatments while also reducing administrative costs for the healthcare system.

The AMA strongly urged health plans, benefit managers, and any other party conducting utilization management, to apply the 21 principles outlined in its proposal. The principles included the following:

- Any utilization management program applied to a service, device or drug should be based on accurate and up-to-date clinical criteria and never cost alone. The referenced clinical information should be readily available to the prescribing/ordering provider and the public.
- Utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues.
- A drug or medical service that is removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year.
- A PA approval should be valid for the duration of the prescribed/ordered course of treatment.
- Utilization review entitles should publicly disclose, in a searchable electronic format, patient-specific utilization management requirements, including PA, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by providers and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers what supporting documentation is needed to complete every PA and step therapy override request.
- Utilization review entities should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing.
- Eligibility and all other medical policy coverage determinations should be performed as part of the PA process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.
- If a utilization review entity requires PA for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information.
- PA should never be required for emergency care.

[82] Prior Authorization and Utilization Management Reform Principles https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf

AMA COMMENTS

- Health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways.

Consensus Statement on Improving the PA Process

In 2018, the AMA collaborated with healthcare providers - including physicians, pharmacists, various medical groups, and hospitals - as well as health benefit plans to identify ways to enhance the PA process. The goals of this collaboration were to ensure safe, timely, and affordable access to evidence-based care for patients, improve efficiency, and reduce administrative burdens. Together, they published the "Consensus Statement on Improving the Prior Authorization Process." [83]

In the statement, five areas were identified that could improve PA programs:

- **Selective Application of PA.** Differentiate the application of PA based on provider performance regarding quality measures, adherence to evidence-based medicine, or other contractual agreements. This approach can help target PA requirements where they are most needed and reduce the administrative burden on healthcare providers. Criteria for selective application may include ordering or prescribing patterns that align with evidence-based guidelines and historically high approval rates for PA.
- **PA Program Review and Volume Adjustment.** Regularly reviewing the list of medical services and prescription drugs subject to PA can help identify therapies that no longer require it due to low variability in utilization or low denial rates. This review can also uncover services, especially new and emerging therapies, where PA may be necessary due to insufficient evidence regarding their effectiveness or safety concerns.
- **Transparency and Communication Regarding PA.** Effective two-way communication channels between health plans, healthcare providers, and patients are essential for timely resolution of PA requests. This can help minimize delays in care and clearly convey PA requirements, criteria, rationale, and any program changes.
- **Continuity of Patient Care.** Maintaining continuity of care is crucial for patients undergoing active treatment, especially when there are changes in formulary or treatment coverage and/or when switching health benefit plans. Access to prescription medications for patients on established chronic therapies can also be impacted by PA requirements. Although many standards are in place regarding timeliness, continuity of care, and appeals—enforced by state and federal laws as well as private accreditation standards—additional efforts should be made to reduce the burdens and disruptions in patient care associated with PA.
- **Automation to Improve Transparency and Efficiency.** Moving towards industry-wide adoption of ePA transactions based on established national standards can streamline and enhance the process for all stakeholders. Additionally, providing electronic access to PA requirements and formulary information directly within EHRs and pharmacy systems can improve efficiency, reduce

[83] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf

time to treatment, and potentially decrease the number of PA requests, as healthcare providers will have the necessary coverage information when making treatment decisions. The adoption of technology by all involved stakeholders, including healthcare providers, health benefit plans, and their partners or vendors, is essential for achieving widespread utilization of standardized ePA processes.

AMA Model Legislation

The AMA has released model legislation multiple times, with the most recent publication in 2025. The goal of the model legislation[84] is to enhance transparency and minimize interruptions to patient care. The following states have adopted language directly from the model legislation: Delaware, Georgia, Illinois, Mississippi, New Jersey, Oklahoma, and Wyoming.

The model legislation recommends the following measures:

- Establishing quick response times: 24 hours for urgent care and 48 hours for non-urgent care.
- Requiring that adverse determinations be made solely by a physician who is licensed in the state and is in the same specialty that typically manages the patient's condition and with experience treating the patient's condition.
- Prohibiting retroactive denials for care that has been preauthorized.
- Requiring that authorizations remain valid for at least one year, irrespective of dose changes, and for those with chronic conditions, they should be valid for the duration 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.
- Prohibiting PA for the provision of medications for opioid use disorder (MOUD).
- Ensuring that new plans honor a patient's PA for at least 90 days.
- Reducing the volume of PA requests through exemptions or gold-carding programs.
- Improving transparency during adverse determinations and denials by requiring the utilization review entity to provide the enrollee and requesting health care provider with specific details about the determination and the enrollee's right to appeal.

The model legislation 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 (PPO), or health maintenance organization (HMO), or an employer with employees who are covered under a

[84] American Medical Association's Ensuring Transparency in Prior Authorization Act: https://fixpriorauth.org/sites/default/files/2025-04/Health%20Plans%2C%20Ensuring%20Transparency%20in%20Prior%20Auth%20Act%202025.pdf

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health benefit plan or health insurance policy. Under the model legislation, 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 the state's Department of Insurance (DOI) that contains specific information about PA requests from the previous calendar year. The DOI is required to submit a report to the legislature that includes a summary of the reports provided by the utilization review entities and recommendations for the removal of PA requirements on services that are regularly approved (80% of the time) for PA.

The model legislation 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. A notification of an adverse determination and a denial of an appeal must include the National Provider Identifier (NPI) of the physician who reviewed the PA request and is responsible for the determination, as well as the physician's credentials, board certifications, and specialty areas, expertise, and training.

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 model legislation 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 EHR/electronic prescribing system must not be considered secure electronic transmission.

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American Psychiatric Association Model Legislation

In 2022, the American Psychiatric Association (APA) developed model legislation[85] 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.

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 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 model 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.

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

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Legislative Organizations

National Council of Insurance Legislators (NCOIL)

Prior Authorization Reform Model Act

In March 2025, the National Council of Insurance Legislators (NCOIL) introduced a draft of the Prior Authorization Reform Model Act.[86] The primary purpose of the model act is to protect the patient-provider relationship from unreasonable third-party interference and to ensure that PA programs do not impede the independent medical judgment of physicians and other healthcare providers. The model act aims to improve timely access to care and increase transparency by establishing new requirements for health insurance companies.

Commented [EC7]: NCOIL recently adopted its model legislation.

Key provisions of the model act include:

- **Transparency and accessibility:** Insurers are required to publicly disclose which services necessitate prior authorization and to provide a transparent approval and denial process. They must also post statistics regarding PA approvals and denials on their websites in an easily accessible format.
- **Evidence-based criteria:** The clinical criteria used for PA decisions must be evidence-based, align with nationally accepted standards, and be made available online.
- **Physician review:** Denials must be reviewed by a physician, and appeals must also be examined by a physician or their representative.
- **Continuity of care:** Insurers must honor PAs from a previous insurer for a specified period (e.g., 90 days) during a patient's transition between health benefit plans.
- **Prohibition of retroactive denials:** Health plans are prohibited from retroactively denying claims for care that was preauthorized.
- **Time limits:** The model act establishes specific time limits for review processes.
- **Chronic conditions:** PAs for chronic or long-term conditions must remain valid for 12 months or the duration of the treatment, whichever is shorter.
- **Reporting:** Insurers must report PA data annually to the relevant state insurance department.

This model act applies to all health insurance insurers, plans, private review agents, and utilization review plans, with exceptions for self-insured health benefit plans under the federal Employee Retirement Income Security Act (ERISA) of 1974 and healthcare provided under the Workers' Compensation Act.

Industry Trade Associations

In June 2025, AHIP and the BCBSA announced a voluntary initiative by 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."[87] The initiative applies to insurance markets including

[86] https://ncoil.org/wp-content/uploads/2025/03/NCOIL-Prior-Auth-Reform-Model-Draft-3-26-25.pdf
[87] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization

commercial coverage, Medicare Advantage, and Medicaid managed care. The participating member health plans voluntarily commit to:

- **Standardize electronic PA** by Jan. 1, 2027. Participating health plans will work toward implementing common, transparent submissions for ePA.
- **Reduce the scope of medical claims subject to prior authorization**, with demonstrated reductions by Jan. 1, 2026. Individual plans will commit to specific reductions to medical PA as appropriate for their particular market.
- **Ensuring continuity of care when patients change plans**, beginning Jan. 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 Jan. 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 requests will be answered in real-time and health insurers will support federally-required technical standards for ePA requirements beyond federal programs across all insurance markets.
- **Ensure medical review of denied requests based on medical necessary/clinical factors**, a standard that is already in place

These commitments build upon ongoing health plan efforts to make PA a more seamless and transparent process and reflect insurers' goal to ensure patients receive the most effective care, at a more affordable cost.

Takeaways

State regulators should work within the broader NAIC to develop Prior Authorization Standards.

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 entire healthcare ecosphere.

Incorporating flexibility in legislation

Any new processes in legislation, while well-intentioned, may cause unintended consequences to consumers. Insurers, and providers. New processes, such as ePA, can cause unneeded delays if systems crash unless there are alternate methods permitted.

Commented [EC8]: We ask the Task Force to consider additional steps such as:
- Aggregating states' experiences with implementation, including challenges with enforcement, and identify best practices for addressing those challenges;
-Developing templates for states to use in their prior authorization data collection efforts so that data can easily be analyzed across payers and across markets;
-Establishing a working group to focus on enforcement opportunities and regulator interventions; and
-Considering the development of a model bill or a model regulation to implement meaningful reforms.

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Build relationships with state partners

In all conversations with providers, regulators and consumer organizations, stay patient focused. The ultimate goal is to get patients the necessary care they need in the shortest amount of time.

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

Observations of State Insurance Laws Regarding Prior Authorization

- 49 states have some form of PA law as well as the District of Columbia and Puerto Rico.
- 22 states and Puerto Rico have gold carding laws with some being enacted as early as 1998 with most having adopted gold carding laws between 2018 and 2024. There has been an increase in state adoptions in the last two years.
- Some states have PA statutes limited to emergency procedures, while others touch on most or all medical procedures that require prior authorization.

Common Provisions in Prior Authorization Laws

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- Response Times: Most jurisdictions have provisions relating to response times. Generally, these require a response in 24-72 hours for urgent requests and 5-7 business days for non-urgent requests. A few jurisdictions allow for automatic approval if no response is received within the required timeframe.
- Retrospective Denials: Half of the jurisdictions have provisions relating to retrospective denials. Most commonly these are prohibitions against pre-approved/authorized services except in cases of fraud, misrepresentation, ineligibility, or coverage lapses.
- Clinical Criteria and Medical Necessity: Just over half of jurisdictions have provisions related to clinical criteria and medical necessity. Common provisions include requirements for evidence-based and/or peer-reviewed standards and transparency requirements (clinical criteria available publicly or upon request) with a few requiring annual review/update of clinical criteria to include new or updated practice and guidelines.
- Qualifications of reviewer: 33 of 56 jurisdictions have requirements related to the qualifications of the reviewer. Most of these require adverse determinations to be made by a licensed physician or healthcare professional and some specify licensure in that state or a same or similar specialty as the treating provider. Other common requirements include board-certification and conflict-of-interest protections.
- Gold carding: 23 jurisdictions have provisions relating to gold carding. Trends in gold carding provisions include PA exemptions for providers with a greater than 90% approval rate and exemptions for certain procedures or services. Gold carding eligibility is typically granted for a specific time period and subject to renewal.
- Peer-to-peer/appeal process: 26 jurisdictions have provisions for peer-to-peer appeal processes. Most commonly these provisions require that providers have the opportunity to engage in a discussion with a clinician of the same or similar specialty as the requesting provider before a denial is considered final. Many also require expedited appeals for urgent conditions, external reviews from independent review organizations, or appeal reviewers to be different from the original reviewer.

