From: Chrisman, Zane A
To: Matthews, Jolie
Subject: Prior Authorization White Paper
Date: Tuesday, September 2, 2025 4:34:33 PM

Jolie,

Please forgive me for my tardiness and informality in trying to get these comments to you before your return to the office tomorrow. Also, as always, thank you for providing Arkansas Blue Cross and Blue Shield with an opportunity to comment.

Members of the company had a similar comment for sentences found on page 4 and page 5 related to technologies. The first sentence on page 4 states, "Providers' electronic health records generally do not integrate with insurer systems, so staff must manually enter data into these systems." The sentence on page 5 states, "Oftentimes, the technologies (including software, web portals, fax machines, and even communication by phone) used by insurer PA systems are outdated and cumbersome." Those who work with quality and prior authorizations in the company noted that these sentences are not entirely true as it is not always the insurer technologies that are outdated. It can also be the provider EMR systems that are outdated. Also, we often see providers who do not have an EMR system. The real issue is not necessarily the failure of an insurer to update its technology, so much as it is incompatibility between two systems. The hope is that as the healthcare industry moves toward adopting API and FIHR processes that this will help address the issue of incompatibility. To address this comment, Arkansas Blue Cross would suggest changing the language on page 5 to the following:

"Oftentimes, the technologies used to facilitate the PA process between the insurer and the provider (including software, web portals, fax machines, and even communication by phone) ~~used by insurer PA systems~~ are outdated and cumbersome, could come with added costs, and, once deployed, compatibility between the systems of the insurer and the provider may pose limitations." (Modifications to the original are in red.)

Also, on page 5, the paper notes that Arkansas passed legislation requiring prior authorization because providers would like more certainty. It seems worth noting that the State of Arkansas passed legislation in 2015, which authorized providers to request "benefit inquiries" before providing a service. ***See*** Ark. Code Ann. 23-99-1113. This statute requires insurance companies to respond to the benefit inquiry within ten (10) days. All of the rules and penalties which apply to prior authorizations also apply to benefit inquiries.

Finally, questions arose related to the statistics provided on page 7, specifically as it applied to the 2,135,041 claims denied by Qualified Health Plans and the 69,315,868 claims denied nationally. It is not clear if these claims were denied because a provider did not ask for a prior

authorization or for other reasons such as the member not having an effective policy or the benefit not being covered. It also fails to account for situations where a prior authorization is sent in without medical records and is denied, only to be overturned on appeal when the medical records are finally sent. Without this information, the sentence provides an inference that perhaps all of the claims were incorrectly denied through the prior authorization process but that the other claims were not appealed. As such, it would be helpful to have data that details why the claims were denied. If data is not available to describe this, Arkansas Blue Cross would support a footnote that explains that information related to what led to the prior authorization denials and why the appeals were subsequently overturned was not available at the time of publication.

Thank you again for the opportunity to comment on the white paper.

Sincerely,

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