Hi Jolie,
Please see BCBSA's feedback on the NAIC Prior Authorization white paper attached and our accompanying cover letter below. Our edits are robust but, provided in the spirit of ensuring a collaborative and balanced consideration of this important issue. We also understand that AHIP likely covers similar themes in their submitted feedback. We are happy to work with them to identify any overlap and provide you with additional clarity on our alignment if that's helpful as you go through the review process.

Best regards,
Randi

Greetings Commissioner Arnold,

BCBSA applauds NAIC's work to develop a source of information for policymakers on prior authorization (PA). PA is an important tool that allows us to balance two essential priorities: Health Plans review certain treatments and medications to make sure they are covered, evidence based and cost effective, while also ensuring every health care dollar is spent wisely. The vast majority of claims do not require PA, but it is an important step for high-risk, high-cost care decisions. We recognize that the PA process can be improved, and health plans are advancing efforts to streamline processes—all with the goal of improving the patient experience and supporting better outcomes. With that in mind, we appreciate NAIC's consideration of our tracked edits in the attached document and have summarized our key recommendations below:

- *Clarifying the insurer perspective (see pg. 9 in the attached redlines)* – We recommend NAIC revise this section to make clear that PA is always grounded in evidence-based medicine and applied to ensure clinical appropriateness, not solely to balance resources. We further recommend including details about ongoing industry efforts to advance electronic prior authorization and streamline processes.
- *Explaining PA rationale by service type (see pg. 4 in the attached redlines)* – We recommend NAIC revise the "common medical services subject to prior authorization" section to include additional context explaining why each service type is subject to PA.
- *Removing reference to misleading statistics (see pg. 7-8 in the attached redlines)* – We recommend NAIC remove the reference to the AMA survey and KFF's Transparency in Coverage claims denial report. The AMA survey reflects physician opinions rather than

objective patient-level outcomes, and the KFF report relies on methodologies that overstate denial rates.

- *Strengthening the takeaways (see pg. 23 in the attached redlines)* – We recommend NAIC revise the "Takeaways" to focus on objectively laying out policy considerations in a a neutral, fact-based tone rather than setting new policy direction.
- *Revising tone and framing (see revisions throughout, examples pg. 5 and 8)* – We recommend NAIC modify the language throughout the paper to maintain a balanced, objective, policy-oriented approach. We specifically recommend avoiding any language that may appear biased, anecdotal or accusatory and focus on presenting a balanced view of the facts.

We truly appreciated the opportunity for BCBSA to speak with regulators during the NAIC Summer National Meeting about health plans' recently announced commitments to streamline, simplify and reduce PA. We're grateful that these commitments were highlighted in the draft white paper and have made clarifications to that section, based on our conversation.

Payers are implementing these commitments, which include standardizing electronic PA, reducing the scope of claims subject to PA, providing more personalized support and transparency and expanding real-time responses to PA requests. These actions are similar to many areas state policymakers have sought to address; and in some cases build upon and extend further than existing requirements in state or federal law. We look forward to collaborating with policymakers to continue industry and state efforts to preserve and improve the PA process for all stakeholders.

BCBS companies have worked to improve PA processes in alignment with state laws and regulations consistent with the commitments referenced above. For example, many plans have instituted gold-carding programs, which exceed industry norms and state requirements to reduce the number of claims subject to PA. Plans have also developed electronic PA systems that are integrated with patients' electronic health records to streamline and expedite the pre-authorization process. As BCBS companies implement these commitments, BCBSA will keep NAIC apprised of updates and progress, while individual Plans will communicate with their DOIs and local regulators.

Thank you for your leadership on this important issue. BCBSA welcomes the opportunity to support further collaboration as the white paper advances. If you need any additional information, please contact Randi Chapman at randi.chapman@bcbsa.com.

Draft: 7/18/25

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

Prior Authorization White Paper

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What is prior authorization?

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

Commented [BCBSA1]: Recommend revising these sentences to maintain a more neutral and balanced tone. These sentences suggest a shift away from clinical appropriateness or medical necessity as core justifications without evidence. PA continues to be grounded in evidence-based medicine and applied to services where variation in quality, safety, or effectiveness exists, not merely to reduce utilization or costs.

How this document can help regulators

In recent years, state legislatures have ~~introduced~~ enacted and updated PA statutes to ~~reduce~~ streamline administrative ~~burdens~~ processes, support patient care, and promote greater transparency and accountability in the use of PA~~negative health outcomes~~. Most proposed legislation focuses on the method by which PA must be requested (e.g., by phone, fax, or online portal) and "provider gold-carding," a system in which providers can bypass the PA process given their previous record of consistently providing necessary medical care. This reference is meant to be a source of information and an objective roadmap of legislative options related to PA.

Commented [BCBSA2]: Recommend revising this sentence to better reflect the full range of state actions listed later in the paper.

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

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

The prior authorization process

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

- ***Submission:*** The health care provider submits a PA request to the insurer, detailing the medication or treatment recommended for the patient.
- ***Review:*** The insurance company ~~reviews~~ evaluates the request ~~, evaluating it~~ against ~~its clinical~~evidence-based clinical criteria and medical necessity standards ~~guidelines and policies~~.
- ~~***Approval or Denial***~~***Decision:*** Based on the review and submission of complete information, the insurer either approves or renders an adverse determination, ~~denies the request~~, often providing an explanation.
- ***Appeals:*** If the request is not approved~~denied~~, the patient or provider may appeal the decision and provide additional information to support the necessity of the treatment.

Common medical services subject to prior authorization

~~Certain types of medical services are more likely to require PA~~Services typically subject to PA are those that are high-risk, high-cost, or subject to clinical variation, where prior review helps ensure appropriate use. Examples include:

- ***High-Cost and Specialty Drugs:*** Medications that are expensive or require careful monitoring, such as biologics or ~~high-dose chemotherapy~~oncology drugs, are often subject to PA to ensure appropriate use and adherence to evidence-based prescribing guidelines.~~.~~
- ***Advanced Imaging:*** ~~Tests~~ Services such as~~like~~ MRI, CT scans, or PET scans may require PA to ensure alignment with evidence-based criteria, prevent unnecessary exposure to radiation, reduce the risk of false-positive and false-negative results, and reduce the use of duplicative or low-value imaging.~~.~~
- ***Surgical Procedures:*** Surgeries that are elective or involve the use of experimental techniques may be subject to PA to confirm medical appropriateness, ensure patients benefit from the best site of service and assess the availability of effective non-surgical alternatives.~~.~~
- ***Durable Medical Equipment:*** Items like wheelchairs or hospital beds are subject to PA to confirm that the equipment is medically necessary, appropriate for the benefit purchased and not duplicative of equipment already issued.~~.~~

Commented [BCBSA3]: Recommend clarifying that reviews are grounded in widely accepted clinical criteria, not just internal policies.

Commented [BCBSA4]: Recommend including information to differentiate denials based on submissions of incomplete information.

Commented [BCBSA5]: Recommend using the term "adverse determination" to be more precise. The terminology better reflects industry standards and aligns with how insurers formally communicate PA outcomes.

Commented [BCBSA6]: Recommend providing important context for why PA is used.

Commented [BCBSA7]: Recommend adding additional detail to each example to explain why the service is subject to PA.

Commented [BCBSA8]: Recommend broadening this to "oncology drugs" since many chemotherapy drugs are low cost and do not require PA.

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

Prior authorization issue perspectives

The provider perspective

Administrative burden and expense

Prior authorization ~~can~~ may create ~~substantial~~ administrative burdens, costs, and inefficiencies. According to a recent American Medical Association (AMA) online survey of 1,000 physicians[2], physicians responded that either they or their staff spend 13 hours per week requesting PAs. To mitigate this, health care providers must also employ and maintain knowledgeable staff who can help monitor the PA process. According to the same AMA survey[3], 40% of participating physicians have staff who work exclusively on PAs. Providers' electronic health records generally do not integrate with insurer systems or the provider utilizes fax machines or the phone to transmit sensitive information, so staff must manually enter data into these systems. Furthermore, incorrect or missing patient demographic and insurance information can delay PA or result in unexplained denials.

Commented [BCBSA9]: Recommend including important details of the survey sample.

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

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

Lack of consistency and transparency

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

Communications of adverse determinations are designed to be in plain language. Health plans adhere to accreditation standards, such as from the National Committee for Quality Assurance (NCQA), which

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

require communications to be understandable and are reviewed during plan evaluations. However, some providers still report that denial letters do not always include detailed clinical reasoning 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. In some cases, challenges associated with the PA process may influence provider participation in certain health plans. ~~Denial letters often lack transparency and provide no information on how the denial was determined. Health care providers are forced to guess why the denial occurred and how to appeal the decision. Some health care providers completely avoid the PA process by not accepting insurance.~~

~~Outdated~~ Technology and ~~inefficient~~ communication ~~technology~~limitations

~~Oftentimes, t~~The technologies (including software, web portals, fax machines, and even communication by phone) used to support ~~by insurer~~ PA systems ~~are~~ vary in efficiency and integration~~outdated and cumbersome~~. While ~~The PA process can be significantly delayed or result in denials if an insurer has not updated its utilization management processes or has not communicated changes to processes or codes. Though~~ some insurer portals make it easy to look up required PA information by simply inputting a procedure's current procedural terminology code, other insurers ~~will not provide information until a provider contacts them~~rely on more manual processes that may create inefficiencies such as requiring ~~. When medical offices are required to contact a health benefit plan by phone, staff experience long hold times. P~~providers ~~often need~~ to create documentation of their communications by phone or fax in case such information is later needed to prove contact was made. However, the effectiveness of these tools can also depend on the provider's internal systems. Many provider organizations, particularly smaller or independent practices, face challenges in adopting or maintaining electronic health record (EHR) systems that are fully interoperable with insurer platforms. As a result, even where modern digital 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.

~~Misalignment~~ Clinical variation and alignment with coverage criteria~~with clinical standards of care~~

In ~~addition to~~ determining whether a requested service is medically necessary for the specific patient, insurers consider current ~~recommended according to research-based~~ evidence, and ~~insurers also consider~~ evaluate whether the service is ~~the most~~ cost-effective and consistent with the patient's health plan coverage ~~way to treat a patient~~. Clinical standards used by providers focus on delivering ~~do not necessarily consider cost and are intended to provide the most~~ efficient and effective care ~~depending~~ tailored to~~on~~ a patient's particular needs, but may not always align with plan coverages or account for cost considerations. ~~As a result, there may be cases where a provider's preferred treatment differs from what is initially approved for coverage. In these situations, the provider may choose to pursue an appeal or submit additional clinical information to support the request. While these mechanisms are intended to resolve disagreements, some providers report that the administrative steps required can delay treatment or impose additional workload.~~

~~Rather than treating a patient with what the health care provider considers to be most appropriate treatment using their knowledge of clinical standards of care, a PA request denial may force a health care~~

Commented [BCBSA10]: Recommend revising this paragraph to improve the tone and precision of the language. The original paragraph uses language (e.g., "forced to guess," "provide no information," "completely avoid"), which may undermine the paper's credibility. The revised paragraph also includes key information on standards and oversight of adverse determinations that health plans adhere to.

Commented [BCBSA11]: Recommend revisions to this section to reflect technology variation across both insurers and providers. The original language overgeneralizes and may imply that all insurer systems are outdated. This version balances the tone, highlights shared infrastructure challenges, and aligns with current federal and industry efforts to modernize electronic PA systems.

Commented [BCBSA12]: Recommend changes to this section to more accurately reflect the balance between clinical practice and coverage determinations. The revisions reflect that health plan decisions are not only based on clinical standards but also medical necessity, nationally established guidelines and cost considerations.

~~provider to prescribe a different therapy, not considered to be in the patient's best interests, but that is covered by the patient's insurer. The provider must choose whether to pursue a lengthy and possibly futile appeal process related to their preferred therapy that will further delay treatment or choose a different therapy less likely to provide optimal results.~~

The consumer perspective

While PA processes are well-meaning for the health care system, the consumer experience ~~is often marred by~~can involve inefficiency, care disruption, and ~~adverse outcomes~~frustration.

Disruptions in care

According to a KFF survey, approximately six in 10 insured adults are not able to use their insurance without experiencing a problem.[5] ~~Of those insured adults that report having an issue with using their insurance,~~ and 16% reported experiencing problems specifically with PA processes.[6] Additionally, a KFF analysis of CMS' 2023 Transparency in Coverage data demonstrated that prior authorization accounted for 9% – more than six million - of in-network claim denials. A 2023 American Medical Association (AMA) survey of 1,000 physicians found that, among patients whose care required prior authorization, 93% of physicians self-reported that the process always, often or sometimes delayed access to necessary care. Additionally, 82% of physicians said that PA issues always, often or sometimes led patients to abandon their recommended course of treatment~~Separately, a physician survey conducted by the AMA in 2023, found that 94% of the patients of participant physicians experienced delays in care that they would not have otherwise experienced.[7] Moreover, the same survey found that 78% of the patients abandoned treatment because of the PA processes~~.[8]

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

Higher costs in the long run

Federal law prohibits plans from requiring PA for coverage of emergency services. While there can be different reasons for delays in seeking care – such as concerns about cost, lack of understanding of coverage options, or fear of receiving a serious diagnosis - some individuals may seek care in an emergency department to avoid these requirements. These delays can result in patients seeking care only when conditions worsen, which may lead to higher costs and more complex interventions~~As a result, some individuals seek care directly from an emergency room rather than engaging with their health insurer to help coordinate care prior to a medical issue becoming emergent~~. According to a survey from the AMA,

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

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

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

[8] Id.

Commented [BCBSA13]: Recommend replacing "adverse outcomes" with "frustration" to reflect a more neutral and accurate description of the consumer experience. "frustration" captures a broader range of possible impact.

Commented [BCBSA14]: Recommend this edit because the cited survey lists 16% of "total insured adults" not "total insured adults that experienced a problem."

Commented [BCBSA15]: Recommend including a citation for this statistic. If the data comes from this study: https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/, we recommend not including the stat since it does not reflect prior authorization denials, but "an initial claim submission denial due to a **lack of** prior authorization."

Additionally the data set used by KFF has significant shortcomings. Specifically, claims that are denied do not necessarily indicate that services are not ultimately paid by the insurer, such as when a new claim is filed instead of resubmitted. Variation in claim adjudication systems also contributes to reporting misrepresentations. Some insurers use systems that apply layered logic and can record multiple reasons for denial, while others capture only the first encountered reason to deny a claim in the workflow and never capture additional reasons the claim may be denied.

Commented [BCBSA16]: Recommend removing these statistics, as they reflect physician-reported perceptions rather than objective patient-level outcomes. Because the data are based on a self-reported survey of physicians, who may have an interest in overreported to address the burden of PA, their inclusion undermines the credibility of the paper.

If NAIC does not delete reference to these statistics we recommend to at minimum revise them (see in-text edits) to accurately reflect that the AMA survey captures physician-reported perceptions, not direct patient-level outcomes data. The original wording overstates the findings by implying that 94% of all patients experienced delays and 78% abandoned treatment. Additionally we recommend the citation to the latest version of AMA's survey as was used for footnote #2.

Commented [BCBSA17]: Recommend revising this paragraph to avoid overstating the role of prior authorization in emergency room utilization. The original claim that individuals seek emergency care to avoid PA is speculative and unsupported by broad evidence. Delays in care are also due to cost concerns, lack of access or fear of diagnosis.

insured adults who received health care in an emergency room would have been twice as likely to encounter PA problems when trying to seek care in a non-emergency setting when compared to those who did not otherwise use the emergency room.[9]

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

Adverse and inequitable outcomes

Within the overall insured population, certain groups of people experience a disproportionate share of PA problems. For example, 31% of adults who use more health care services (defined as having more than 10 doctor visits a year) experience difficulties navigating PA processes.[12] About a quarter (26%) of individuals with mental health conditions who sought treatment or a prescription experienced problems or delays as a result of their difficulties navigating PA processes.[13] Seeking medical care can be stressful, complicated, and expensive, and adding the burden of PA processes ~~can~~ could 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%).[14]

The appeals process

It is important to note that most PA requests are approved. For example, for Medicare Advantage plans in 2023, 90% of PA determinations were fully favorable.[15] When a request is not approved, consumers and providers have access to an appeals process through which additional clinical information can be submitted for reconsideration. However, some stakeholders have raised concerns that these processes can be complex and burdensome, potentially discouraging some consumers from pursuing an appeal. Ensuring that appeals processes are accessible and transparent may help mitigate delays in care and support more equitable outcomes. ~~In the event of a PA denial, there are mechanisms to appeal. These processes are often byzantine and difficult to access and discourage consumers who receive a denial from appealing.~~ In Pennsylvania, for example, of the 2,135,041 claims denied by Qualified Health Plans in the state's individual health insurance market, just 3,156 internal appeals were filed. Of those internal appeals, nearly half (48%) were overturned in favor of providing coverage for the requested service.[16] The pattern is repeated at the national level. Qualified Health Plans offering individual health insurance coverage through

Commented [BCBSA18]: Recommend clarifying where in the citation this statistic is derived from. Additionally, if this statistic is included, similar to our comment above, it should be clarified that the result is reported based on physician perception.

Commented [BCBSA19]: Recommend including the percentages to provide important context/details of the result.

Commented [BCBSA20]: Recommend revising this paragraph for tone and accuracy. The original language ("byzantine," "staking the availability of coverage") may be seen as editorializing. The revised version maintains a balanced, policy-oriented tone and better reflects the data point cited by noting that most PA requests are approved and that appeal pathways exist.

[9] Id.
[10] https://www.healthsystemtracker.org/brief/emergency-department-visits-exceed-affordability-thresholds-for-many-consumers-with-private-insurance/#Total%20and%20Out-Of-Pocket%20Costs%20for%20Emergency%20Department%20Visits,%202019
[11] Id.
[12] https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/
[13] Id.
[14] Id.
[15] https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/#:~:text=Of%20the%2049.8%20million%20prior,of%2014%20requested%20therapy%20sessions.
[16] https://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

the Federally Facilitated Exchange in 2022 denied 69,315,868 claims. Less than one percent of those denials was appealed, and 42% of the appeals filed were overturned.[17] ~~Staking the availability of coverage for medical services on the ability to navigate administrative processes can have negative impacts on health outcomes.~~

The insurer perspective

From the insurer perspective, the primary goal~~s~~ of PA ~~include~~is to balance different priorities:

- Supporting safe, evidence-based care to help patients receive treatments that are medically appropriate and reduce the risk of harm from duplicative, inappropriate, or unproven services.
- Helping keep care affordable by identifying cost-effective alternatives, including lower-cost sites of care and therapies with equivalent outcomes to ultimately reduce out-of-pocket costs for members and help maintain sustainable premiums.
- Promoting efficient use of health care resources by avoiding unnecessary or redundant services, such as duplicate tests or high-cost procedures when more effective evidence-based alternatives exist.

~~Flagging newer and better treatments for patients to improve the quality of care;~~

~~Preventing excessive, unnecessary, harmful or fraudulent health care utilization; and~~

~~Containing claims costs.~~

Patient Safety

Prior authorization supports patient safety by helping ensure that care decisions are based on clinical evidence and tailored to individual needs. For example, PA requirements can help prevent duplicative or unnecessary treatments, such as repeating diagnostic tests that a patient has already received, thereby reducing exposure to potential risks and avoiding delays in appropriate care. Similarly, PA can prevent ~~Health insurers often cite examples of clearly~~ harmful activity by providers, such as providing inappropriate cancer treatments to patients who may not even suffer from cancer, to demonstrate how PA supports patient safety.[18] While comprehensive data on the frequency of harm prevention is limited, these processes demonstrate how PA can serve as a safeguard against unsafe or unnecessary care. ~~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.~~ Additionally, because advances in medicine occur so rapidly, PA also serves as a tool to support providers in aligning with the most current evidence-based and cost-effective standards of care.

Cost containment

Insurers ~~claim~~ note that PA ~~prevents~~ helps reduce the use of low-value ~~health care~~ or unnecessary services, generating savings for both consumers and health plans ~~saving insurer and member dollars~~

Commented [BCBSA21]: Recommend not including a citation to these statistics due to the claim denial numbers being misrepresented in the transparency in coverage public use files, which this report is based on. These denial numbers represent every instance a claim is denied, even if it is ultimately paid by the insurer such as when a new claim is filed instead of resubmitted. The denial could be due to reasons such as being duplicative of another claim, missing or incorrect data, the provider sending claim to an insurer who does not cover the patient for the service, etc.

Commented [BCBSA22]: Recommend revising this section to reflect the broader goals of prior authorization from the insurer perspective based on direct feedback from regulators at the Summer meeting.

Commented [BCBSA23]: Recommend revising this section to adopt a more balanced tone and avoid anecdotal examples that may seem unverifiable. The updated language reinforces that PA helps ensure care is appropriate and evidence-based, while acknowledging that data on harm prevention is limited.

Commented [BCBSA24]: Recommend revisions to this section to present a more comprehensive explanation of PA's role in cost containment. Added references to studies to provide empirical support for the cost-saving function of PA. This helps align the section with established research and health plan experience.

[17] Id.

[18] 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

without compromising quality of care~~adverse health consequences.~~[19]. While the research on the value ~~proposition~~ of ~~health care~~specific services may be clear in some cases, it is evolving~~disputed~~ in others, particularly ~~. Especially~~ for newer ~~modes of~~ treatments that may lack a large evidence base. This can lead to disputes, appeals and complaints to regulators.

Though~~ere is not yet~~ definitive, system-wide data on ~~research to determine~~ the overall economic value of PA is still developing, studies and empirical evidence have demonstrated a potential cost savings~~for insurers~~. ~~However, insurer representatives consistently articulate the centrality of PA for their efforts to contain costs and improve quality of care.~~For example, a 2023 study estimated that eliminating PA programs across the commercial market could result in up to a $63 billion annual increase in premiums.[20] In the public sector, when South Carolina Medicaid eliminated PA for rehabilitative behavioral health services in 2014, costs for those services jumped from $300,000 to $2 million per week, leading to a $54 million budget shortfall and an eventual reinstatement of PA requirements.[21] 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.[22]

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.[23] 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 model underscores a broader recognition, even within the public sector, that the thoughtful application of PA is an important tool to balance access, quality and affordability.

Commented [BCBSA25]: Recommend including information on CMS' WISeR model to highlight relevant federal government actions on PA to contain costs.

The ~~potential~~ cost containment ~~benefits~~ function of PA may be particularly important in the context of the Affordable Care Act's (ACA) insurance reforms. Core ACA provisions such as guaranteed issue, community 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 ~~it may be unsurprising that PA requirements appear to be on rise in recent years, as they may~~ 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.

Friction with providers and members

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

~~[19] One often-cited source is the Low-Value Care Task Force at VBID Health: https://vbidhealth.com/low-value-care-task-force/~~

[20] https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/8-18-23_BCBSA-Prior-Authorization-Impact.pdf

[21] https://kffhealthnews.org/news/article/prior-authorization-insurer-denials-patients-run-out-of-options/

[22] https://www.nber.org/papers/w30878

[23] https://www.cms.gov/priorities/innovation/innovation-models/wiser

Electronic prior authorization

Insurers have supported the shift away from manual and paper-based PA toward more streamlined, electronic processes. This includes support for the Centers for Medicare & Medicaid Services' (CMS) 2024 final rule requiring the use of standardized prior authorization application programming interfaces (APIs) to improve data exchange and PA transparency.[24] These federal requirements represent an important step forward in reducing administrative burdens for all stakeholders. ~~Health insurance carriers have been broadly supportive of moving away from manual and "paper" processes for PA and toward more uniform electronic submission standards. For example, carriers supported federal adoption of a rule on PA interoperability in 2024.~~[25] Carrier advocates have typically argued that state activity in this area should focus on aligning state requirements for insurers with these federal rules, and that states should consider more proactively implementing requirements for health care providers.[26] Carriers have suggested that more rapid adoption and effective implementation of electronic PA on the part of health care providers can resolve some of their concerns about administrative burdens.

In June 2025, nearly sixty (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. In their commitment to improve PA processes, health plans support increasing the use of electronic prior authorization, through the development of standardized data and submission requirements that will support faster turn-around times across all lines of business. The health plans committed that as of Jan. 1, 2027, 80% of medical PA requests with complete information will be processed in near real-time.[27]

Selective use

Selective use, also called gold carding, means applying different PA processes and expectations based on provider performance.[28] Some h~~H~~ealth insurers have typically opposed statutory or regulatory mandates in the area of selective use, preferring to be permitted the flexibility to explore a range of options to strike a favorable balance between administrative simplification, patient protection and cost containment. However, many health insurers voluntarily apply selective use policies as part of their PA programs.

Questions regarding the evidence base

One of the key purposes of PA cited by insurers is to ensure that covered services are evidence-based and effective. Insurers use evidence-based guidelines, medical society recommendations, and peer-reviewed literature to help determine when services are appropriate, safe, and effective. However, questions regarding the evidence base can still arise in several ways. ~~Some insurers have expressed concerns about~~

Commented [BCBSA26]: Recommend revising this section to more accurately reflect recent federal and industry developments related to electronic prior authorization.

[24] https://www.ahip.org/news/press-releases/ahip-statement-on-the-cms-interoperability-and-prior-authorization-final-rule
[25] ~~https://www.ahip.org/news/press-releases/ahip-statement-on-the-cms-interoperability-and-prior-authorization-final-rule~~
[26] ~~https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states~~
[27] https://www.bcbs.com/news-and-insights/article/right-care-right-place-right-time
[28] See e.g., https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf

~~the evidence base behind PA and have pushed for stricter requirements in this area.[29] Insurers are unlikely to be supportive of restricting their flexibility in this area for a variety of reasons. For example:~~

- C~~P~~linical evidence is often evolving, particularly for newer treatments or therapies that lack long-term outcome data. In such cases, health plans seek to strike a balance between access and caution, using PA as a tool to evaluate emerging treatments based on the best information available. Appeals and independent external review processes exist to provide safeguards and ensure decisions can be revisited if new evidence or case-specific considerations warrant it. ~~A 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.~~
- 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~~with significant cost differences have similar effectiveness in treating a health condition but may have differential effects on the patient experience in other respects~~, such as comfort, convenience or aesthetic considerations.[30]

Solutions and examples

States

Gold carding

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

Under state gold carding programs, a health insurer is required by the state to evaluate a health care provider's history of requesting PA for a particular health care service to determine whether the provider qualifies for an exemption from PA for that particular service. The insurer examines medical records to determine the number of times a health care provider requested PA for a particular service and compare that number to the number of times the provider's request for that service was approved. If the percentage of approved requests meets the number mandated by the state legislature, the insurer will be required to issue the provider a gold card exemption for that service. Gold carding laws vary by state. Some include broad exemptions from all PA requirements and some laws include periodic reevaluations or allow insurers to revoke gold card status under certain conditions.

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,

Commented [BCBSA27]: Recommend deleting this given the citation is outdated. There have been updated versions of H.R. 3173 that no longer include this provision.

~~[29] 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~~

~~[30] Potential examples could include proton beam therapy for cancer treatment or autologous breast reconstruction following mastectomy.~~

research has shown that they may also increase service utilization and place upward pressure on health care costs.[31] In some cases, the thresholds for exemption are set low, which can pose risks to patient safety. Additionally, some laws limit an insurers' 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 often allow for more flexibility, service-specific targeting and closer monitoring.

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

Commented [BCBSA28]: Recommend including this additional paragraph to include the emerging nature of state-level gold carding laws. Including this context provides a more balanced perspective by highlighting potential risks of gold-carding laws such as increased utilization, weakened oversight and patient safety concerns. It also allows the section to recognize insurer-led gold carding initiatives as an alternative model.

Arkansas

Arkansas has extended its gold card programs to PAs for prescription drugs. Insurers in Arkansas examine the health care provider's history of all PAs requested for all health care services, which Arkansas defines to include prescription drugs.[32] 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.[33] 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.[34]

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.[35] When an insurer receives approval to continue requiring PA for a particular drug, the approval is good for two years, and the insurer may continue requiring PAs for that drug from all health care providers, regardless of any gold card exemption privilege a health care provider would have otherwise had.

Texas

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

Commented [BCBSA29]: Recommend updating this with Texas' most recent gold carding bill. The bill had necessary updates that should be mentioned (below).
HB 3812 (Rep. Bonnen & Sen. Hancock):
o Extends the length of gold cards from six months to one-year.
o Includes claims from products not regulated by TDI in gold card evaluations (however, gold cards would not extend to these products).
o Places restrictions on administrative licenses only for the physician in charge of all utilization management for a health plan and physicians making recissions.
o Effective 9/1/25.

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

[31] https://legislature.vermont.gov/assets/Legislative-Reports/Blue-Cross-VT-Provider-Passport-Program-Report-01-15-2023.pdf
[32] Ark. Code Ann. § 23-99-1103(10)(A).
[33] Ark. Code Ann. § 23-99-1120(a).
[34] Ark. Code Ann. § 23-99-1122(a)(3).
[35] Ark. Code Ann. § 23-99-1128(b).

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. [36]

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

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

West Virginia

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

Wyoming

The Wyoming legislature passed legislation regarding provider exemptions from PA requirements (Gold Carding).[37] The law will go into effect January 2026. The legislation establishes guidelines for a provider to be exempted from completing PAs for health care services that have been authorized 90% of the time in the proceeding twelve months. The provider must have submitted no fewer than five PAs for the procedure during that time. The insurer can review the exemption every twelve months, but they may establish a longer exemption period. In addition, an exemption cannot be revoked before twelve months have passed.

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

Addressing continuity concerns

District of Columbia

The District of Columbia requires a PA to be valid for at least one year or for the course of the treatment, including any dosage changes.[38]

Commented [BCBSA30]: Recommend including a footnote citation for every state to strengthen the white paper's value as a reference tool.

[36] 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

[37] Wyo. Stat. Ann. § 26-55-112

[38] 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.

Illinois

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

Oklahoma

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

Tennessee

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

Texas

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

Wyoming

The Wyoming Insurance Code, titled *Ensuring Transparency in PA Act* was passed in 2024[39] and addresses continuity of care and step therapy. If an individual changes health care coverage and has an approved PA with their prior insurer, and the health care service is a covered benefit under the new plan, the new insurer must honor the PA for at least 90 days.

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

Reducing response times

Oklahoma

House Bill 3190[40], which took effect on January 1, 2025, requires utilization review entities to respond more promptly to PA requests. After a utilization review entity has obtained all necessary information to make a decision, the entity must respond within 72 hours for urgent requests and within seven days for non-urgent requests. These expedited timelines are intended to facilitate timely care for patients.

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.

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

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

Washington

The Evergreen State has implemented shorter turnaround times for PA approvals[41], 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 electronic PA requests, carriers must make a decision and notify the provider and facility of the decision within three calendar days for a standard request and within one calendar day for an urgent request. The turnaround times are a little longer for non-electronic requests - within five calendar days for a standard request and two calendar days for an urgent request.

West Virginia

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

Wyoming

The *Ensuring Transparency in PA Act* relied heavily on the American Medical Association model and established response times for PA requests.[42] PA response times for non-emergent responses are to be within five calendar days of obtaining all necessary information to complete the review. Urgent authorizations are to be completed within 72 hours of obtaining all necessary information. Health insurers and contracted utilization review entities shall not require PA for medications used for opioid use disorder. In addition, a health insurer or contracted utilization review entity shall not require PA for rehabilitative or habilitative services including, but not limited to, physical therapy service or occupations therapy services for the first twelve visits for each new episode of care.

Updating technology and systems

Texas

In 2014, Texas mandated standardized PA request forms for health care services and prescription drug benefits.[43] The code, which took effect on September 1, 2015, established an advisory committee tasked with updating the forms every two years. Its primary goal was to streamline the PA process, making it more efficient and transparent for both providers and patients. By standardizing the forms and ensuring their accessibility, the code aimed to reduce confusion and facilitate a smoother authorization process for necessary health care services. The forms must be provided in both paper and electronic formats and made accessible on health plan websites. Medicaid and CHIP are required to accept these forms.

[41] Washington RCW 48.43.830 https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.830
[42] Wyo. Stat. Ann. §§ 26-55-101 through -113
[43] see 28 Tex. Admin. Code § 19.1810

Washington

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

With the passage of Engrossed Second Substitute House Bill (ESSHB)1357[44] 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[45] 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[46].

West Virginia

During the 2024 Legislative Session, WV updated PA laws[47] to require a health insurer to submit requests with any related communication via an electronic portal.

Improving transparency

Oklahoma

House Bill 3190[48] requires health insurers to publish their PA requirements online, ensuring they are accessible to patients and providers. If a utilization review entity—defined as an individual or organization that performs PA for a health benefit plan—plans to implement a new requirement or change an existing one, they cannot do so until their website reflects the updated information.

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

[44] 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

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

[46] 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

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

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

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

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

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

Pennsylvania

Pennsylvania passed Act 146 in 2022 to overhaul its PA rules. Specifically, health insurers are now required to post their medical policies and the medical services that are subject to PA on public-facing websites. Additionally, health care providers and health insurers will need to use electronic portals to streamline document and information exchange. Adjustments to individual states' PA rules along these lines may alleviate the administrative tangles that often result from a health care provider's unfamiliarity with a health insurer's policies.

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.[49] Determinations must be made by an individual licensed to practice medicine in Texas who has the same or similar specialty as that physician. The physician or provider has the right to a review regarding a PA exemption to be conducted by an independent review organization.[50]

Washington

Starting October 1, 2020, and annually thereafter, carriers in Washington must include in their annual report to the OIC aggregated and deidentified data related to their PA practices and experience for the prior plan year.[51] For each category (inpatient medical or surgical, outpatient medical or surgical, mental health and substance use disorder, durable medical equipment, diabetes, and prescription), carriers must list the ten codes with the:

- highest total number of PA requests during the previous plan year, including the total number of PA requests for each code and the percentage of approved requests for each code;

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

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

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

West Virginia

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

Wyoming

The *Ensuring Transparency in PA Act* and established guidelines for review of adverse determinations.[52] 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, the insurer or contracted utilization review entity shall make any PA requirements and restrictions easily accessible on their website to enrollees, health providers and the public. Should a provider ask for the PA requirements or restrictions from an insurer, the insurer must provide the list to the requesting party within 24 hours.[53] Furthermore, any changes to the requirements must be posted 60 days in advance of the change's enactment.[54] These deadlines have to do with the disclosure and review of prior authorization requirements, not a specific patient PA.

Provider Associations

American Medical Association Model Legislation

The goal of the AMA model legislation[55] is to improve transparency and limit interruptions to patient care. The following states have taken language directly from the model legislation: Delaware, Georgia, Illinois, Mississippi, New Jersey, Oklahoma, and Wyoming.

Commented [BCBSA31]: Recommend citing and summarizing the latest version of AMA's model legislation: https://fixpriorauth.org/sites/default/files/2025-04/Health%20Plans%2C%20Ensuring%20Transparency%20in%20Prior%20Auth%20Act%202025.pdf

The legislation recommends:

- Establishing quick response times (24 hours for urgent, 48 hours for non-urgent care).

[52] Wyo. Stat. Ann. § 26-55-101 through -106
[53] Wyo. Stat. Ann. § 26-55-103
[54] Wyo. Stat. Ann. § 26-55-103
[55] American Medical Association's Ensuring Transparency in Prior Authorization Act https://www.ama-assn.org/system/files/model-bill-ensuring-transparency-in-prior-authorization.pdf

- Requiring adverse determinations to be made only by a physician licensed in the state and of the same specialty that typically manages the patient's condition.
- Prohibiting retroactive denials if care is preauthorized.
- Requiring authorizations to be valid for at least 1 year, regardless of dose changes, and for those with chronic conditions, to be valid for the length of treatment.
- Requiring the public release of insurers' PA data by drug and service as it relates to approvals, denials, appeals, wait times and more.
- Requiring new plans to honor a patient's PA for at least 60 days; and
- Reducing volume using PA exemptions or gold-carding programs.

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

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

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

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

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

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

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

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

American Psychiatric Association Model Legislation

In 2022, the American Psychiatric Association (APA) developed model legislation[56] aimed at reforming the PA process to reduce unnecessary administrative burdens and improve patient access to care. This legislation focuses on streamlining the authorization process, increasing transparency, and ensuring timely decision-making. It protects the rights of patients with mental health conditions, preventing unfair denial of coverage or excessive delays in accessing necessary care.

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

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

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

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

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

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.

The federal government

In addition to state legislative action, the Centers for Medicaid and Medicare Services (CMS) within the federal Department of Health and Human Services (HHS), issued the~~a~~ CMS Interoperability and PA Final Rule[57] in 2024 in an effort to set uniform national PA standards for the federal health coverage programs under its jurisdiction, as well as for Qualified Health Plans offering ACA compliant coverage through Federally Facilitated Exchanges. The rule created uniform timeframes for PA decisions, data exchange requirements, transparency requirements, and other digitization efforts. While this rule does not reach health insurers operating in states with State-Based Exchanges, having a federal baseline may help encourage national uniformity as states continue to grapple with the issue.

Private industry

In June 2025, ~~AHIP announced efforts by its member health insurance providers~~many insurers announced a series of commitments to simplify prior authorization.~~, with a focus on "connecting patients more quickly to the care they need while minimizing administrative burdens on providers."~~[58] The pledge was informed in part by a survey of~~ is the outcome of a survey of~~ AHIP's members[59] and applies to insurance markets including Commercial coverage, Medicare Advantage, and Medicaid managed care. These commitments build upon ongoing health plan efforts to make prior authorization a more seamless and transparent process and reflect insurers' goal to ensure patients receive the most effective care, at a more affordable cost. The participating member health plans commit to:

- **Standardize electronic PA** by January 1, 2027. Participating health plans will work toward implementing common, transparent submissions for electronic PA.
- **Reduce the scope of claims subject to prior authorization**, with demonstrated reductions by January 1, 2026. Individual plans will commit to specific reductions to medical PA as appropriate for their particular market.
- **Guarantee continuity of care when patients change plans**, beginning January 1, 2026. When a patient changes insurance companies during a course of treatment, the new plan will honor existing PAs for benefit-equivalent in-network services as part of a 90-day transition period.
- **Enhance communication and transparency on determinations,** operational for fully insured and commercial coverage by January 1, 2026, with a focus on supporting regulatory changes for expansion to additional coverage types.

Commented [BCBSA32]: Recommend revisions since the commitments were not exclusively the outcome of the AHIP survey.

[57] ~~https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability~~
[58] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization
[59] https://ahiporg-production.s3.amazonaws.com/documents/202506_AHIP_Report_Prior_Authorization-final.pdf

- **Expand real-time responses.** In 2027, at least 80% of complete electronic prior authorization requests will be answered in real-time.
- **Ensure medical review of denied requests**, a standard that is already in place

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

Takeaways

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

Take advantage of data calls

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

Incorporating flexibility in legislation

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

Alignment with federal requirements and industry standards

To reduce administrative complexity and accelerate implementation timelines, states should align PA standards and technical requirements with federal rules (such as CMS's Interoperability and Prior Authorization Final Rule) and industry-led efforts, including implementation guides developed by HL7 and other standards bodies. Consistency across jurisdictions helps limit the need for separate technology builds or duplicative compliance processes for insurers operating in multiple markets.

Support provider adoption of technology

Successful implementation of electronic prior authorization (ePA) depends on both health plans and providers investing in and adopting interoperable systems. While many health plans are modernizing their platforms in alignment with CMS's Interoperability and Prior Authorization Final Rule, provider adoption has been slower in some areas due to cost and complexity. States can encourage or incentivize provider-side upgrades, offering grants or technical assistance. Supporting provider readiness will accelerate the benefits of automation, reduce administrative burden, and improve care coordination.

Build relationships with state partners

In all conversations with providers, health plans, 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.

Commented [BCBSA33]: Recommend including additional details and specifics on this point and including it under a new section to distinguish it from the health insurers' PA commitments.

Commented [BCBSA34]: Recommend revising the title of this section to be, "Policy Considerations for State Policymakers" to clarify the content in this section. "Takeaways" is a broader term and could be misinterpreted to be a summary of the paper.

Commented [BCBSA35]: Recommend focusing the document on objectively laying out the policy activity and data and not fold in policy recommendations. We believe this paper should should serve as a resource for state policymakers to understand the landscape, not as a vehicle for setting new policy direction.

Commented [BCBSA36]: Recommend adding this policy consideration to the paper to better ensure regulatory consistency across states. Encouraging alignment with CMS's Interoperability and Prior Authorization Final Rule, as well as HL7 implementation guides, reduces the burden of compliance and supports seamless provider-insurer communication.

Commented [BCBSA37]: Recommend adding this policy consideration to acknowledge a key barrier to realizing the full benefits of ePA. By highlighting the need to consider provider readiness and offering support where feasible, the paper offers a more holistic and balanced approach to successful PA reform.

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 and consider opportunities to coordinate with health plans, particularly given many plans' recent commitment to enhance communication of PA determinations. 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.

Commented [BCBSA38]: Recommend including language on coordination with health plans to promote collaboration.

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

