FROM THE NAIC HEALTH CONSUMER REPRESENTATIVES

August 29, 2025

To: Commissioner Grace Arnold, Chair, and Joylynn Fix, Vice-Chair, of the Regulatory Framework (B) Task Force

RE: NAIC Consumer Representatives' Comments on the Prior Authorization White Paper

On behalf of the undersigned Consumer Representatives to the National Association of Insurance Commissioners (NAIC), thank you for the opportunity to comment on the Task Force's draft white paper on prior authorization. We applaud the Task Force for addressing the critical issue of prior authorization, a practice that has grown greatly over the past few years and can cause irreparable harm to consumers when used inappropriately.

We encourage the Task Force to ensure that the white paper effectively articulates the current challenges related to prior authorization, the steps states can take to address these challenges, and specific next steps the NAIC can take to aid regulators in their implementation and enforcement activities, with an eye toward providing a practical roadmap for legislators and regulators considering future actions on prior authorization.

Articulating the Challenges

As described to the Task Force at the Spring National Meeting, in addition to previous venues, improper use of of prior authorization poses numerous challenges to consumers (previous comments can be found starting on page 158 of the meetings materials- https://content.naic.org/sites/default/files/n ational_meeting/Materials%20-%20Regulatory%20Framework%20%28B%29%20Task%20Force%20rev%203-25.pdf).

It is essential that the white paper clearly articulate these challenges in order to identify appropriate solutions. Most concerningly, the current white paper draft does not emphasize that the most dangerous challenge for consumers is that inappropriate prior authorization criteria interfere with access to clinically appropriate care. While we are concerned that the current structure of the white paper, which separates the various challenges into stakeholder perspective sections, may be confusing for audiences who are not as familiar with these issues, we have limited our specific comments to the Consumer Perspective section. Please see the attached red line. We are happy to discuss any questions and look forward to working with you to finalize this section.

Solutions to Address the Challenges

We appreciate the section of the white paper that offers examples from states. We think this section could be made simpler for regulators and interested parties to understand if it were instead organized or grouped by the challenge it is trying to solve. For example, "gold carding"

laws are one part of broader reforms intended to help address the high-volume of prior authorization requests for regularly approved services for some providers. They are not in and of themselves a solution to the challenges described in the paper. Notable missing solutions include "address public health and mental health crises" and "require prior authorization criteria to be based on a clinically recommended and evidence-backed standard of care."

Similarly, we would strongly recommend the inclusion of a description of the solution and what problem it is trying to solve for each of these sections, as it will likely be difficult for readers to understand the common theme amongst the cited state examples or why these particular states have been chosen to be highlighted. We outlined a way to organize this content in our comments this spring and would encourage the Task Force to review those materials.

Next Steps at the NAIC

The taskforce and workgroup structure of the NAIC is well positioned to provide a platform for regulators to engage in the takeaways outlined in the end of the paper. This is in part because it is important that issues with prior authorization be addressed with the broader context of claims denials and in alignment with other committee work looking at the use of AI and third parties (see our report published in 2024 on AI as a reference). However, the final section of the white paper stops short of recommending specific and concrete next steps for NAIC. We urge you to move forward in two ways.

Model Law Development

We urge the Task Force to utilize the findings from this white paper to initiate a new model law and regulation addressing prior authorization, including in the context of claims reviews, approvals, denials, and appeals. A model law will help states adopt uniform reforms to prior authorization practices in the overall context of claims assessment and support regulators in implementation and enforcement of the laws.

Enforcement and Implementation

We urge the creation of a new Working Group, similar to the newly adopted Pharmacy Benefit Management (D) Working Group, to give regulators a platform to discuss aligned enforcement and market oversight activities. One area this working group could focus on is the development of standards and guidelines for data collection on prior authorization as one part of the claims denial ecosystem. Standards would support states in collecting data that is uniform, specific, valid, and comparable across states.

The working group could also consider adopting examination standards, monitor and address market conduct trends across states, and provide a mechanism to facilitate conversation with federal agencies to ensure collaboration and reduce duplication. And perhaps most importantly, the working group could serve as a forum to share best practices, examination findings, and compliance issues encountered with regulating prior authorization practices.

In Conclusion

The consumer representatives are grateful to the Task Force members and staff for their efforts in drafting the white paper. We are at an inflection point with the challenges prior authorization and claims denials can present and the technological capabilities and priorities across federal and state governments and organizations. With federal rules going into effect over the next two years requiring more transparency around prior authorization and the voluntary pledge from payers to participate in reform conversations, this is a critical time to ensure standards and processes are in place to ensure robust enforcement of prior authorization reforms and drive accountability amongst plans for how improper denials impact consumers. We stand at the ready to partner with you on this work moving forward.

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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.

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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 appropriate, medically necessary, and covered by a health plan. This was initially intended to ensure safety (e.g., prevent negative drug interactions) and reduce utilization of medically unnecessary treatments, with the overall aim of containing health care costs. Now, PA is used for a broad swath of treatments, both prescriptions and procedures. Though not all services require PA, for services that do it is sometimes applied for non-medical and other reasons that burden providers and limit and delay patient access to health care. If PA is properly instituted, it can achieve a favorable balance between costs and benefits for both insurers and their members, and ensure that patients receive the most appropriate treatment without delays, administrative barriers. ~~.~~ ~~B~~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. However, inappropriate prior authorization criteria interfere with access to clinically appropriate care and be a burden for providers, especially when over utilized by payers. ~~While PA can benefit insurers, providers, and consumers, the process has a reputation of burdening providers and delaying care for consumers~~.

How this document can help regulators

In recent years, state legislatures have introduced and updated PA statutes to reduce administrative burdens and negative health outcomes. Most proposed legislation focuses on the method by which PA must be requested (e.g., by phone, fax, or 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 a roadmap of legislative options related to PA.

Please note that this document will not elaborate on the growing 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 AI in prior authorizations in any forthcoming materials.

The prior authorization process

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

- ***Submission:*** The health care provider submits a PA request to the insurer, detailing the medication or treatment recommended for the patient.
- ***Review:*** The insurance company reviews the request, evaluating it against its clinical guidelines and policies.
- ***Approval or Denial:*** Based on the review, the insurer either approves or denies the request, often providing an explanation.
- ***Appeals:*** If the request is denied, the patient or provider may appeal the decision and provide additional information to support the necessity of the treatment.

Common medical services subject to prior authorization

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

- ***High-Cost and Specialty Drugs:*** Medications that are expensive or require careful monitoring, such as biologics or high-dose chemotherapy drugs.
- ***Advanced Imaging:*** Tests like MRI, CT scans, or PET scans.
- ***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 care***: More intensive services, and often any medications, for treating these conditions.~~, including especially higher levels of care beyond out-patient~~
- While these were the initial focus of PA, over time insurers have expanded its use to include many other prescription drugs and services based on other factors, including rebates negotiated by insurers and PBMs for prescription drugs.

[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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Prior authorization issue perspectives

The provider perspective

Administrative burden and expense

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

In many cases, health insurers require PA to be completed at certain intervals during a course of treatment. This may take the form of step therapy (the process by which an insurer requires the use of certain 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 – time that could be spent treating the patient.

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

Lack of consistency and transparency

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

Denial letters often 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.

[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

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Outdated and inefficient technology

Oftentimes, the technologies (including software, web portals, fax machines, and even communication by phone) used by insurer PA systems are outdated and cumbersome. 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. When medical offices are required to contact a health benefit plan by phone, staff experience long hold times. Providers often need to create documentation of their communications by phone or fax in case such information is later needed to prove contact was made.

Misalignment with clinical standards of care

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 do not necessarily consider cost and are intended to provide the most efficient and effective care depending on a patient's particular needs. Rather than treating a patient with what the health care provider considers to be most appropriate treatment using their knowledge of clinical standards of care, a PA request denial may force a health care provider to prescribe a different therapy, not considered to be in the patient's best interests, but that is covered by the patient's insurer. The provider must choose whether to pursue a lengthy and possibly futile 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 can be ~~are~~ well-meaning for the health care system, the consumer experience is often marred by inefficiency, care disruption, lack of transparency, ~~and~~ adverse outcomes, and surprises (e.g., reversals of prior authorizations relied upon for coverage of care).

Lack of access to~~PA criteria often misaligned with~~ clinically appropriate ~~standards of~~ care

The criteria used by plans to make prior authorization determinations ~~varies greatly plan to plan, is not transparent to consumers, and~~ is often not in alignment with clinical standards of care. For example, plans may deny a prior authorization and require individuals to "fail first" at a less effective course of treatment before covering the standard of care for that condition that will lead to the best health outcomes for the consumer. This poses significant risk to those consumers who are unable to receive medically necessary care in a timely manner and those who have disruptions in their care due to unnecessary or mid-treatment prior authorization denials. It also undercuts a consumer's ability to file an appeal or bring complaints to state regulators if they do not have access to the medical necessity criteria and are not made aware of why their claim was denied.

Commented [1]: We recommend NAIC utilize the below language in the consumer perspective section to reflect suggested edits, additions, and deletions from the consumer community. This includes deletion of the section on emergency medical care.

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Delays and d~~D~~isruptions in care

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

Lack of transparency interferes with consumer rights and creates additional burdens~~Reason for denial is not clear~~

The criteria used by plans to make prior authorization determinations varies greatly plan to plan and is not transparent to consumers. ~~L~~The lack of transparency also extends to ~~in~~denials, which is equally concerning for consumers. When denial letters lack transparency and provide no information on how the denial was determined, consumers do not have the necessary information to appeal the decision or file appropriate complaints with state officials.

Because of this complexity and lack of transparency, in practice the only way a provider or consumer can discover the rules that are in effect is through trial and error. For consumers this requires extra visits and calls to the provider, costing them time and money. This "blind alley" effect makes dealing with prior authorization extremely burdensome and undercuts the concept of "incentivizing the most appropriate use of medical services".

Higher costs in the long run

When the recommended treatment is denied by an insurer or a PA is reversed, then consumers are left with two options: forego the appropriate treatment or pay for it out-of-pocket. Those who forego treatment, or accept a less effective treatment as an alternative, are less likely to improve and may experience significant setbacks in their treatment and recovery such that their conditions become worse and more acute.

[5] https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/
[6] Id.
[7] https://web.archive.org/web/20240819003745/https:/www.ama-assn.org/system/files/prior-authorization-survey.pdf
[8] Id.

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C~~For those c~~onsumers who ~~do~~ require~~seek~~ care in an emergency room setting as a result, ~~they~~ will incur significant out-of-pocket costs that may otherwise be avoided by seeking or receiving appropriate 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]

Consumers who pay out-of-pocket for the treatment they need, especially for ongoing services or medications, are more likely to go into debt or be forced to choose between health care and other basic necessities. Medical debt has already reached crisis proportions, with an estimated 100 million Americans already saddled with medical bills they cannot afford, and that number is only expected to grow as recent federal actions increase the uninsured rate.

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.[13]

For many conditions, including mental health and substance use disorders, there may only be a short window of time when patients are both willing and able to seek treatment, and these types of delays in accessing care can lead to death.

Prior authorization is consistently ranked as the top arthritis-related challenge in Arthritis Foundation advocacy surveys each year. In a 2023 prior authorization survey, the Arthritis Foundation found that 77% of respondents waited 3 or more days for a prior authorization decision, with 31% waiting more than seven days. While prior auth was approved in 88% of cases, of those who were denied 43% appealed and were still denied and 28% did not appeal. As a result of a denial, 35% of respondents used a different medication, 20% went a period of time without medication, and 15% paid out of pocket.

What we have learned from many focus groups, panel conversations, and patient interviews is that the prior authorization process often represents enormous administrative burden, with many patients likening it to a full time job; it causes anxiety and in some cases depression; and it can have negative irreversible health

[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.

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consequences. Patients frequently report that they want more transparency in the prior authorization process so they can plan better and streamline the approval process itself.

Most consumers don't know they can appeal and the process is challenging

According to the KFF Survey of Consumer Experiences with Health Insurance, 40% of insured adults know they have the right to appeal a coverage denial.[14] 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] 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 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 necessarily has~~can have~~ negative impacts on health outcomes.

[14] https://www.kff.org/affordable-care-act/kff-survey-of-consumer-experiences-with-health-insurance/
[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
[17] Id.

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An example of the often cumbersome nature of appeals and denial can be seen in durable medical equipment (DME). This report has already noted that DME is a medical need that is commonly subject to prior authorization. Patterns of prior authorization for mobility devices can therefore be seen as a microcosm for how unchecked prior authorization practices affect consumers. Among those who have mobility-related equipment needs, prior authorization for medically necessary mobility devices is a tremendous problem leading to frequent denials, high out-of-pocket expenses, and literally months of delay during which the insured person may be unable to attend school, work and family functions, can't go into the community without risking breakdowns, could experience progressive nerve damage from an ill-fitting chair, and may be limited in performing common self-care activities in their own home. An April 2025 report analyzing the experiences of wheelchair users across the country found that 37% used private insurance, and of this group, 37% experienced a denial of wheelchair coverage within the last five years. Even more tellingly, 25% of those surveyed said their experience of denied prior authorization was so common that they didn't even try to use their insurance coverage for their last wheelchair because they were certain insurance would not timely authorize equipment that would meet their needs. Over half of the denials were of a specific wheelchair component such as a seat elevator, power assist, customized seat cushions, or sturdier motors.

To give more context, there are approximately 5.5 million mobility device users in the US with about 900,000 in this group who need highly customized adaptive motorized or manual wheelchairs and other specialized wheeled mobility devices. This is a relatively small population subgroup whose wheelchair need can be due to a number of specific medical conditions such as a spinal cord injury or muscular dystrophy, who are likely to have long-term care needs, and who are using a relatively high-cost device that must be replaced every 5-7 years because of the individual owner's needs, which will change/grow as they age, or simply due to mechanical failure. The individualized nature of wheelchair needs may make it harder to come up with a single set of clinical standards that apply to all insured persons, but each wheelchair user's mobility device prescription tends to be carefully developed by a team of providers that include medical doctors and occupational and physical therapists. Nonetheless, these tailored prescriptions from specialist healthcare providers and fitters were denied 43% of the time across all public and private insurers with over 63% not appealing the denial and taking their chances with an ill-fitting chair while trying to save enough for a new one or attempting crowd-funding.

Third parties involved in PA lack regulation

A recent Federal Trade Commission report on pharmacy benefit managers (PBMs) details how increasing vertical integration and market concentration has enabled the six largest PBMs to manage nearly 95 percent of all prescriptions filled in the United States.[18] As part of the services they provide, PBMs can impose prior authorization policies, and the report finds evidence that this is being used to discourage utilization of generic medications:. "Drug utilization management services help payers limit their costs, though concerns are routinely raised regarding potentially abusive utilization management

[18] https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

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practices that put payers' financial interests before patients' best interests." In addition, some plans use third-party administrators for other types of utilization management, including the design and operation of such practices in some or all of their benefits, but regulations may not effectively or adequately extend to these third parties.[19]

Lack of data for enforcement and corrective action

Due to the perspectives articulated above, it is essential for consumer protection that regulatory agencies have comprehensive data and enforcement capabilities to take corrective actions. Without this, regulators are at just as much of a disadvantage in trying to understand the types of services receiving denials, the reason for the denials, and the reason for the prior authorization request in the first place.

The insurer perspective

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

- 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

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.[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

Insurers claim that PA prevents the use of low-value health care services, saving insurer and member dollars without adverse health consequences.[21] While the research on the value proposition of health care services may be clear in some cases, it is 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. There is not yet definitive research to determine the overall economic value of PA for insurers. However, insurer representatives consistently articulate the centrality of PA for their efforts to contain costs and improve quality of care.

[19] https://www.oig.dol.gov/public/reports/oa/2025/09-25-001-12-001.pdf

[20] 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

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

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The potential cost containment benefits of PA may be particularly important in the context of the Affordable Care Act's (ACA) insurance reforms. Core ACA provisions such as guaranteed issue, community rating and prohibitions on pre-existing condition exclusions provide important consumer protections but also leave insurers on the hook for higher health care costs. In this context, it may be unsurprising that PA requirements appear to be on rise in recent years, as they may represent one of the few tools remaining for insurers to contain costs, which in turn can help keep premiums and out-of-pocket costs in check.

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.

Electronic prior authorization

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.[22] 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.[23] 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.

Selective use

Selective use, also called gold carding, means applying different PA processes and expectations based on provider performance.[24] Health insurers have typically opposed statutory or regulatory mandates in the area of selective use, preferring to be permitted the flexibility to explore a range of options to strike a favorable balance between administrative simplification, patient protection and cost containment. However, many health insurers voluntarily apply selective use policies as part of their PA programs.

Questions regarding the evidence base

One of the key purposes of PA cited by insurers is to ensure that covered services are evidence-based and effective. Some insurers have expressed concerns about the evidence base behind PA and have pushed

[22] https://www.ahip.org/news/press-releases/ahip-statement-on-the-cms-interoperability-and-prior-authorization-final-rule

[23] https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states

[24] See e.g., https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf

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for stricter requirements in this area.[25] Insurers are unlikely to be supportive of restricting their flexibility in this area for a variety of reasons. For example:

- PA denials are typically subject to appeal and external review requirements that provide the opportunity for an independent check on practices not aligned with clinical evidence.
- Questions about the value proposition of particular health care services may not be entirely resolvable by clinical evidence. For example, there may be cases where two therapies with significant cost differences have similar effectiveness in treating a health condition but may have differential effects on the patient experience in other respects, such as comfort or aesthetic considerations.[26]

Solutions and examples

States

Reducing Prior Authorization

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

Limitations and Exemptions

Some states have addressed burdensome use of PA by requiring PA criteria to be based on clinically-recommended standards of care. There are many ways states have sought to accomplish this, including exempting primary care services; exempting maintenance therapies for the life of the prescription; and exempting categories of treatments like preventive care and substance use disorder treatment. For example, 17 states have prohibited PA for PrEP services. IL, VT, and MN also have laws limiting or excluding certain services from prior authorization. VT prohibits prior authorization from treatments and services ordered by a primary provider and exempts chronic conditions from repeat prior authorization; IL prohibits prior authorization for in-patient mental health services; and MN prohibits prior authorization for preventive services and certain pediatric services in addition to non-medication cancer and out-patient mental health and substance use disorder treatment.

Gold carding

"Gold carding" describes a process by which a health care provider may qualify for an exemption from a health insurer's PA requirements. A provider who has qualified for a gold card for a particular health care

[25] 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

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

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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.

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

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.[27] 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.[28] 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.[29]

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.[30] 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

[27] Ark. Code Ann. § 23-99-1103(10)(A).
[28] Ark. Code Ann. § 23-99-1120(a).
[29] Ark. Code Ann. § 23-99-1122(a)(3).
[30] Ark. Code Ann. § 23-99-1128(b).

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to reduce delays in patient care and allow physicians to dedicate more time to their patients. The Texas Department of Insurance (TDI) is responsible for overseeing the implementation of this law.

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

1. Submitted five or more eligible PA requests for the particular health care service in the most recent evaluation period; and
2. At least 90% of the eligible PA requests for a particular service were approved. [31]

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).[32] 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.

[31] 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

[32] Wyo. Stat. Ann. § 26-55-112

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CONSUMER REPRESENTATIVE COMMENTS

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.[33]

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. IL 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.~~IL 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~~.[34]

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[35] 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.

[33] 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.

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

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

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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[36], 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.

Washington

The Evergreen State has implemented shorter turnaround times for PA approvals[37], 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.[38] 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

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

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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.[39] 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.

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[40] 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[41] 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[42].

West Virginia

During the 2024 Legislative Session, WV updated PA laws[43] to require a health insurer to submit requests with any related communication via an electronic portal.

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

[40] 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

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

[42] 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

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

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CONSUMER REPRESENTATIVE COMMENTS

Improving transparency

Oklahoma

House Bill 3190[44] requires health insurers to publish their PA requirements online, ensuring they are accessible to patients and providers. If a utilization review entity—defined as an individual or organization that performs PA for a health benefit plan—plans to implement a new requirement or change an existing one, they cannot do so until their website reflects the updated information.

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

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

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

For appeals, the requirements are 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.[45] Determinations must be made by an individual licensed to practice medicine in Texas who has

[44] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400
[45] see 28 Tex. Admin. Code §19.1732(b)

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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.[46]

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.[47] For each category (inpatient medical or surgical, outpatient medical or surgical, mental health and substance use disorder, durable medical equipment, diabetes, and prescription), carriers must list the ten codes with the:

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

West Virginia

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

Wyoming

The *Ensuring Transparency in PA Act* and established guidelines for review of adverse determinations.[48] 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. [49] Furthermore, any changes to the requirements must be posted 60 days in advance of the

[46]

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

[48] Wyo. Stat. Ann. § 26-55-101 through -106

[49] Wyo. Stat. Ann. § 26-55-103

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change's enactment.[50] 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[51] is to improve transparency and limit interruptions to patient care. The following states have taken language directly from the model legislation: Delaware, Georgia, Illinois, Mississippi, New Jersey, Oklahoma, and Wyoming.

The legislation recommends:

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

Commented [2]: Recommend also including the 21 principles with over 100 signatories from 2014 and the consensus agreement from 2018 that 6 cross-stakeholder trade associations signed, including insurance trades https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf

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

[50] Wyo. Stat. Ann. § 26-55-103

[51] 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

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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[52] 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.

[52] 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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2) Any prescription drug, whether generic or brand-name, that is not classified as a controlled substance in federal or state law, after the insured or enrollee has been prescribed the drug without interruption for six months.

3) Any prescription drug, whether generic or brand-name, where the insured or enrollee has already undergone PA for the same dosage and received approval for coverage, on the grounds of therapeutic duplication.

4) Any prescription drug, whether generic or brand-name, when the dosage has been adjusted by the prescriber.

5) Any long-acting injectable prescription drug.

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

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

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

The federal government

In addition to state legislative action, the Centers for Medicaid and Medicare Services (CMS) within the federal Department of Health and Human Services (HHS), issued a CMS Interoperability and PA Final Rule[53] 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.

Commented [3]: Recommend noting that the CMS final rule does not apply to drugs

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

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CONSUMER REPRESENTATIVE COMMENTS

Private industry

In June 2025, AHIP announced voluntary efforts by its member health insurance providers to simplify prior authorization, with a focus on "connecting patients more quickly to the care they need while minimizing administrative burdens on providers."[54] The pledge is the outcome of a survey of AHIP's members[55] and applies to insurance markets including Commercial coverage, Medicare Advantage, and Medicaid managed care. While a number of the proposed actions are already required by law and regulations, t~~T~~he 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.
- **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.

Commented [4]: Similarly, it should be noted the scope of this does not include drugs

Commented [AH5]: We recommend adding examples of successful use of these take-aways, such as the data call NM did for PrEP to hold issuers accountable for compliance

[54] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization
[55] https://ahiporg-production.s3.amazonaws.com/documents/202506_AHIP_Report_Prior_Authorization-final.pdf

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CONSUMER REPRESENTATIVE COMMENTS

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.

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.

Changes to PA processes or requirements could also have unintended consequences, such as leading to greater use of retrospective reviews or post-payment audits to contain costs, so state agencies should monitor for these types of shifts and consider how to proactively prevent them, such as by prohibiting insurers from retrospectively denying or refusing to pay for care that was pre-approved.

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

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