REGULATORY FRAMEWORK (B) TASK FORCE

Regulatory Framework (B) Task Force Dec. 10, 2025, Minutes

- Regulatory Framework (B) Task Force Oct. 20, 2025, Minutes (Attachment One)
  - Regulatory Framework (B) Task Force 2026 Proposed Charges (Attachment One-A)
- Regulatory Framework (B) Task Force Sept. 22, 2025, Minutes (Attachment Two)
  - Draft Prior Authorization White Paper July 18, 2025 (Attachment Two-A)
- Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group Dec. 10, 2025, Minutes (Attachment Three)
- Prescription Drug Coverage (B) Working Group Dec. 9, 2025, Minutes (Attachment Four)

Draft Pending Adoption

Draft: 12/15/25

Regulatory Framework (B) Task Force
Hollywood, Florida
December 10, 2025

The Regulatory Framework (B) Task Force met in Hollywood, FL, Dec. 10, 2025. The following Task Force members participated: Grace Arnold, Chair (MN); Allan L. McVey, Vice Chair, represented by Joylynn Fix (WV); Heather Carpenter represented by Sarah S. Bailey (AK); Mark Fowler represented by Yada Horace (AL); Maria Ailor represented by Fausto Burruel (AZ); Michael Conway represented by Debra Judy and Lila Cummings (CO); Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); Michael Yaworsky represented by Alexis Bakofsky (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Shannon Hohl (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Craig VanAalst (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Kevin P. Beagan (MA); Robert L. Carey represented by Robert Wake (ME); Angela L. Nelson represented by Jo A. LeDuc (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson and Maggie Reinert (NE); D. J. Bettencourt represented by Michelle Heaton (NH); Ned Gaines (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready and Andy Schallhorn (OK); TK Keen (OR); Michael Humphreys represented by Lindsi Swartz (PA); Larry D. Deiter represented by Jill Kruger and Gretchen Brodkorb (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Jane Beyer (WA); and Nathan Houdek represented by Coral Manning (WI).

1. Adopted its Oct. 20, Sept. 22, and Summer National Meeting Minutes

The Task Force met Oct. 20 and Sept. 22. During these meetings, the Task Force took the following action: 1) discussed the Aug. 29 comments received on the July 18 draft of the *Prior Authorization White Paper*; and 2) adopted its 2026 proposed charges and the 2026 proposed charges of its working groups.

Croom made a motion, seconded by Manning, to adopt the Task Force's Oct. 20 (Attachment One), Sept. 22 (Attachment Two), and Aug. 11 minutes (*see NAIC Proceedings – Summer 2025, Regulatory Framework (B) Task Force*). The motion passed unanimously.

2. Adopted the Reports of its Working Groups

Fix made a motion, seconded by Peck, to adopt the following working group reports: 1) Employee Retirement Income Security Act (ERISA) (B) Working Group; 2) Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group (Attachment Three); and 3) Prescription Drug Coverage (B) Working Group (Attachment Four). The motion passed unanimously.

3. Adopted the *Prior Authorization White Paper*

Commissioner Arnold reminded everyone that the Health Insurance and Managed Care (B) Committee and NAIC leadership directed the Task Force to develop a white paper on prior authorization (PA) frameworks. She discussed the Task Force's work in developing the *Prior Authorization White Paper*, which was before the Task Force for adoption at this meeting.

Commissioner Arnold stated that as discussed during the Task Force's meeting at the Summer National Meeting, the Task Force exposed an initial white paper draft in July for a public comment period ending Aug. 29. The Task Force met Sept. 22 to discuss the comments received. She stated that following the Sept. 22 meeting, the PA

Drafting Group, which developed the initial white paper draft, reviewed the comments to consider which, if any, to incorporate into a revised draft. She said that in October, the Task Force exposed a revised white paper draft reflecting the Aug. 29 comments received for a public comment period ending Nov. 19. She said the white paper draft before the Task Force for adoption today is a revised draft that includes non-substantive revisions to the Oct. 28 draft, as suggested in some of the Nov. 19 comments. She noted that the non-substantive changes are in tracked, redlined language.

Commissioner Arnold asked for comments from Task Force members and interested regulators. There were no comments. She asked for comments from interested parties. Lucy Culp (Blood Cancer United), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives support the white paper draft. She said they believe it captures the different perspectives on PA. She urged the Task Force to think of next steps, such as developing a new model law and regulation addressing PA and appropriate referrals related to PA enforcement to the Market Regulation and Consumer Affairs (D) Committee.

Beyer made a motion, seconded by Beagan, to adopt the *Prior Authorization White Paper* (*see NAIC Proceedings – Fall 2025, Health Insurance and Managed Care (B) Committee, Attachment Six*). The motion passed unanimously.

Commissioner Arnold said the Health Insurance and Managed Care (B) Committee will consider adoption of the white paper during its Dec. 11 meeting. She said that following Committee adoption, she anticipates additional discussion among NAIC leadership on next steps.

4. Heard a Presentation from the NCQA on 2026 Updates to its UM Standards

Kristine Toppe (National Committee for Quality Assurance—NCQA) and Alan Immelman (NCQA) discussed updates to the NCQA's utilization management (UM) standards for 2026. Toppe said the NCQA's presentation outlines how the NCQA is supporting both federal and state goals for improving the care experience of individuals and their providers by addressing the hurdles in the UM process chain that result in delays in care, provider dissatisfaction, and administrative inefficiencies. She stated that the NAIC's focus on PA, and the recently adopted *Prior Authorization White Paper* reinforce the importance that has been collectively placed on addressing this problem.

Toppe provided an overview of the NCQA's work, explaining that it offers more than 20 accreditation, certification, and recognition programs, which are all focused on helping organizations improve and deliver quality health care. She said the NCQA has the most widely used standardized performance measurement tool in health care: the Healthcare Effectiveness Data and Information Set (HEDIS).

Immelman discussed the NCQA's UM management program suite, which includes health plan accreditation (HPA) UM requirements, UM accreditation, and behavioral organization accreditation. He noted that the NCQA's standards apply across all lines of business for health plans, including Medicare, Medicaid, commercial, and Affordable Care Act (ACA) exchange plans. Immelman discussed the NCQA's UM requirements, which include policies and procedures for PA, timely decision-making, appeals and grievance processes, and qualified clinical staff involvement. He discussed the key 2026 UM standard updates, which include updates related to: 1) UM data collection and trends analysis; 2) evaluation and measurement of effectiveness when interventions are implemented; 3) the availability of UM criteria to practitioners at the point of care; and 4) the timeline for UM decision making for non-urgent requests. Immelman said these changes collectively: 1) build trust with providers; 2) build trust with members; 3) mitigate risk; 4) facilitate process improvement; 5) strengthen internal benchmarking; and 6) demonstrate value.

Toppe stated that the updated UM standards are effective July 1, 2026. She said the NCQA produces its standards and any updates to standards in advance of the year to give organizations time to prepare their data systems and

processes. She said that once the updates are effective, plans and organizations accredited with the NCQA will begin collecting data consistent with the updated requirements.

Commissioner Arnold said that one of the best practices noted in the *Prior Authorization White Paper*, particularly if a state has just enacted PA legislation, is data collection and learning from the information collected. She acknowledged that the NCQA does not make the UM data it collects public, but she asked, despite this, whether the NCQA has a way of informing state insurance regulators and other state regulators when there could be an issue with an accredited plan. Toppe said the NCQA strives to support state insurance regulators. She said that in a situation like the one Commissioner Arnold described, involving an NCQA-accredited plan that is required to be accredited by the state, the NCQA would be happy to provide a briefing to the state on an individual basis or to states collectively.

Heaton asked Toppe and Immelman about the potential for duplicate UM data collection requirements when states have their own UM data collection requirements. Toppe said the NCQA will certainly review New Hampshire's data collection requirements to eliminate any duplication of efforts for NCQA-accredited plans in New Hampshire, which is one of the things the NCQA accreditation team already does.

Beagan said Massachusetts tracks UM request denials, approvals, and modifications. He asked how the NCQA tracks UM request modifications because he believes it is important to track this data as well. Immelman said the NCQA also tracks UM request modifications as part of its data information integrity requirements, which has been a UM accreditation standard requirement for the past few years.

Beyer asked how the NCQA's updated UM accreditation standards compare with the federal PA data reporting requirements, which will be effective next year. Immelman said that as part of its updating process, the NCQA spends a considerable amount of time and effort making sure that any new time frames or new data elements it plans to introduce in its standards do not conflict. He said that, specifically regarding the new federal PA data reporting requirements, the NCQA's updated UM accreditation standard requirements do not conflict.

5. Received an Update on the ERISA (B) Working Group's Work

Wake said that during the ERISA (B) Working Group's meeting at the Summer National Meeting, the Working Group asked for volunteers to participate in an ERISA Pharmacy Benefit Manager (PBM) Drafting Group to discuss developing guidance for state insurance regulators looking at ERISA preemption of state PBM laws since the *Rutledge v. Pharmaceutical Care Management Association (PCMA)* U.S. Supreme Court decision. He said the goal is to develop guidance, based on current case law, to assist insurance regulators in determining what PBM laws may be more or less vulnerable to ERISA preemption.

Wake said the ERISA PBM drafting group, which is made up of state insurance regulators from Iowa, Maine, Massachusetts, Missouri, Nebraska, North Dakota, Virginia, Washington, and West Virginia, has been meeting every other week since late September to develop an initial draft of the guidance document. He said the ERISA PBM Drafting Group is making progress. It has an initial draft and is currently working on refinements to it. Its next meeting is Dec. 22. Wake said he anticipates forwarding an initial draft of the guidance document to Working Group members for their review and comment by the end of this year or early next year and exposing a draft of the guidance document for public comment early next year.

Wake said the Working Group is also working to complete its assignment from the Health Insurance and Managed Care (B) Committee and NAIC leadership to develop guidance on level-funded plans and other alternative arrangements as related to the small group market. He said that to obtain more information on, and a better understanding of, level-funded plans, the Working Group heard a presentation from the National Association of Benefits and Insurance Professionals (NABIP) on level-funded plans during the Summer National Meeting. He said

that after that meeting and presentation, it became clear the Working Group needed to gather additional perspectives to draft guidance that thoughtfully examines level-funded plans in relation to the small group market. Wake said the Working Group has had trouble finding presenters willing to speak on the topic. He said that recently, however, the Self-Insurance Institute of America Inc. (SIIA) agreed to speak to the Working Group on the issue of stop-loss insurance, including its use in level-funded plans. Wake said he anticipates the Working Group scheduling a meeting early next year to hear the presentation.

Given his anticipated retirement from the Maine Bureau of Insurance early next year, Fix thanked Wake for his contributions to the work of the ERISA (B) Working Group and the NAIC as a whole. She said he will truly be missed. Commissioner Arnold also thanked Wake for his many contributions.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft: 10/30/25

Regulatory Framework (B) Task Force
Virtual Meeting
October 20, 2025

The Regulatory Framework (B) Task Force met Oct. 20, 2025. The following Task Force members participated: Grace Arnold, Chair (MN); Allan L. McVey, Vice Chair, represented by Joylynn Fix (WV); Heather Carpenter represented by Sarah Bailey (AK); Mark Fowler represented by Yada Horace (AL); Maria Ailor represented by Fausto Burruel (AZ); Michael Conway represented by Debra Judy (CO); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Paige Little (DC); Michael Yaworsky represented by Alexis Bakofsky (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron (ID); Holly W. Lambert represented by Alex Peck (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark (KY); Michael T. Caljouw represented by Cara Libman (MA); Robert L. Carey represented by Robert Wake (ME); Angela L. Nelson represented by Amy Hoyt (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson (NE); D. J. Bettencourt represented by Michelle Heaton (NH); Ned Gaines represented by Diana Branciforte (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready (OK); TK Keen represented by Jesse O'Brien (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Heidi Clausen (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Rocky Patterson and Heather Shimoji (WA); and Nathan Houdek represented by Coral Manning (WI).

1. Adopted its 2026 Proposed Charges

Commissioner Arnold said the purpose of the Task Force's meeting is to discuss and consider adoption of the Task Force's 2026 proposed charges. She said the 2026 proposed charges remove an obsolete charge and clarify other charges, such as revising the Employee Retirement Income Security Act (ERISA) (B) Working Group's charge to require the Working Group to monitor, analyze, and report developments related to "group coverage" instead of "association health plans (AHPs)."

Commissioner Arnold said the 2026 proposed charges also add a new charge for the Task Force to "examine regulatory factors contributing to disparities in coverage and recommend appropriate steps to reduce those disparities." She said this charge stems from the former work of the Special (EX) Committee on Race and Insurance's Health Workstream being transferred to NAIC letter committees after the Special (EX) Committee on Race and Insurance was disbanded last year.

Commissioner Arnold said the Task Force received comments on its 2026 proposed charges from the NAIC consumer representatives, the American Medical Association (AMA), and Schiffbauer Law Office. Carl Schmid (HIV+Hepatitis Policy Institute), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives submitted a comment letter to the Task Force expressing support for the Task Force's 2026 proposed charges. He noted, however, that the NAIC consumer representatives suggest the charges include specific language related to the Task Force's work on prior authorization (PA). He said the NAIC consumer representatives urge the creation of two new working groups focusing on PA, similar to how the Task Force addressed work on pharmacy benefit managers (PBMs). Schmid said that, due to the high level of state activity on the PA issue and its importance to consumers, providers, and payers, these new working groups would provide state insurance regulators with a platform to discuss and share their work.

Lauren Finke (The Kennedy Forum), also speaking on behalf of the NAIC consumer representatives, urged the Task Force to consider the NAIC consumer representatives' suggestions for revisions to the Mental Health Parity and

Addiction Equity Act (MHPAEA) (B) Working Group's charges. She said the NAIC consumer representatives' suggested revisions would add the language "compliance oversight" to the Working Group's charge 3D and revise charge 3E to clarify what specific coordination and guidance the Working Group would provide to the Market Regulation and Consumer Affairs (D) Committee.

William Schiffbauer (Schiffbauer Law Office) said he submitted comments suggesting the Task Force reconsider its proposed revisions to charge 1F. He said the Task Force should not delete the language "excepted benefits coverage and short-term, limited duration (STLD) coverage" and replace it with "non-major medical coverage." He suggested that instead, the Task Force add the following language to the end of the charge: "health sharing ministry coverage, and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage." He said he suggests this revision because health sharing ministries and short-term health insurance policies are not excepted benefits, and unlike excepted benefits, these coverages can be marketed as major medical coverage. The Task Force discussed his suggested revision with Task Force members, who expressed support for it.

Commissioner Arnold discussed the NAIC consumer representatives' suggestion that the Task Force establish a new PA working group. She suggested that although it is an important issue for the states, she is unsure that establishing such a working group is appropriate at this time, given that there are still ongoing discussions regarding the PA issue. In addition, she explained that the Task Force has not yet completed its work on the PA white paper, and any recommendations or takeaways it includes will be examined by the new committee leadership in 2026, which will then decide the Task Force's 2026 priorities related to the PA issue. Commissioner Arnold said the time for discussing next steps on the PA issue, including whether to establish a new working group to work on PA issues, will be early next year, when the 2026 priorities are being discussed. She assured Task Force members, interested regulators, and interested parties that the PA issue will not be going away, but discussing next steps, such as establishing a new PA working group, is premature.

Swanson made a motion, seconded by Commissioner Clark, to accept the Schiffbauer Law Office's suggested revisions to charge 1F and adopt the Task Force's 2026 proposed charges (Attachment One-A). The motion passed unanimously.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Revised: 10/20/25
Adopted by the Executive (EX) Committee and Plenary, Dec. __, 2025
Adopted by the Health Insurance and Managed Care (B) Committee, Nov. __, 2025
Adopted by the Regulatory Framework (B) Task Force, Oct. 20, 2025

2026 Proposed Charges

REGULATORY FRAMEWORK (B) TASK FORCE

The mission of the Regulatory Framework (B) Task Force is to: 1) develop NAIC model acts and regulations for state health care initiatives; and 2) consider policy issues affecting state health insurance regulation.

Ongoing Support of NAIC Programs, Products, or Services

1. The **Regulatory Framework (B) Task Force** will:
   A. Coordinate and develop the provision of technical assistance to the states regarding state-level implementation issues raised by federal health legislation and regulations.
   B. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery. Recommend appropriate revisions to regulatory jurisdiction, authority, and structures.
   C. Examine regulatory factors contributing to disparities in coverage, and recommend appropriate steps to reduce those disparities.
   ~~C.~~D. Consider the development of new NAIC model laws and regulations and the revision of existing NAIC model laws and regulations, including those affected by federal legislation and final federal regulations promulgated pursuant to such legislation.
   ~~D. Continue to review NAIC models recommended for revision by the former Affordable Care Act (ACA) Model Review (B) Working Group, and, as appropriate, appoint a working group or subgroup to revise the NAIC model(s) prioritized for revision in 2025.~~
   E. At the direction of the Health Insurance and Managed Care (B) Committee, through the work of the Employee Retirement Income Security Act (ERISA) (B) Working Group, monitor, analyze, and report developments related to ~~association health plans (AHPs)~~group coverage.
   F. Monitor, analyze, and report, as necessary, developments related to excepted benefits coverage, ~~and~~ short-term, limited-duration (STLD) coverage, health sharing ministry coverage, and coverage that is offered and marketed as a substitute for, or an alternative to, comprehensive major medical coverage.

2. The **ERISA (B) Working Group** will:
   A. Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate with the states and the U.S. Department of Labor (DOL) efforts related to sham health plans.
   C. Monitor, facilitate, and coordinate with the states and the DOL regarding compliance and enforcement efforts regarding the Affordable Care Act (ACA) that relate to ERISA.
   D. Review the *Health and Welfare Plans Under the Employee Retirement Income Security Act: Guidelines for State and Federal Regulation* (ERISA Handbook), and modify it, as necessary, to reflect developments related to ERISA. Report annually.

REGULATORY FRAMEWORK (B) TASK FORCE *(continued)*

3. The **Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group** will:
   A. Monitor, report, and analyze developments related to the MHPAEA, and make recommendations regarding NAIC strategy and policy with respect to those developments.
   B. Monitor, facilitate, and coordinate best practices with the states, the DOL, and the U.S. Department of Health and Human Services (HHS) related to the MHPAEA.
   C. Develop and provide resources to the states to support a greater understanding of laws, policies, and market conditions related to the MHPAEA.
   D. Provide supplemental resources to support documentation and reporting in the MHPAEA chapter of the *Market Regulation Handbook*.
   E. Coordinate with and provide input to Market Regulation and Consumer Affairs (D) Committee groups, as necessary, regarding mental health parity market conduct examinations.

4. The **Prescription Drug Coverage (B) Working Group** will:
   A. Serve as a forum to educate state insurance regulators on issues related to prescription drug coverage regulation and stakeholders in the prescription drug ecosystem.
   B. Gather and share information, best practices, experience, and data to inform and support dialogue and information-sharing among state insurance regulators on issues related to prescription drug coverage regulation, such as pharmaceutical drug pricing and transparency, formularies, pharmacy payments, pharmacy benefit managers (PBMs), and coverage options.
   C. Maintain a current listing of prescription drug coverage laws and regulations and case law ~~as~~ that fall under the purview of state-based insurance.
   D. Disseminate materials and reports, via the NAIC, to the states and the U.S. territories wishing to use the information gathered by the Working Group.
   E. Monitor, facilitate, and coordinate with the states and federal agencies to ensure compliance and enforcement efforts regarding prescription drug coverage and PBMs.
   F. Provide assistance and input to the Market Regulation and Consumer Affairs (D) Committee and/or any of its groups, as necessary, on matters related to PBM enforcement.

NAIC Support Staff: Jolie H. Matthews/Jennifer ~~R.~~ Cook

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Draft: 10/9/25

Regulatory Framework (B) Task Force
Virtual Meeting
September 22, 2025

The Regulatory Framework (B) Task Force met Sept. 22, 2025. The following Task Force members participated: Grace Arnold, Chair (MN); Allan L. McVey, Vice Chair, represented by Joylynn Fix (WV); Heather Carpenter represented by Jeanne Murray (AK); Mark Fowler represented by Yada Horace (AL); Maria Ailor represented by Fausto Burruel (AZ); Michael Conway represented by Debra Judy (CO); Andrew N. Mais represented by Jared Kosky (CT); Karima M. Woods represented by Howard Liebers (DC); Michael Yaworsky represented by Alexis Bakofsky (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Holly W. Lambert represented by Bobbi Henn (IN); Vicki Schmidt represented by Julie Holmes and Craig VanAalst (KS); Sharon P. Clark (KY); Michael T. Caljouw (MA); Robert L. Carey (ME); Angela L. Nelson represented by Amy Hoyt (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson (NE); D. J. Bettencourt represented by Michelle Heaton (NH); Ned Gaines (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Ashley Scott, Andy Schallhorn, and Mike Rhoads (OK); Andrew R. Stolfi represented by Jesse O'Brien (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Rachel Bowden (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Rocky Patterson (WA); and Nathan Houdek (WI).

1. Heard Comments on Draft Prior Authorization White Paper

Commissioner Arnold said the purpose of the Task Force's meeting is to discuss the comments received on the July 18 draft prior authorization (PA) white paper (Attachment Two-A). She thanked the PA Drafting Group for developing the initial draft. Commissioner Arnold said the Task Force received 11 comment letters in response to the Task Force's request for comments due Aug. 29. She said those who commented included AHIP, the American Medical Association (AMA), the Blue Cross and Blue Shield Association (BCBSA), the Arkansas Blue Cross and Blue Shield, the NAIC consumer representatives, Dialysis Patient Citizens (DPC), the Pharmaceutical Care Management Association (PCMA), the Pulmonary Hypertension Association (PHA), the Pharmaceutical Research and Manufacturers of America (PhRMA), and several state departments of insurance (DOIs). Commissioner Arnold invited those who submitted comments to provide an overview of their comments.

Miranda Motter (AHIP) said AHIP's comments included: 1) suggested revisions to the insurer perspective section to include language on utilizing evidence-based criteria as part of the PA process and adding language on accreditation, which is a large component of PA oversight; 2) a recommendation that the federal PA requirement section be moved toward the beginning of the white paper to provide additional background on the PA issue; and 3) suggested revisions to ensure the white paper provides a neutral and objective tone.

Emily Carroll (AMA) said the AMA's comments generally offered for the Task Force's consideration some updated information related to its annual physician PA survey and its model PA legislation for inclusion in the white paper's provider associations' section and private industry section. She said the AMA also suggests that the Task Force consider broadening the scope of topics to include more discussion of state action, such as the section on gold carding. Carroll said the AMA believes the white paper draft's effort to encapsulate state efforts to reform the PA process is a good start, but it hopes the next draft goes a bit further by including options for state insurance regulators to consider for enforcement and highlighting best practices in this area.

Randi Chapman (BCBSA) said that, like AHIP, the BCBSA also touched on the tone of the white paper draft in its comment letter. She said many of its redline comments suggest revisions to address this concern. Chapman said the BCBSA's comments also focus on the insurer perspective section, suggesting revisions to this section to ensure that the language reflects that PA is grounded in evidence-based medicine and applied to ensure clinical appropriateness and patient safety. Chapman said the BCBSA also suggests revisions to the white paper draft reflecting the BCBSA's participation in the industry initiative announced in May to streamline and simplify the PA process. She said the BCBSA also suggests that the Task Force review the statistics cited in the white paper to ensure that it is a reliable and objective source of information on PA.

Commissioner Arnold said she appreciated AHIP's and the BCBSA's comments related to the statistics cited in the white paper draft. She noted that in drafting the white paper, the PA Drafting Group found data from insurers, providers, and consumers, but there appears to be a lack of peer-reviewed academic data. She said that because the PA process is designed to have outcomes based on clinical standards, she is asking the commenters and other stakeholders to provide any peer-reviewed academic data or information to the Task Force as the PA Drafting Group works to revise the white paper draft. She said including such information would strengthen the white paper.

Anna Hyde (Arthritis Foundation), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives support the AMA's comments. She said the NAIC consumer representatives' comment letter details what they would like the white paper to include, and they have provided a redline document with suggested revisions to address their concerns. She said the NAIC consumer representatives encourage the Task Force to ensure that the white paper effectively articulates the current challenges related to PA, the steps states can take to address those challenges, and specific next steps the NAIC can take to assist state insurance regulators in their implementation and enforcement activities. Hyde said the NAIC consumer representatives would particularly like the white paper with respect to implementation and enforcement to highlight state successes. She also said the Task Force should view its work on the PA issue within the context of the broader claim denial issue because PA is one piece of it.

Peter Fjelstad (PCMA) thanked the Task Force for giving the PCMA the opportunity to comment on the white paper draft. He said the PCMA's comments also focused on the tone of the draft. He said he appreciated Commissioner Arnold's comments explaining the PA Drafting Group's approach to the white paper and the different PA perspectives it includes. Fjelstad said the PCMA stands ready to work with the Task Force on any specific language related to prescription drug benefits or pharmacy benefits as it moves forward with its work to complete the white paper. Charise Richard (PhRMA) also thanked the Task Force for the opportunity to comment on the white paper draft. She noted that PhRMA's comments include information on recent research and statistics related to PA and utilization management practices for the Task Force's consideration as it moves forward with its work.

Commissioner Arnold said the PA Drafting Group will review all the comments received and consider revisions to the draft based on the suggested revisions included in the comments. She said she hopes to be able to release a revised draft for public comment by the end of October. Commissioner Arnold reiterated her request for stakeholders to submit any third-party peer-reviewed academic research and data they are aware of for the PA Drafting Group's consideration and possible inclusion in the next white paper draft.

Having no further business, the Regulatory Framework (B) Task Force adjourned.

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Draft: 7/18/25

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

Prior Authorization White Paper

Contents

What is prior authorization?

Prior authorization (PA) is a mechanism used to check that a service, treatment, or medication is medically necessary and covered by a health plan. This 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. 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.

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 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.

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

Prior authorization issue perspectives

The provider perspective

Administrative burden and expense

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

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

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 are well-meaning for the health care system, the consumer experience is often marred by inefficiency, care disruption, and adverse outcomes.

Disruptions in care

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

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

have otherwise experienced.[7] Moreover, the same survey found that 78% of 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. As a result, some individuals seek care directly from an emergency room rather than engaging with their health insurer to help coordinate care prior to a medical issue becoming emergent. According to a survey from the AMA, insured adults who received health care in an emergency room would have been twice as likely to encounter PA problems when trying to seek care in a non-emergency setting when compared to those who did not otherwise use the emergency room.[9]

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

Adverse and inequitable outcomes

Within the overall insured population, certain groups of people experience a disproportionate share of PA problems. For example, 31% of adults who use more health care services (defined as having more than 10 doctor visits a year) experience difficulties navigating PA processes.[12] About a quarter (26%) of individuals with mental health conditions who sought treatment or a prescription experienced problems or delays as a result of their difficulties navigating PA processes.[13] Seeking medical care can be stressful, complicated, and expensive, and adding the burden of PA processes can be harmful. Among individuals who reported problems with PA processes, they were twice as likely (than individuals who did not report experiencing issues with PA processes) to report that their health declined as a result.[14]

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

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] 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 can have negative impacts on health outcomes.

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.[18] 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.[19] 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

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

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.

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.[20] 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.[21] 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.[22] 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.

[20] https://www.ahip.org/news/press-releases/ahip-statement-on-the-cms-interoperability-and-prior-authorization-final-rule
[21] https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states
[22] See e.g., https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf

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 for stricter requirements in this area.[23] 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.[24]

Solutions and examples

States

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 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

[23] 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

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

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.[25] 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.[26] 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.[27]

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.[28] 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.

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. [29]

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.

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

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).[30] 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.[31]

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

[30] Wyo. Stat. Ann. § 26-55-112

[31] 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.

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[32] 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[33], 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[34], 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

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

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.[35] 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.[36] 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

[35] Wyo. Stat. Ann. §§ 26-55-101 through -113
[36] see 28 Tex. Admin. Code § 19.1810

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[37] 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[38] 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[39].

West Virginia

During the 2024 Legislative Session, WV updated PA laws[40] to require a health insurer to submit requests with any related communication via an electronic portal.

Improving transparency

Oklahoma

House Bill 3190[41] 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;

[37] 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
[38] Washington SHB 1706 https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/House/1706-S.SL.pdf
[39] 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
[40] W. Va. Code Ann. §33-15-4s et.seq.
[41] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400

- 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.[42] 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.[43]

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.[44] 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

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

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

- 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.[45] 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.[46] Furthermore, any changes to the requirements must be posted 60 days in advance of the change's enactment.[47] 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[48] 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).

[45] Wyo. Stat. Ann. § 26-55-101 through -106
[46] Wyo. Stat. Ann. § 26-55-103
[47] Wyo. Stat. Ann. § 26-55-103
[48] 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[49] 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.

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

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[50] 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 to simplify prior authorization, with a focus on "connecting patients more quickly to the care they need while minimizing administrative burdens on providers."[51] The pledge is the outcome of a survey of AHIP's members[52] and applies to insurance markets including Commercial coverage, Medicare Advantage, and Medicaid managed care. 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.

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

- **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.

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.

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

Draft: 12/12/25

Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Hollywood, Florida
December 10, 2025

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Hollywood, FL, Dec. 10, 2025. The following Working Group members participated: Jane Beyer, Chair (WA); Chrystal Bartuska, Vice Chair (ND); Crystal Phelps (AR); Gio Espinosa and Leanette Henagan (AZ); Kayte Fisher (CA); Lila Cummings and Debra Judy (CO); Kurt Swan (CT); Pratima Lele (DC); Elizabeth Nunes and Simone Edmonson (GA); Josh Carlson (KS); Mary Kwei (MD); Robert Croom (NC); Michelle Heaton (NH); Viara Ianakieva and Jessica Sanchez (NM); Sara Donlon (OH); Ashley Scott (OK); Matthew Tarpley (TX); Ryan Jubber (UT); Julie Blauvelt (VA); Darcy Paskey (WI); Joylynn Fix (WV); and Tana Howard (WY). Also participating were: Michael Muldoon, Maggie Reinert, and Martin Swanson (NE).

1. Heard Presentations on the Development and Use of Reporting Templates by States

Beyer reviewed the Working Group's activity during the year. She stated that its session at the Spring National Meeting featured presentations by the U.S. Department of Labor (DOL) on its report to Congress and by experts on state laws that define clinical standards insurers may use in making medical necessity and other determinations. She said regulator-to-regulator sessions during the year focused on federal decision-making and on sharing reporting templates and other resources among states. She said the Working Group had not worked to develop any new reporting templates.

Henagan presented on Arizona's work to enforce mental health parity standards. She said Arizona passed legislation in 2020 to grant enforcement authority to the department of insurance (DOI) as well as create a mental health parity advisory committee. She said the committee includes families, providers, advocacy groups, and insurers, but it has no regulatory authority itself.

Henagan said Arizona finalized rules in 2022 after revisions to reduce industry burden. She said Arizona developed its reporting template by merging models from Texas and Oklahoma. She said the rules require reporting every three years, and the state allowed flexibility for insurers in the first reporting cycle. She stated that reporting for the first cycle occurred in March 2023, with 12 insurers submitting data. The reviews conducted by the state were collaborative, involving formal letters, meetings, and entrance and exit interviews. Common issues the state identified included combining multiple non-quantitative treatment limitations (NQTLs) in one analysis, a lack of clarity in definitions, and insufficient detail in analyses. However, no major violations were found; the state provided recommendations for improvement to insurers.

Henagan said Arizona plans to adopt a self-assessment tool inspired by New Mexico, update templates for deeper analysis, and potentially require standardized templates. She said the next reporting deadline is in March 2026. She said updates to the state's rules are on hold pending federal decisions on the 2024 parity rule.

Ianakieva and Sanchez presented on New Mexico's parity enforcement processes. Ianakieva said New Mexico's efforts were originally built on federal grant funding and contractor support, later strengthened by updated state legislation in 2023. The legislation expanded state authority and codified requirements for mental health and substance use disorder (MH/SUD) coverage. The law requires out-of-network access at in-network rates, parity in

provider payments based on regional rates, no prior authorization or step therapy for certain treatments, and use of generally accepted standards of care for medical necessity decisions.

Sanchez outlined the state's compliance framework, which includes provider network and reimbursement review, claims and utilization management compliance, and claims file audits. Sanchez said the state collects data in three ways: self-attestation tools, NQTL comparative analysis templates, and raw data collection (including de-identified claims data) for cross-verification.

Sanchez said key outcomes included: 1) 131 objection letters addressing 537 compliance issues; 2) nine voluntary corrective actions, including claim reprocessing and reimbursement rate increases; and 3) education through frequently asked questions (FAQ) and outreach events. She said future plans include progressive enforcement and rulemaking to clarify statutory interpretations.

2. Heard a Presentation from Groom Law Group on Health Plan Perspectives on Parity Reporting Templates

Lisa Campbell (Groom Law Group) shared health insurers' perspectives on state parity reporting templates. She said state templates and clear instructions are helpful, but excessive variation across states creates an administrative burden and confusion. She said the burden can be excessive when detailed reporting is required for individual items, services, or drugs. She said small datasets and differing assumptions complicate comparisons when states are reviewing data. She said state templates can be inconsistent with federal law.

Campbell stated that uniformity and alignment with federal standards are critical for efficiency and compliance. Campbell recommended stakeholder engagement during template development to improve clarity and reduce follow-up questions. She said building templates using federal guidance, especially federal DOL self-compliance tools, would support consistency.

Campbell said health plans have invested significant resources in parity compliance. She said variation in reporting templates across states increases costs without necessarily improving access. She encouraged state insurance regulators to move beyond documentation to achieve real-world improvements in access and provider participation.

Fisher commented that insurers in California have challenged the state's authority to enforce the MHPAEA. Reinert asked for an example of a state that collects data effectively. Campbell said that different states do well in different areas, but uniformity across states is also valuable.

Beyer asked how states can best collect the data to support analysis that results in actual changes in access to behavioral health care. Campbell said there is still work to be done, but plans have been made to enhance their networks. She said plans would like to share their thoughts as states develop reporting tools to help clarify which data points are helpful to states. Currently, the amount of data collected makes it hard for plans to know which are most relevant.

Having no further business, the MHPAEA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues related to federal legislation or regulation) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

Draft: 12/14/25

Prescription Drug Coverage (B) Working Group
Hollywood, Florida
December 9, 2025

The Prescription Drug Coverage (B) Working Group of the Regulatory Framework (B) Task Force met in Hollywood, FL, Dec. 9, 2025. The following Working Group members participated: Joylynn Fix, Chair (WV); Ashley Scott, Vice Chair (OK); Sarah S. Bailey, Kayla Erickson, and Molly Nollette (AK); Jimmy Gunn and Anthony Williams (AL); Tolanda McNeal and Gio Espinosa (AZ); Lena Bahar and Tricia Dave (CT); Howard Liebers (DC); Sheryl Parker (FL); Andria Seip (IA); Shannon Hohl (ID); Chris Heisler and Ryan Gillespie (IL); Craig Van Aalst (KS); Shaun Orme and Daniel McIlwain (KY); Frank Opelka (LA); Joe Stoddard (MI); Norman Barrett and T.J. Patton (MN); Amy Hoyt (MO); David Dachs (MT); Robert Croom (NC); Cheryl Wolff and Maggie Reinert (NE); Ralph Boeckman and Erin Porter (NJ); Alejandro Amparan (NM); Sylvia Lawson (NY); Lindsi Swartz (PA); Maria Morcelo (PR); Jud Jones (TN); Shelley Wiseman and Ryan Jubber (UT); Jane Beyer (WA); Lori Luder and Coral Manning (WI); and Lauren White (WY). Also participating were: Kevin P. Beagan (MA); Marti Hooper (ME); Tony Bonofiglio (OH); and Jill Kruger (SD).

1. Adopted its Summer National Meeting Minutes

Hohl made a motion, seconded by Beyer, to adopt the Working Group's Aug. 11 minutes *(see NAIC Proceedings – Summer 2025, Regulatory Framework (B) Task Force, Attachment Two)*. The motion passed unanimously.

2. Heard a Presentation from The INS Companies on Prescription Drug Formularies and Specialty Medications

Matthew Sankey (The INS Companies) discussed prescription drug formularies and specialty medications. He discussed how formularies are developed and designed, including how pharmacy and therapeutics (P&T) committees are set up and formulary considerations related to rebate optimization. Sankey highlighted the considerations in designing the formulary related to formulary tiering as well as prior authorization and step therapy requirements. He also discussed how specialty medications are treated under prescription drug formularies, including accessibility, costs, rebates, and reimbursement. Sankey discussed how consumers may be impacted by the types of medications health plans choose to include in their formulary and formulary design, and the lack of transparency. He highlighted how the increase in some medication exclusions raises concerns about patient access. He also discussed state oversight over formulary design and specialty medications. Sankey concluded his presentation with a few key points: 1) formularies are becoming more complex with increased numbers of tiers; 2) patients are required to try and fail therapy or pay higher costs to remain on treatment; and 3) specialty medications may not always be "specialty."

Beagan said that while he agrees that consumers' accessibility to the prescription drugs they need is an issue, he believes Massachusetts's biggest problem is the cost. He stated that, in looking at recent rate filings in Massachusetts, the trends for pharmaceutical benefits include cost increases of 14% and 18%. He said Massachusetts is also trying to find ways to improve transparency, particularly by making sure better information is available to all.

Beagan asked Sankey to provide additional information about why certain drugs are excluded from formularies. Sankey said one issue is the proliferation of pharmaceutical drug advertisements, which lead consumers to request certain drugs that might not be appropriate for them. However, he noted that that is a side issue. Sankey said that, as specifically related to his presentation on the reason certain drugs are excluded, he believes this

might occur because pharmacy benefit managers (PBMs) are incentivized to promote brand-name drugs over generic drugs due to rebates and other incentives, which likely results in higher costs for consumers.

Beagan said he believes there is a lack of understanding and clear definition of what a generic drug is versus a brand-name drug. He said there is also a lack of clear understanding of the terms "biosimilar" and "biologics." He said this issue arose recently in Massachusetts regarding insulin. Beagan asked Sankey to discuss this issue and whether there was some sort of commonality between the terms. Sankey explained the progression of a brand-name drug to a generic drug. He said a generic drug that is manufactured exclusively by one drug manufacturer is considered a brand-name drug. A multi-source generic drug, which is manufactured by multiple drug manufacturers, is a true generic drug. Sankey stated that, with respect to biologics and biosimilars, a biologic drug, such as Humira, is considered a brand-name drug. He said a biosimilar can be created from this biologic brand-name drug, but when it is compounded, the molecules are so small and so precise that the biosimilar cannot qualify as a substitutable generic. Sankey explained that the biosimilar is a generic product that, therapeutically, does the same thing as the biologic brand-name drug; however, the way it is constituted does not allow it to be a substitutable generic. Sankey explained the difficulties a consumer could encounter in trying to obtain the biosimilar to Humira as a cheaper alternative.

Amparan asked Sankey about multi-source and single-source generics and the seemingly increasing exclusion of single-source generics from drug formularies. Sankey discussed the incentives for preferring brand-name drugs on the formulary, and the potential impact of certain contract language and patents drug manufacturers use in manufacturing single-source generics, which leads to the exclusion, at least temporarily, of single-source generics from the drug formulary.

Carl Schmidt (HIV+Hepatitis Policy Institute) expressed appreciation for Sankey's presentation. He said the issues discussed in the presentation, particularly those related to formulary design, are extremely important for consumers. He asked that the Working Group consider holding another meeting in the near future to allow for additional discussion of these issues from a consumer perspective. Fix agreed to consider holding such a meeting in early 2026.

3. Discussed a Future Meeting on Prescription Drug Discount Cards

Fix said the Working Group would like to hold a meeting to hear an educational presentation on drug discount cards, including how they are set up, the main process of how they are adjudicated, how pharmacies get paid, and how the discount company gets paid. She asked that anyone with suggestions for a presenter on the topic reach out to her or Scott.

Having no further business, the Prescription Drug Coverage (B) Working Group adjourned.

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