Revised date: 12/1/25

2025 Fall National Meeting
Hollywood, Florida

REGULATORY FRAMEWORK (B) TASK FORCE
Wednesday, December 10, 2025
12:00 – 1:00 p.m.
Diplomat Convention Center—Grand Ballroom West—Level 2

ROLL CALL

NAIC Member	Representative	State/Territory
Grace Arnold, Chair	Grace Arnold, Chair	Minnesota
Allan L. McVey, Vice Chair	Joylynn Fix, Vice Chair	West Virginia
Mark Fowler	Yada Horace	Alabama
Heather Carpenter	Sarah Bailey	Alaska
Peter M. Fuimaono	Peter M. Fuimaono	American Samoa
Maria Ailor	Fausto Burruel	Arizona
Michael Conway	Lila Cummings/Debra Judy	Colorado
Jared Kosky	Jared Kosky	Connecticut
Karima M. Woods	Howard Liebers	District of Columbia
Michael Yaworsky	Alexis Bakofsky/Mike Milnes	Florida
Dean L. Cameron	Weston Trexler	Idaho
Holly W. Lambert	Holly W. Lambert	Indiana
Doug Ommen	Andria Seip	Iowa
Vicki Schmidt	Craig Van Aalst	Kansas
Sharon P. Clark	Shaun Orme	Kentucky
Robert L. Carey	Robert Wake	Maine
Michael T. Caljouw	Michael T. Caljouw	Massachusetts
Angela L. Nelson	Angela L. Nelson	Missouri
Remedio C. Mafnas	Remedio C. Mafnas	N. Mariana Islands
Eric Dunning	Martin Swanson	Nebraska
Ned Gaines	Ned Gaines	Nevada
D. J. Bettencourt	Michelle Heaton	New Hampshire
Justin Zimmerman	Justin Zimmerman	New Jersey
Mike Causey	Robert Croom	North Carolina
Jon Godfread	Chrystal Bartuska	North Dakota
Judith L. French	Laura Miller	Ohio
Glen Mulready	Glen Mulready	Oklahoma
TK Keen	Jesse O'Brien	Oregon
Michael Humphreys	Michael Humphreys	Pennsylvania
Larry D. Deiter	Jill Kruger	South Dakota
Cassie Brown	Rachel Bowden	Texas

Jon Pike	Tanji J. Northrup	Utah
Scott A. White	Julie Blauvelt	Virginia
Patty Kuderer	Jane Beyer	Washington
Nathan Houdek	Coral Manning	Wisconsin

NAIC Support Staff: Jolie H. Matthews/Jennifer Cook

AGENDA

1. Consider Adoption of its Oct. 20, Sept. 22, and Summer National Meeting Minutes—*Commissioner Grace Arnold (MN)* — Attachment One, Attachment Two

2. Consider Adoption of the Reports of its Working Groups —*Commissioner Grace Arnold (MN)*
   A. Employee Retirement Income Security Act (ERISA) (B) Working Group—*Robert Wake (WA)*
   B. Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group—*Jane Beyer (WA)*
   C. Prescription Drug Coverage (B) Working Group—*Joylynn Fix (WV)*

3. Consider Adoption of the Prior Authorization (PA) White Paper —*Commissioner Grace Arnold (MN)*

4. Hear a Presentation from the National Committee for Quality Assurance (NCQA) on Updates to its 2026 Utilization Management (UM) Standards—*Alan Immelman (NCQA) and Kristine Toppe (NCQA)*

5. Receive a Status Report on the ERISA (B) Working Group's Work to Develop Guidance on Pharmacy Benefit Manager (PBM) ERISA Issues and Develop Guidance on Level-Funded Plans and Other Alternative Arrangements as Related to the Small Group Market—*Robert Wake (ME)*

6. Discuss Any Other Matters Brought Before the Task Force —*Commissioner Grace Arnold (MN)*

7. Adjournment

Agenda Item #1

Consider Adoption of its Oct. 20, Sept. 22, and Summer National Meeting Minutes
—Commissioner Grace Arnold (MN)

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.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2025 Fall Meeting/RFTF 10-20-25 MtgMin.docx

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.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2025 Fall Meeting/RFTF 9-22-25 MtgMin.docx

Draft Pending Adoption

Draft: 8/19/25

Regulatory Framework (B) Task Force
Minneapolis, Minnesota
August 12, 2025

The Regulatory Framework (B) Task Force met in Minneapolis, MN, Aug. 12, 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 Jane Callanan (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 and Weston Trexler (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 Beagan (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 and Michael Muldoon (NE); Justin Zimmerman (NJ); Ned Gaines (NV); Judith L. French represented by Laura Miller and Tony Bonofiglio (OH); Glen Mulready (OK); T.K. Keen (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Latif Almanzan (TX); Jon Pike represented by Shelley Wiseman (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Jane Beyer (WA); and Nathan Houdek represented by Coral Manning (WI). Also participating was: Marie Grant (MD).

1. Adopted its Spring National Meeting Minutes

Kruger made a motion, seconded by Swanson, to adopt the Task Force's March 25 minutes (*see NAIC Proceedings – Spring 2025, Regulatory Framework (B) Task Force*). The motion passed unanimously.

2. Adopted the Reports of its Working Groups

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

3. Heard Opening Remarks

Commissioner Arnold said that during today's meeting, the Task Force will hear from AHIP and the BlueCross BlueShield Association (BCBSA) on new commitments by some of their member companies to streamline and simplify the prior authorization (PA) process. She explained that there would not be a lot of time for questions on this new initiative. As such, she anticipates limiting questions on it to Task Force members and interested state insurance regulators. Commissioner Arnold said the Task Force's agenda also includes an update on the work being done to develop a white paper on PA frameworks. She said that although PA is not going to be the subject of the bulk of the Task Force's agenda for its meeting today, she anticipates the Task Force discussing PA more over the next few months as it continues its work on the white paper.

4. Heard an Update from the BCBSA and AHIP on Health Plans' Commitment to Streamlining and Simplifying PA

Monica Auciello (BCBSA) provided a high-level overview of AHIP's and the BCBSA's PA industry initiative to streamline and simply the PA process. She said AHIP and the BCBSA sent a joint letter to the NAIC in July outlining

the commitments of about 60 health insurance plans across the country to join this initiative. She said these commitments were developed jointly by AHIP and the BCBSA at the direction of their chief executive officers (CEOs) who recognized and were aligned on the need to improve and drive meaningful change in the PA process to build a better system of health and better experience for members and providers.

Auciello said that, as payers, their mission is to ensure they provide coverage for care that is safe, effective, and evidence-based while ensuring health care resources are used wisely. She said that while PA is a critical tool in that process, both AHIP and the BCBSA recognize that the process is not perfect. She acknowledged that state insurance regulators and other state policymakers have been receiving calls and hearing complaints from members and providers expressing frustrations with the PA process, which reinforces the need for change.

Auciello said the PA industry initiative focuses on three key areas: 1) reducing the scope of claims subject to PA; 2) expanding real-time responses; and 3) enhancing communication and transparency on determinations. She said these commitments build on actions that individual plans have already begun. Auciello said the BCBSA appreciates the Task Force's work on the PA white paper. She said the BCBSA is also committed to working with the Task Force to identify additional opportunities to collaborate on the work already underway in many states to improve the PA process.

Jeanette Thornton (AHIP) said that as Auciello noted, the PA industry initiative stems from the recognition that people are frustrated with the PA process. She said that to address this, AHIP and the BCBSA began joint discussions with their leadership and worked through what can be done today to make the PA process work better for both patients and providers. She said the commitments being made to improve the PA process align around those goals. Thornton acknowledged the work that a number of states have already done to improve the PA process. She said many of the commitments reflect this work and build on it. She also said AHIP and the BCBSA recognize that they will need to work with providers as well as the states as they work to implement the initiative. Thornton discussed AHIP's and the BCBSA's outreach to provider, consumer, and employer stakeholders as they were developing these commitments.

Thornton said AHIP and the BCBSA are committed to measuring the progress of those plans that have committed to participating in the PA industry initiative and plan to hold them accountable with public reporting on their progress. She said AHIP and the BCBSA look forward to detailed briefings and discussions with the states and the NAIC on this progress. She discussed the commitments that participating plans have made by Jan. 1, 2026, concerning transparency in PA determinations. Those include: 1) explaining with clear and personalized language about any prior authorization denials, including information about next steps and available appeals processes; 2) providing staff to help plan members understand the PA process and their options after a PA determination is made; and 3) greater standardization of the data processes and questions supporting PA determinations.

Beyer asked if AHIP and the BCBSA intentionally have not included prescription drugs in their PA industry initiative because the federal Transparency in Coverage (TIC) rule does not include prescription drugs. Thorton acknowledged that PA industry initiative does not address every issue with PA. She said the vast majority of the PA requests do not involve prescription drugs. She said, however, the commitments regarding continuity of care do apply to prescription drugs. Thorton said she anticipates additional federal rules will include prescription drugs and that AHIP and the BCBSA will be actively involved in that process.

Commissioner Arnold asked Auciello and Thornton to expand on, if possible, the benchmarks and data that AHIP and the BCBSA plan to use to evaluate and monitor progress on the commitments being made as part of the PA industry initiative. Thornton said AHIP and the BCBSA plan to collect information from the participating plans and publicly report that information. She said that as far as benchmarks are concerned, AHIP and the BCBSA will be reporting plan progress for all the commitments, some of which will take effect in 2026 and others in 2027. In measuring that progress, AHIP and the BCBSA will be looking at where PA was reduced, how continuity of care

was supported, and what actions plans took to streamline and simplify their notices. Commissioner Arnold asked if AHIP and the BCBSA plan to survey patients and providers as another way of measuring progress. Thornton said they will commit to conducting such surveys.

AHIP and BCBSA were asked if they have specific plans to discuss the PA industry initiative with state insurance regulators and discuss how the commitments under that initiative could affect consumers in that state. Auciello said AHIP and the BCBSA have encouraged all their plan members participating in the initiative to have direct conversations with state insurance regulators on the actions they plan to take in their states both to align with the state's regulatory requirements and to ensure that state insurance regulators can also measure progress in streamlining and simplifying the PA process in their state.

Hohl asked if Thornton could elaborate on the timeline for plans participating in the PA industry initiative to complete certain commitments. Thornton said commitments to be completed by Jan. 1, 2026, are commitments to: 1) reduce the volume of in-network medical PAs and measure that reduction plans will provide data for public reporting of the extent of such reductions reflecting actions taken since January 2024; and 2) support continuity of care by honoring a previous plan's PA for the same service, under the same type of benefit in network for a 90-day transition period when a member changes plans after starting a course of treatment. She said the other set of comments applying on Jan. 1, 2027, concern standardization and faster decision time. She said the Jan. 1, 2027, date for these commitments is because AHIP and the BCBSA are dovetailing on what is required under the federal TIC rule.

Beagan asked if, as part of this industry PA initiative, AHIP and the BCBSA are looking to develop other guidelines related to utilization review, such as retrospective review and concurrent review. Thornton said they started with PA, but they could possibly extend it to those other areas. She said standardization will be particularly relevant if they move in that direction in the future. Trexler said standardization seems to be critical to many of the PA industry initiative commitments to streamlining and simplifying the PA process. He asked how state insurance regulators can assist AHIP and the BCBSA to have this commitment to more standardization be implemented in a timely manner. Thornton described the elements needed for the standardization piece to move forward. She said providers are a critical component. Thornton said AHIP and the BCBSA would be happy to talk more about standardization during a future Task Force meeting.

Carl Schmid (HIV+Hepatitis Policy Institute), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives appreciate the Task Force's and, as reflected in the AHIP and BCBSA PA industry initiative, the plans' attention to PA. He said despite the plan commitments being made, it is voluntary. He said there still needs to be state and federal laws in place to ensure these commitments become a reality. Schmid pointed out that many of these commitments are required by federal law, including the time frames for implementation for many of them. He also noted that for the commitment to reduce the number of claims requiring PA, there is no clear goal or percentage required to show such reductions. Schmid said there also remains the need to address prescription drugs. He said the NAIC consumer representatives look forward to continuing to work with the Task Force and AHIP and the BCBSA on PA.

5. Heard a Discussion on the Federal Deregulation Initiative

Katie Keith (Center for Health Policy and the Law at the O'Neill Institute, Georgetown Law) provided background on the Trump Administration's federal deregulation initiative. She said the Trump Administration has issued at least nine deregulatory directives in the first six months. These include directives requiring that 10 rules be cut for every new rule, allowing federal agencies to repeal regulations without public notice, and eliminating disparate impact liability for civil rights protections.

Keith said there has been less deregulatory action at the U.S. Department of Health and Human Services (HHS) to date. She said, however, that this most likely will not continue given the HHS' Request for Information (RFI): "Ensuring Lawful Regulation and Unleashing Innovation to Make America Healthy Again" issued in May.

Keith highlighted the HHS' deregulation activity to date, which includes: 1) revocation of guidance under the federal Emergency Medical Treatment and Active Labor Act (EMTALA); 2) revocation of Medicaid and the Children's Health Insurance Program (CHIP) guidance on health-related social needs and Section 1115 waivers; and 3) nonenforcement of the short-term, limited-duration (STLD) plan rule. She also discussed health care deregulatory action at other federal agencies, including the federal Consumer Financial Protection Bureau's (CFPB's) revocation of the federal No Surprises Act (NSA) reporting requirements and deceptive medical debt collection practices.

Keith said that in addition to the deregulatory actions she discussed that the HHS has taken to date, in February 2025, HHS Secretary Robert Kennedy, Jr. rescinded the Richardson waiver. She said that in rescinding that waiver, the Secretary said the prior policy was contrary to the text of the federal Administrative Procedure Act (APA) and imposed extra-statutory obligations on the HHS. She explained that the federal APA exempts certain agency actions from notice and comment procedures: 1) agency management, personnel, public property, loans, grants, benefits, or contracts; or 2) for "good cause" if notice and comment is "impracticable, unnecessary, or contrary to the public interest." The Richardson waiver required HHS to use notice and comment for these categories of agency action and to use the "good cause" exception "sparingly." She said that the February 2025 notice rescinding the Richardson waiver allows use of the "good cause" exception "in appropriate circumstances." Keith said despite rescinding the Richardson waiver, to date, HHS has continued to use notice and comment procedures for many of its health care rules.

Keith discussed implications for consumers and stakeholders regarding the Trump Administration's federal deregulation initiative. She said broad deregulation could disrupt the complex, highly regulated health system that consumers and patients rely on because of abrupt changes to consumer protection laws and other federal programs. She said notice and public comment are critical for transparency and allow those most affected to explain how proposed changes would support or limit access to care or impose new burdens on providers, insurers, state officials, and other stakeholders. Keith said deregulatory changes will contribute to confusion at the same time as federal agencies experience staffing reductions, reorganizations, and funding freezes.

Keith highlighted certain issues and considerations for state insurance regulators as the Trump Administration moves forward with its deregulation initiative. She said those include whether HHS will move forward more aggressively in the fall with deregulatory action and, if so, whether HHS will try to invoke the Richardson waiver or use the notice and comment processes. She said another issue to watch is how much litigation there will be and how it will change how the courts interpret the federal APA and its requirements.

Brian Blase (Paragon Health Institute) discussed some of the major items of insurance regulation that will affect the states this year and next year. He said the first is the STLD plan regulation. He explained that the federal agencies on Aug. 7 announced suspension of enforcement of the Biden Administration's STLD plan rule. Blase said the federal agencies should restore the policy adopted by the Trump Administration in 2018. He said there is no evidence that permitting STLD plans harmed the ACA market. He said that, in fact, the ACA market was strengthened in those states that fully permitted the sale of STLD plans under the 2018 rule. Blase discussed research supporting his assertion.

Blase next discussed farm bureau health benefit plans. He explained how they are regulated, noting that more than a dozen states exempt farm bureau health benefit plans from the definition of "insurance." He highlighted and detailed the average monthly premium costs as compared to certain ACA plans for such plans offered in Kansas, Missouri, and Nebraska.

Blase next discussed association health plans (AHPs). He said that in 2018, the U.S. Department of Labor (DOL) adopted a rule creating another pathway for small businesses to join together regardless of the type of business. He said the rule was struck down in 2019, and later the Biden Administration reversed it. Blase said that one action the Trump Administration could take is to initiate rulemaking addressing the court's concerns.

Blase next discussed individual coverage health reimbursement arrangement (ICHRAs). He said the Trump Administration adopted this rule in 2019 to provide another way for employers to offer health insurance. He explained that the rule allows employers to provide a tax-preferred contribution to employees to use toward purchasing an ACA-compliant individual market plan. He said there is a large set of rules for how employers can structure ICHRAs.

Blase discussed issues with enhanced ACA premium subsidies. He said that based on Paragon's research, those issues included billions in improper federal spending and potential enrollment fraud with more than one in three individual market enrollees using $0 of medical care in 2024, a huge increase from 2020. Blase said extending the enhanced subsidies would cost around $40 billion per year, including interest costs on additional deficits. He said Paragon suggests that Congress allow the enhanced subsidies to expire or fundamentally revise the provision.

Burruel asked Blase about the statistics on the individual market enrollment based on STLD plans based on favorable or unfavorable states. He said he would like more background on the statistics because he would assume that if a state is unfavorable towards STLD plans, there would be an increase in enrollment as compared to the favorable states. Blase said there is a paper he authored in 2023 posted on Paragon's website that describes his methodology. He said that using data from the Commonwealth Fund, Paragon splits states into favorable states and unfavorable states. Favorable states were those states that fully permitted STLD plans consistent with the Trump Administration's 2018 rule. Blase said that about half the states fell into that category, and about half the states fell into the other unfavorable category. He said that to get the numbers, Paragon obtained exchange enrollment in 2018 and 2023 in both of those categories of states. Paragon also obtained data on insurer participation and premium costs. He said Paragon was also surprised by the results, which ran against the narrative that expanding STLD plans would harm the individual market, reduce insurer participation, and increase premiums.

Commissioner Zimmerman said this has not been New Jersey's experience. He said New Jersey restricted STLD plans, which resulted in an increase in insurer participation. He acknowledged that it is just one state's experience, but he suggested that Blase provide the information supporting his findings. Blase agreed to submit the information to the Task Force.

Lucy Culp (The Leukemia & Lymphoma Society—LLS), speaking on behalf of the NAIC consumer representatives, said the NAIC consumer representatives have concerns about the Trump Administration's deregulation initiative. She said the NAIC consumer representatives are particularly concerned about the initiative as it relates to plans that are less generous to consumers than those on the ACA exchanges, such as Farm Bureau health benefit plans and STLD plans. She said the NAIC consumer representatives appreciate the discussions today on this issue and look forward to participating in additional discussions on the issue in the future.

6. Heard an Update on Work to Develop a PA Framework White Paper

Commissioner Arnold provided a quick update on the Task Force's work to develop a PA framework white paper. She said that at the beginning of July, the Task Force's small drafting group completed its work to develop an initial white paper draft. She said that on July 18, NAIC staff distributed the draft for a public comment period ending Aug. 29. Commissioner Arnold said that after the public comment period ends, she anticipates the Task Force holding at least one meeting to discuss the comments received and discuss whether it wants to incorporate any

of the suggested revisions. She said she believes the Task Force remains on track to adopt the white paper by the end of the year.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2025 Summer Meeting/RFTF 8-12-25 MtgMin.docx

Agenda Item #2

Consider Adoption of its Working Group Reports—*Commissioner Grace Arnold (MN)*

- *Employee Retirement Income Security Act (ERISA) (B) Working Group—Robert Wake (ME)*
- *Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group —Jane Beyer (WA)*
- *Prescription Drug Coverage (B) Working Group—Joylynn Fix (WV)*

Agenda Item #3

Consider Adoption of the Prior Authorization (PA) White Paper
—Commissioner Grace Arnold (MN)

Final Draft: 12/4/25

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 covered by the health plan and is appropriate, medically necessary, safe, and cost effective. It is intended to ensure safety (e.g., prevent negative drug interactions), reduce utilization of medically unnecessary or ineffective treatments or services, and contain health care costs. PA is used for a broad range of services, treatments, and medications. By formalizing in advance, in writing, the insurer's commitment to covering a health care service, PA can achieve a favorable balance between costs and benefits for both insurers and their members. It can also provide needed assurance for consumers and providers prior to the provision of services. While PA can benefit insurers, providers, and consumers, the process has been criticized for burdening providers and delaying care for consumers.

How this document can help regulators

In recent years, state legislatures have enacted and updated PA statutes to streamline PA processes to reduce administrative burdens, support improved patient outcomes, and promote greater transparency in the PA process. Most proposed legislation focuses on the method by which PA must be requested (e.g., by phone, fax, or electronic means, such as through an electronic health record (EHR) or an online portal),

timeframes for plan responses, and "provider gold-carding," which is a system in which providers can bypass the PA process given their previous record of consistently providing evidence-based medical care. This white paper is meant to be a source of information and a roadmap of legislative options related to PA.

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

The prior authorization process

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

- ***Submission:*** The health care provider submits a PA request to the insurer, detailing the medication, treatment, or service recommended for the patient.
- ***Review:*** The insurer reviews the request, verifies the patient is currently covered with the insurer, determines if PA applies to the requested medication, treatment, or service, and then evaluates it against its clinical guidelines and policies.
- ***Decision:*** Based on its review, the insurer either approves or partially approves the coverage request or makes an adverse determination by denying the coverage request, often providing an explanation.
- ***Appeals:*** If the request is ~~denied~~not approved, the patient or provider may appeal the adverse determination through the insurer's appeal process and provide additional information to support the necessity of the treatment. Two levels of appeals processes are typically available—internal and external review.

Common treatments and medical services subject to prior authorization

Services and treatments more likely subject to PA are those that are high-risk, high-cost, or subject to clinical variation. Examples include:

- ***High-Cost and Specialty Drugs:*** Medications that are expensive or require careful monitoring, such as biologics or oncology drugs.
- ***Advanced Imaging:*** Services such as magnetic resonance imaging (MRI), computed tomography (CT) scans, or positron emission tomography (PET) scans.
- ***Surgical Procedures:*** Surgeries that are elective or involve the use of experimental techniques.

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

- ***Durable Medical Equipment:*** Items like wheelchairs or hospital beds.
- ***Mental Health and Substance Use Disorder Services:*** More intensive services and some medications for treating these conditions.

Prior authorization issue perspectives

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

The provider perspective

Administrative burden and expense

Prior authorization seemingly imposes substantial administrative burdens, costs, and inefficiencies on providers. According to a recent American Medical Association (AMA) online survey of one thousand (1,000) physicians[2], physicians or their staff spend 13 hours per week requesting PAs. Health care providers must employ and maintain knowledgeable staff who can help monitor the PA process. According to the same AMA survey[3], 40% of participating physicians have staff who work exclusively on PAs. Providers' EHRs do not always integrate with insurer systems, requiring provider staff to manually enter data into these systems or use antiquated technology, such as fax machines, and phones to transmit sensitive information. Furthermore, incorrect or missing patient demographic and insurance information can delay PA or result in unexplained denials.

In some cases, health insurers require PA to be completed at defined intervals during a course of treatment. This may take the form of step therapy, which is the process by which an insurer requires the use of a particular treatment first, and only upon failure will a preferred or prescribed treatment be approved, or requirements for regular authorizations to monitor treatment progress and efficacy. Navigating these PA requirements during ongoing treatment of a patient burdens a provider with additional administrative tasks.

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

Additionally, treating physicians sometimes encounter health plan reviewers who have no experience treating the patient's condition, who are not in the same specialty, or who are not physicians at all. This

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

results in significant and unnecessary time spent attempting to justify a course of treatment to an inexperienced health plan representative and the potential for an inappropriate denial due to reviewer's lack of experience.

Lack of consistency and transparency

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

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

Technology and communication limitations

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

Moreover, some providers report significant delays or denials resulting from an insurer not updating its utilization management processes or communicating changes to processes or codes. Though some insurer portals make it easy to look up required PA information by simply inputting a procedure's current procedural terminology code, other insurers use manual processes that create inefficiencies when a provider is required to contact them. Many provider organizations, particularly smaller or independent practices, face challenges in adopting or maintaining EHR systems that are fully interoperable with insurer platforms. As a result, even where modern digital PA tools are available, provider staff may still need to manually enter information, make phone calls, or document communications via fax to complete the PA process.

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

Clinical variation and alignment with coverage criteria

In addition to determining whether a requested service is recommended according to research-based evidence, insurers also consider whether the service is the most cost-effective way to treat a patient. Clinical standards used by providers focus on delivering efficient and effective care depending on a patient's particular needs but may not always align with plan coverages or account for cost considerations. As a result, there may be times that a provider's preferred treatment differs from what is initially approved

for coverage. Rather than treating a patient with what the health care provider considers to be the most appropriate treatment using their knowledge of clinical standards of care, a health care provider ~~denied~~that receives an adverse determination for a PA request must choose whether to appeal and possibly further delay treatment or prescribe a different therapy that is covered by the patient's insurer.

The consumer perspective

While PA processes are well-meaning for the health care system and ~~designed~~are intended to help control costs and avoid unnecessary utilization of health care services, the consumer experience can be affected by inefficiency, care disruption, and adverse outcomes.

Disruptions in care

According to a KFF survey, approximately six in 10 insured adults are not able to use their insurance without experiencing a problem.[4] Of those insured adults that report having an issue with using their insurance, 16% reported experiencing problems specifically with PA processes.[5] Additionally, a KFF analysis of CMS' 2023 Transparency in Coverage data demonstrated that lack of prior authorization or appropriate referral accounted for 9% – more than six million - of in-network claim denials. Separately, a self-reporting physician survey conducted by the AMA in ~~2023~~2024, found that ~~94%~~93% of ~~the patients of participant~~participating physicians reported that PA leads to patients experiencing delays in care that they would not have otherwise experienced.[6] Moreover, ~~78%~~82% of the physicians in the same survey reported that PA processes can lead patients to abandon treatment.[7]

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

Effect on Costs

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

---

[4] https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/
[5] Id.
[6] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf. ~~https://web.archive.org/web/20240819003745/https://www.ama-assn.org/system/files/prior-authorization-survey.pdf~~
[7] Id.
[8] For example: https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/8-18-23_BCBSA-Prior-Authorization-Impact.pdf.

For those consumers who do seek care in an emergency room setting, they will incur significant out-of-pocket costs that may otherwise be avoided by seeking care in non-emergency room settings.[9] For example, one study found that an insured spends $646 out-of-pocket on average for an emergency room visit.[10]

Adverse and inequitable outcomes

Within the overall insured population, certain groups of people experience a disproportionate share of PA problems. For example, 31% of adults who use more health care services (defined as having more than 10 doctor visits a year) experience difficulties navigating PA processes.[11] About a quarter (26%) of individuals with mental health conditions who sought treatment or a prescription experienced problems or delays as a result of their difficulties navigating PA processes.[12] Seeking medical care can be stressful, complicated, and expensive, and adding the burden of PA processes can be harmful. Among individuals who reported problems with PA processes, they were twice as likely (than individuals who did not report experiencing issues with PA processes) to report that their health declined as a result (26% v. 11%, respectively).[13]

The appeals process

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

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

The following statistics are not specific to coverage denials related to prior authorization, but they illustrate the relatively low number of appeals in relation to denied claims. In Pennsylvania, for example, of the 2,135,041 claims denied by qualified health plans (QHPs) in the state's individual health insurance market, just 3,156 internal appeals were filed. Of those internal appeals, nearly half (48%) were overturned in favor of providing coverage for the requested service.[15] The pattern is repeated at the national level. QHPs offering individual health insurance coverage through the Federally Facilitated Exchange (FFE) in 2022 denied 69,315,868 claims. While the total number of denied claims does not account for claims that were, for example, ultimately paid before an appeal was filed, the numbers still demonstrate that a very small

---

[9] https://www.healthsystemtracker.org/brief/emergency-department-visits-exceed-affordability-thresholds-for-many-consumers-with-private-insurance/#Total%20and%20Out-Of-Pocket%20Costs%20for%20Emergency%20Department%20Visits,%202019

[10] Id.

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

[12] Id.

[13] Id.

[14] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf

[15] https://www.pa.gov/content/dam/copapwp-pagov/en/insurance/documents/posted-filings-reports-orders/posted-reports/aca-plan-transparency-reports/transparency-coverage-report-aca-health-plans-2024.pdf

percentage of denials are appealed, and 42% of the appeals filed were overturned.[16] Increased transparency and streamlined functionality of the appeals process will help ensure fair and comprehensive claim adjudication.

The insurer perspective

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

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

Patient Safety

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

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

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

It is difficult to determine how frequently these forms of consumer harm are prevented by PA, but there is no reason to doubt that such harms are a legitimate concern.

---

[16] Id.

[17] Examples: https://www.propublica.org/article/anthony-olson-thomas-weiner-montana-st-peters-hospital-leukemia; https://www.thelundreport.org/content/tenth-lawsuit-claims-oregon-labs-testing-caused-women-harm-unneeded-chemotherapy

[18] Ganguli I, Simpkin AL, Lupo C, et al. Cascades of care after incidental findings in a US national survey of physicians. JAMA Netw Open. 2019;2(10):e1913325. doi:10.1001/jamanetworkopen.2019.13325

[19] Rosenkrantz AB, Sadigh G, Carlos RC, Silva E 3rd, Duszak R Jr. Out-of-Pocket Costs for Advanced Imaging Across the US Private Insurance Marketplace. J Am Coll Radiol. 2018 Apr;15(4):607-614.e1. doi: 10.1016/j.jacr.2017.12.010. Epub 2018 Feb 22. PMID: 29477290.

[20] Duff, J., Cullen, L., Hanrahan, K. et al. Determinants of an evidence-based practice environment: an interpretive description. Implement Sci Commun 1, 85 (2020). https://implementationsciencecomms.biomedcentral.com/articles/10.1186/s43058-020-00070-0

Cost containment

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

On behalf of the Blue Cross Blue Shield Association (BCBSA), the actuarial firm Milliman conducted an analysis of claims data to determine the impact to commercial premiums nationally if prior authorization was eliminated across all medical and pharmacy services.[22] The study determined that eliminating PA for all services would result in a premium increase of almost $30 PMPM; even eliminating PA for a narrow scope of services would lead to a premium increase of over $20 PMPM. Across the entire commercial market, Milliman calculates that premium increases could total between $43B and $63B annually. Milliman also notes cost-sharing would increase with the elimination of PA.

The same Milliman study found that PA encourages performance improvement, because providers in a program know they are being evaluated against ~~evidence based~~evidence-based clinical criteria. In an independent study, Milliman estimated that eliminating this effect by restricting the use of PA may result in premium increases of 5.6% - 16.7% for plans in Massachusetts.[23]

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

When South Carolina's Medicaid program eliminated PA for rehabilitative behavioral health services in 2014, costs for those services reportedly jumped from $300,000 to $2 million per week, leading to a $54 million budget shortfall and an eventual reinstatement of PA requirements.[24] Similarly, researchers have found that in Medicare Part D, PA restrictions reduced spending on drugs by $96 per beneficiary-year (3.6% of drug spending), while only generating about $10 in paperwork costs.[25]

The Centers for Medicare & Medicaid Services (CMS) recently announced an Innovation Center model, the Wasteful and Inappropriate Service Reduction (WISeR) Model, for patients and providers in Original Medicare.[26] The model will test technology-enabled PA and pre-payment review to expedite and improve the review process for a pre-selected set of services that are vulnerable to fraud, waste and abuse. CMS

---

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

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

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

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

[25] Zarek C. Brot-Goldberg, Samantha Burn, Timothy Layton & Boris Vabson, "Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare," January 2023. Available at https://www.nber.org/papers/w30878

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

describes the goals as helping patients avoid unnecessary or inappropriate care, lowering costs and easing administrative burden on providers.

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

For context, however, it is important to note that an industry survey reported that insurers across all lines of business do not base their PA programs on cost alone[27].

Friction with providers and members

For insurers, the benefits of PA must be weighed against the administrative costs and burdens of administering a PA program and the friction and conflict that can arise with health care providers and members. This friction results from issues including administrative burden on providers and members, potential reductions in provider time available for patient care, provider resentment at being second-guessed, patient frustration with delays, and poorer quality outcomes due to delayed or abandoned care. These frictions are explored in detail in other sections of the white paper, but it is important to note that they may generate costs and burdens for insurers as well as other PA stakeholders.

Electronic prior authorization (ePA)

Health insurers have been broadly supportive of moving away from manual and "paper" processes for PA and toward more uniform electronic submission standards. For example, insurers supported federal adoption of the CMS Interoperability and PA final rule in 2024, which is discussed in more detail in the Federal Government section.[28] This rule was followed by a complementary health information technology certification rule published on Aug. 4, 2025. Insurer advocates have typically recommended that state activity in this area should focus on aligning state requirements for insurers with these federal rules, and that states should consider proactively implementing requirements for health care providers to use electronic processes.[29] An initiative by insurers covering more than 50 million Americans found that implementing ePA led to faster time to patient care, faster times to decisions, and improved information for providers.[30] Despite this, an AHIP survey of member plans reports that manually submitted PA requests still account for nearly half of all PA requests.[31]

In June 2025, nearly 60 national and regional health plans, representing 257 million lives, announced a series of new voluntary commitments aimed at simplifying and improving the PA process.[32] Through these commitments, participating health plans support increasing the use of ePA through the development of

---

[27] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf
[28] https://www.ahip.org/news/press-releases/ahip-statement-on-the-cms-interoperability-and-prior-authorization-final-rule
[29] https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states
[30] https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states
[31] https://ahiporg-production.s3.amazonaws.com/documents/AHIP-Commercial-PA-survey-infographic_6.27.25.pdf
[32] https://www.bcbs.com/news-and-insights/article/right-care-right-place-right-time

standardized data and submission requirements that will support faster turn-around times. Participating health plans committed that as of Jan. 1, 2027, 80% of medical ePA ~~requests~~approvals with complete information will be processed in near real-time.

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

Several states are moving forward with implementation of a unified approach across both public and private commercial health insurance markets by extending the federal electronic PA requirements and standards for medical items and services to the private commercial market. Examples include Virginia, Alaska[33], California, Tennessee, Utah, and Washington[34].

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.

Selective use, gold carding, and other streamlining initiatives

Health plans have implemented a number of modifications to streamline the PA process and reduce the burden of PA for certain subsets of providers and patients. Gold carding is one such initiative that involves a process by which a high performing health care provider may qualify for an exemption from an insurer's PA requirements.[35] Other approaches to streamlining the PA process include removing some services and drugs from PA requirements, reducing or waiving PA for patients undergoing active treatment, and reducing or waiving PA requirements for providers in value-based contracts.[36]

Some health insurers have opposed statutory or regulatory mandates in this area, preferring to be permitted the flexibility to explore a range of options to strike a favorable balance between administrative simplification, patient protection and cost containment.

Evidence base

One of the key purposes of PA is to ensure that covered services are evidence-based and effective. In light of concerns from some physicians, advocates and policymakers about the evidence base used in PA,[37] it is important to clarify the current practices and requirements in this area.

Health plans collect and assess medical evidence for the specific populations they serve. PA programs are typically based on guidelines from medical societies like the American College of Cardiology and the

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

American College of Radiology, as well as scientific evidence from recently published, peer-reviewed medical literature. Practicing community physicians and subject matter experts at leading academic institutions may also contribute to the development of clinical guidelines.

Health plans subject to accreditation typically undergo rigorous reviews of insurers' clinical guidelines. In addition, guidelines must also meet state and federal laws and Center for Medicare & Medicaid Services (CMS) requirements where applicable. Many state laws require guidelines to be ~~evidenced~~evidence-based and updated annually. In addition, PA denials are typically subject to appeal and external review requirements that provide the opportunity for an independent check on practices not aligned with clinical evidence.

It is also important to note that questions about the value proposition of particular health care services may not be entirely resolvable by clinical evidence. For example, there may be cases where two therapies offer comparable clinical outcomes but differ significantly in cost or other factors relevant to patient experience, such as comfort, convenience or aesthetic considerations.[38]

Accreditation Standards for PA

The majority of states utilize accreditation entities such as the National Committee on Quality Assurance (NCQA) or URAC to ascertain that insurers are meeting a state's regulatory requirements. These accreditation bodies review an insurer's utilization management program, including prior authorization requirements. Accreditation standards typically address areas such as the clinical criteria used for decisions, regular review and availability of the criteria, practitioner involvement, qualifications of health professionals making PA decisions, and timeframes for decisions, among other areas. Accreditation standards are updated regularly. For example, many of these standards are in the process of being updated to align with the new federal requirements mentioned in this white paper.

Reform examples

States

Gold carding

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

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

Under state-mandated gold carding programs, a health insurer is required to evaluate a health care provider's history of requesting PA for a particular health care service to determine whether the provider

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

qualifies for an exemption from PA for that particular service. The insurer examines ~~medical records~~plan data to determine the number of times the provider's request for a particular service was approved. If the percentage of approved requests meets the threshold rate mandated by the state, the insurer will be required to issue the provider a gold card exemption for that service. State-level gold carding laws are relatively new, and their long-term impacts remain uncertain. While these laws are intended to reduce administrative burden by exempting providers from certain PA requirements, research has shown that they may also increase service utilization and place upward pressure on health care costs.[39] In some cases, the thresholds for exemption are set low, which can pose risks to patient safety. Additionally, some laws limit an insurer's ability to review or revoke a provider's gold card status except on an infrequent basis, such as once every 12 months. This restricted oversight can delay timely intervention when concerns arise. At the same time, some insurers have begun developing their own gold carding initiatives, which may allow for more flexibility, service-specific targeting, and closer monitoring.

A gold card is insurer-specific such that a health care provider may meet the standard for obtaining a gold card from some insurers but not others, except~~ing~~ in instances where a state has mandated broad-based gold-carding requirements. Even if a provider has been granted a gold card for a particular service, if an insurer determines that a service provided by the provider holding a gold card exemption for that service was not medically necessary or otherwise fails to meet plan eligibility standards, the insurer may still decline to cover the service.

Arkansas

Arkansas includes PA for prescription drugs its gold card program requirement. Insurers in Arkansas examine a health care provider's history of all PAs requested for all health care services, which Arkansas defines to include prescription drugs.[40] 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.[41] 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.[42]

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.[43] 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 enacted House Bill 3459, known as the Texas Gold Act[44]. This Act was amended in 2025 with the passage of House Bill 3812.[45] House Bill 3812: 1) extended the length of gold cards from six months to one year; 2) included claims from products not regulated by the Texas Department of Insurance (TDI) in

[39] https://legislature.vermont.gov/assets/Legislative-Reports/Blue-Cross-VT-Provider-Passport-Program-Report-01-15-2023.pdf.
[40] Ark. Code Ann. § 23-99-1103(10)(A).
[41] Ark. Code Ann. § 23-99-1120(a).
[42] Ark. Code Ann. § 23-99-1122(a)(3).
[43] Ark. Code Ann. § 23-99-1128(b).
[44] https://legiscan.com/TX/text/HB3459/2021.
[45] Texas House Bill 3812 https://legiscan.com/TX/text/HB3812/id/3247239

gold card evaluations; and 3) placed restrictions on administrative licenses only for the physician in charge of all utilization management for a health plan and physicians making recissions. The law ~~is effective beginning~~became effective on Sept. 1, 2025.

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

It is important to note that these laws do not apply to patients insured by Medicaid or Children's Health Insurance Program (CHIP). The TDI oversees the implementation of this law.

A provider or physician in Texas qualifies for an exemption once they have: 1) submitted five or more eligible PA requests for the particular health care service in the most recent evaluation period; and 2) at least 90% of the eligible PA requests for a particular service were approved. [46]

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

Under the law, the notice granting exemptions must contain a plain language explanation of the effect of the PA exemption and any claim coding guidance to properly document the exemption. Exemptions must remain in place for at least 12 months before being rescinded.

West Virginia

An updated West Virginia statute lowered the requirements to qualify for a gold card program[47]. This allows a health care provider to earn exemption from PA requirements based on the provider's track record of previous PA approvals and the frequency with which the provider performs the procedure. If a health care provider has performed an average of 30 procedures per year and has received a 90% final prior approval rating in a six-month period, the health insurer may not require a PA for at least the next six-month period, or longer if the insurer allows. The state legislature clarified in 2025 that prescription drugs and related authorizations are exempted from the gold card program.

Wyoming

The Wyoming legislature passed legislation regarding provider exemptions from PA requirements (gold carding).[48] The law will go into effect January 2026. The legislation establishes guidelines for a provider to be exempted from completing PAs for health care services that have been authorized 90% of the time in the preceding 12 months. The provider must have submitted no fewer than five PAs for the procedure during that time. The insurer can review the exemption every twelve months, but they may establish a longer exemption period. In addition, an exemption cannot be revoked before twelve months have passed.

---

[46] 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

[47] https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/IB%2021-08%20Electronic%20PA%20(1).pdf.

[48] Wyo. Stat. Ann. § 26-55-112

Providers are not required to apply for an exemption. The insurer or contacted utilization review entity shall provide a health care provider with: 1) a statement that notifies the health care provider that the provider qualifies for the exemption; 2) a list of services for which the exemption applies; and 3) a statement of the 12-month duration. A health care provider may appeal a health insurer's or contract utilization review entity's decision to deny an exemption.

Addressing continuity concerns

District of Columbia

The District of Columbia[49] requires a PA to be valid for at least one year or for the course of the treatment, including any dosage changes.[50]

Illinois

Illinois also requires health insurers to honor an approved PA for the first 90 days of a health insurance consumer's coverage under a new health insurance policy. Illinois also prohibits concurrent review and post-service utilization review for certain services for which PA has been prohibited, which is important to ensure PA is not shifted to another manner of utilization management or cost-shifting to patients.[51]

New Hampshire

Starting Jan. 1, 2025, under New Hampshire's PA law, an approved PA cannot be revoked, limited, conditioned, or restricted for 60 business days.[52]

New Mexico

In New Mexico, health insurers are prohibited from rescinding or modifying prior authorizations for mental health or substance use disorder services once care has been rendered in good faith based on a medical necessity determination, except in cases of fraud or violations of the provider's contract. NMSA 1978, Section 59A-22B-6. Insurers also may not require prior authorization or referrals for urgent behavioral health services, including acute care, acute episodes of chronic conditions, or initial in-network treatment. NMSA 1978, 59A-22B-7(A). For ongoing or additional services, prior authorization decisions must be made in consultation with the patient's provider. NMSA 1978, 59A-22B-7(B).

Additionally, New Mexico law prohibits prior authorization and step therapy requirements for FDA-approved medications prescribed to treat autoimmune disorders, cancer, substance use disorders, or rare diseases, provided a medical necessity determination is made by a healthcare professional in the same or similar specialty. NMSA 1978, Section 59A-22B-8(A). A "rare disease or condition" is defined as one affecting fewer than 200,000 individuals in the United States. NMSA 1978, Section 59A-22B-2(Q).

[49] https://code.dccouncil.gov/us/dc/council/laws/25-100.
[50] 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.
[51] https://www.ilga.gov/documents/legislation/103/HB/10300HB5395enr.htm
[52] RSA 420-J:6.

Oklahoma

House Bill 3190[53] specifies that PAs are valid for at least 45 days, or for six months in the case of chronic conditions, creating a more predictable and less disruptive process for patients. A health plan cannot revoke, limit, condition, or restrict PA if care is provided within 45 business days from when the health care provider received the PA, unless the enrollee was no longer eligible for care on that day.

Tennessee

Tennessee passed a law[54] 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[55] and addresses continuity of care and step therapy. If an individual changes health care coverage and has an approved PA with their prior insurer, and the health care service is a covered benefit under the new plan, the new insurer must honor the PA for at least 90 days.

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

Reducing response times

Michigan

Michigan's PA law[56] requires a review period of 72 hours for urgent PA requests, or within 72 hours of receiving additional information, if necessary. For non-urgent requests, insurers must act within 7 calendar days of submission or within 7 calendar days of receiving additional information. If an insurer fails to act within these timeframes, the prior authorization is automatically granted. Approved prior authorizations are valid for a minimum of 60 days or for the clinically appropriate duration, whichever is longer.

New Hampshire

Beginning Jan. 1, 2025, New Hampshire's PA law requires all PA requests to be processed within 7 calendar days if submitted electronically and 14 calendar days if submitted non-electronically. Urgent requests must be processed within 72 hours. If the health insurer does not notify the covered person and their provider within these time limits, the PA request will be considered approved.[57]

---

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

Oklahoma

House Bill 3190[58], which took effect on Jan. 1, 2025, requires utilization review entities to respond more promptly to PA requests. After a utilization review entity has obtained all necessary information to make a decision, the entity must respond within 72 hours for urgent requests and within seven days for non-urgent requests.

Texas

According to TDI, commercial insurers have two business days to approve a PA request after receiving all necessary information. Life-threatening conditions require a response within one hour and concurrent care within 24 hours.

Washington

Washington has implemented shorter turnaround times for PA approvals[59], ranging from one to five calendar days, aiming for timely patient access to care. The required turnaround times differ depending on how the request is submitted to the carrier (non-electronic versus electronic) and whether the request is urgent. For ePA requests, carriers must make a decision and notify the provider and facility of the decision within three calendar days for a standard request and within one calendar day for an urgent request. Turnaround times are a little longer for non-electronic requests - within five calendar days for a standard request and two calendar days for an urgent request.

West Virginia

West Virginia statute allows for a bundled request per episode of care[60]. An episode of care is defined as a medical condition or specific illness. For non-life threatening or routine medical conditions, the health insurer must respond within five business days from the date the PA was received. For life threatening or non-routine medical conditions, the insurer must respond within two business days. Incomplete PAs must be corrected within two business days by the provider from the date of receipt of the insurer. The health care provider shall provide the requested information within three business days from the date of the returned request, and the health insurer shall render a determination within two business days after the receipt of the requested information.

Wyoming

Wyoming's *Ensuring Transparency in PA Act* relied heavily on the American Medical Association (AMA) model legislation and established response times for PA requests.[61] PA response times for non-emergent responses are to be within five calendar days of obtaining all necessary information to complete the review. Urgent authorizations must be completed within 72 hours of obtaining all necessary information. Health insurers and contracted utilization review entities shall not require PA for medications used for opioid use disorder. In addition, a health insurer or contracted utilization review entity shall not require PA for rehabilitative or habilitative services including, but not limited to, physical therapy service or occupations therapy services for the first 12 visits for each new episode of care.

---

[58] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400
[59] Washington RCW 48.43.830 https://app.leg.wa.gov/rcw/default.aspx?cite=48.43.830
[60] https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/IB%2021-08%20Electronic%20PA%20(1).pdf
[61] Wyo. Stat. Ann. §§ 26-55-101 through -113

Updating technology and systems

New Hampshire

Starting Jan. 1, 2025, New Hampshire's PA laws incentivize electronic submissions by applying shorter processing timeframes for requests submitted electronically. Additionally, it permits providers to initiate peer-to-peer review before a determination is made.[62]

Texas

In 2014, Texas mandated standardized PA request forms for health care services and prescription drug benefits.[63] The regulation, which took effect on Sept. 1, 2015, established an advisory committee tasked with updating the forms every two years. Its primary goal was to streamline the PA process, making it more efficient and transparent for both providers and patients. The forms must be provided in both paper and electronic formats and made accessible on health plan websites. Medicaid and CHIP are required to accept these forms.

Washington

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

With the passage of Engrossed Second Substitute House Bill (ESSHB)1357[64] 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[65] 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[66].

West Virginia

During the 2024 Legislative Session, West Virginia updated its PA laws[67] to require a health insurer to submit requests with any related communication via an electronic portal.

---

[62] RSA 420-J:6.

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

[64] 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

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

[66] 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

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

Ensuring qualifications of health benefit plan reviewers

Oklahoma

Oklahoma's House Bill 3190[68] requires all adverse determinations and appeal decisions to be made by a physician or licensed mental health professional to ensure that qualified professionals are involved in medical decisions. For adverse determinations, the physician or licensed mental health professional must:

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

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

Texas

Texas' regulations require PA determinations to be made by an individual licensed to practice medicine in Texas who has the same or similar specialty as that physician. The physician or provider has the right to a review regarding a PA exemption to be conducted by an independent review organization.[69]

Improving transparency

New Hampshire

Beginning March 31, 2026, New Hampshire's PA law requires health insurers to report PA as specified in 45 CFR 156.223 to the commissioner and requires the New Hampshire DOI to post insurer-specific data online.[70]

Oklahoma

House Bill 3190[71] 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

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

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

Pennsylvania

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

Texas

If a PA exemption is denied, the insurer is required to provide a notice to the provider describing why the exemption was denied, directions on how to appeal the denial and information on how to file a complaint with TDI.[72]

Virginia

Virginia requires each health insurer to make available by posting on its website no later than March 31 of each year the PA data for health care services for the previous calendar year for all metrics required for compliance with federal law and CMS regulations.[73] These specifically include those promulgated under 42 C.F.R. §§ 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c).[74] It also requires carriers to make available through one central location on the carrier's publicly accessible website or other electronic application, the list of services and codes for which prior authorization is required."[75]

Washington

Starting Oct. 1, 2020, and annually thereafter, carriers in Washington must include in their annual report to the OIC aggregated and deidentified data related to their PA practices and experience for the prior plan year.[76] For each category (inpatient medical or surgical, outpatient medical or surgical, mental health and substance use disorder, durable medical equipment, diabetes, and prescription), insurers must list the ten codes with the:

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

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

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

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

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

[76] 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

Wyoming's *Ensuring Transparency in PA Act* establishes guidelines for review of adverse determinations.[77] Individuals qualified to make adverse determinations need sufficient knowledge in the applicable practice area or specialty, knowledge of coverage criteria, have an unrestricted license to practice within the scope of their profession recognized in the United States or District of Columbia, and knowledge of the person's medical history and diagnosis. The health insurer or contracted utilization review entity shall provide the opportunity for the provider to discuss the medical necessity of the service. An attempt to schedule the discussion should take place within five days of the provider's request.

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

The Federal Government

In addition to state legislative action, the CMS issued the CMS Interoperability and PA Final Rule[80] in 2024 to set uniform national PA standards for the federal health coverage programs under its jurisdiction, as well as for QHPs offering ACA compliant coverage through FFEs. The rule created uniform timeframes for PA decisions, data exchange requirements, transparency requirements, and other digitization efforts.

Specifically, the rule sets federal standards for PA response timeframes, generally requiring impacted payers to send a PA decision within 72 hours for expedited or urgent requests and 7 calendar days for standard or non-urgent requests. The rule also requires impacted payers to specify a reason when they deny a PA request, regardless of the method used to send the PA request. The reason for denial must be of sufficient detail to enable the provider to know what action to take as follow-up – that is, whether to appeal, submit additional documentation, or identify alternative treatment options.

---

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

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

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

- Electronic access to information for patients on PA requests and decisions;
- Electronic access to information for providers on when PA is required and what information is required to accompany a PA request;
- Electronic exchange of PA requests and decisions between providers and payers; and
- Electronic exchange of PA information across payers.

Although this rule does not reach health insurers operating in states with State-Based Exchanges (SBEs), having federal standards may help encourage national uniformity as states continue to grapple with the issue. Additionally, as discussed in the Industry Trade Associations section, an industry PA initiative includes a voluntary commitment across more than 45 plans to support the new technical standards for ePA beyond the federal programs impacted by the rule to all lines of business.

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

Provider Trade Associations

American Medical Association (AMA)

AMA PA and Utilization Management Reform Principles

To address its concerns with utilization management programs, such as PA, in 2014, the AMA published its Prior Authorization and Utilization Management Reform Principles.[81] This proposal received endorsement

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

from over 100 medical and physician associations. The goal was to ensure that patients have timely access to necessary treatments while also reducing administrative costs for the healthcare system.

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

- Any utilization management program applied to a service, device or drug should be based on accurate and up-to-date clinical criteria and never cost alone. The referenced clinical information should be readily available to the prescribing/ordering provider and the public.
- Utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues.
- A drug or medical service that is removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year.
- A PA approval should be valid for the duration of the prescribed/ordered course of treatment.
- Utilization review entitles should publicly disclose, in a searchable electronic format, patient-specific utilization management requirements, including PA, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by providers and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers what supporting documentation is needed to complete every PA and step therapy override request.
- Utilization review entities should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing.
- Eligibility and all other medical policy coverage determinations should be performed as part of the PA process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.
- If a utilization review entity requires PA for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information.
- PA should never be required for emergency care.
- Health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways.

Consensus Statement on Improving the PA Process

In 2018, the AMA collaborated with healthcare providers - including physicians, pharmacists, various medical groups, and hospitals - as well as health benefit plans to identify ways to enhance the PA process. The goals of this collaboration were to ensure safe, timely, and affordable access to evidence-based care

for patients, improve efficiency, and reduce administrative burdens. Together, they published the "Consensus Statement on Improving the Prior Authorization Process." [82]

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

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

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

AMA Model Legislation

The AMA has released model legislation multiple times, with the most recent publication in 2025. The goal of the model legislation[83] is to enhance transparency and minimize interruptions to patient care. The following states have adopted language directly from the model legislation: Delaware, Georgia, Illinois, Mississippi, New Jersey, Oklahoma, and Wyoming.

The model legislation recommends the following measures:

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

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

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

Utilization review entities are also required to submit an annual report to the state's Department of Insurance (DOI) that contains specific information about PA requests from the previous calendar year. The DOI is required to submit a report to the legislature that includes a summary of the reports provided by the

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

utilization review entities and recommendations for the removal of PA requirements on services that are regularly approved (80% of the time) for PA.

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

Furthermore, a utilization review entity issuing an adverse determination must explain its reasoning using its own PA requirements as a basis, provide the clinical criteria used, inform the enrollee of their right to appeal and the process to file an appeal, and provide all information necessary to support a successful appeal. A notification of an adverse determination and a denial of an appeal must include the National Provider Identifier (NPI) of the physician who reviewed the PA request and is responsible for the determination, as well as the physician's credentials, board certifications, and specialty areas, expertise, and training.

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

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

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

American Psychiatric Association Model Legislation

In 2022, the American Psychiatric Association (APA) developed model legislation[84] aimed at reforming the PA process to reduce unnecessary administrative burdens and improve patient access to care. This legislation focuses on streamlining the authorization process, increasing transparency, and ensuring timely decision-making.

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

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

1) Generic prescription drugs that are not classified as controlled substances under 21 CFR 1308.11 through 21 CFR 1308.15 or under any state criminal law.

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

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

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

5) Any long-acting injectable prescription drug.

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

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

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

Legislative Organizations

National Council of Insurance Legislators (NCOIL)

Prior Authorization Reform Model Act

In March 2025, the National Council of Insurance Legislators (NCOIL) introduced a draft of the Prior Authorization Reform Model Act.[85] The primary purpose of the model act is to protect the patient-provider relationship from unreasonable third-party interference and to ensure that PA programs do not impede the independent medical judgment of physicians and other healthcare providers. The model act aims to

[85] https://ncoil.org/wp-content/uploads/2025/03/NCOIL-Prior-Auth-Reform-Model-Draft-3-26-25.pdf

improve timely access to care and increase transparency by establishing new requirements for health insurance companies. NCOIL adopted the model act on Nov. 15, 2025.[86]

Key provisions of the model act include:

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

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

Industry Trade Associations

In June 2025, AHIP and the BCBSA announced a voluntary initiative by health ~~insurance providers~~insurers to simplify ~~prior authorization~~PA, with a focus on "connecting patients more quickly to the care they need while minimizing administrative burdens on providers."[87] The initiative applies to insurance markets including commercial coverage, Medicare Advantage, and Medicaid managed care. The participating member health plans voluntarily commit to:

- **Standardize electronic PA** by Jan. 1, 2027. Participating health plans will work toward implementing common, transparent submissions for ePA.
- **Reduce the scope of medical claims subject to prior authorization**, with demonstrated reductions by Jan. 1, 2026. Individual plans will commit to specific reductions to medical PA as appropriate for their particular market.

[86] https://ncoil.org/wp-content/uploads/2025/11/NCOIL-Prior-Auth-Model-November-2025.pdf
[87] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization

- **Ensuring continuity of care when patients change plans**, beginning Jan. 1, 2026. When a patient changes insurance companies during a course of treatment, the new plan will honor existing PAs for benefit-equivalent in-network services as part of a 90-day transition period.
- **Enhance communication and transparency on determinations,** operational for fully insured and commercial coverage by Jan. 1, 2026, with a focus on supporting regulatory changes for expansion to additional coverage types.
- **Expand real-time responses.** In 2027, at least 80% of approvals of electronically submitted complete medical PA requests will be answered in real-time and health insurers will support ~~federally-required~~federally required technical standards for ePA requirements beyond federal programs across all insurance markets.
- **Ensure medical review of denied requests based on medical necessary/clinical factors**, a standard that is already in place

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

Takeaways

State regulators should work within the broader NAIC to develop ~~Prior Authorization~~PA ~~S~~standards or best practices. In addition, the following best practices should be helpful to states considering PA reforms.

Take advantage of data calls

Make use of targeted data calls while in the legislative process to understand ~~your market~~the state-specific market conditions. This data will prove invaluable to mold future legislation that will benefit ~~your~~the entire healthcare ecosphere.

Incorporating flexibility in legislation

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

Build relationships with state partners

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

Implementation processes

As with any health care legislation, prior authorization changes to law can require significant effort to implement. It is important for state agencies to understand their roles with any changes, and to have mechanisms in law or processes in place to communicate how actions or decisions by one agency may impact the work of other agencies. In addition, many of the changes to facilitate faster processing time

require IT updates at both the insurer and provider levels, taking both time and a financial commitment to achieve.

Develop provider and consumer education

States may pursue public awareness campaigns so that health insurance consumers and their physicians become familiar with PA processes and the attendant appeal rights. States may also highlight rules currently in effect designed to significantly increase transparency of health insurer processes. Bringing more focus to the health insurance consumer experience with PA will greatly benefit those depending on the coverage they purchased to help navigate and address complex health concerns.

Create structure for enforcement

New PA requirements can have complicated enforcement mechanisms, and some may require additional staff expertise or investment in training. The Regulatory Framework (B) Task Force will evaluate the need for an ad hoc or other group to support regulators newly embarking on PA enforcement.

APPENDIX—CHART ON STATE PA LAWS AND TYPE PRIOR AUTHORIZATION LAW

Observations of State Insurance Laws Regarding Prior Authorization

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

Common Provisions in Prior Authorization Laws

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

State	Citation (s)	Response Times	Retrospective Denials	Clinical Criteria & Medical Necessity	Qualifications of Reviewer	Gold Carding	Peer-to-Peer/Appeal Process
AL	27-3A-5	(a)(4)(c)(6) Response in 2 working days and no later than 30 days from appeal.			(a)(4)(a) by physician in same or similar specialty.		(a)(4)(c) 48 hours expedited appeal.
AK	Alaska Statute 21.07.250(14); 21.07.020; 300gg-19a; 3 AAC 28.908 – 3 AAC 28.914, 3 AAC 28.989.	PA for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless PA is based on materially incomplete or inaccurate information.	(21.07.020) for materially incomplete or inaccurate info on behalf of provider.			(b)(1)(300gg-19a)For emergency services.	
AZ	ARS 20-2803	None for initial med. Screening, otherwise 24 hours by phone or fax.			(E)Access to a physician when necessary for determinations.		
AR	23-99-1105	(a)Two days for nonurgent; expedited one day; (e)(1) Emergency service requiring post evaluation or stabilization shall make an auth within sixty minutes of receiving request.	(23-99-1109)(b)(1) cannot rescind PA based on med. Necessity at least three days before scheduled admission or service.	(23-99-1103)(B) "Medical necessity" includes the terms "medical appropriateness", "primary coverage criteria", and any other terminology used by a utilization review entity	(23-99-1111)(c)(1) An adverse determination regarding a request for prior authorization shall be made by a physician who possesses a current and unrestricted Arkansas license to practice medicine .	(23-99-1120)(a)(2) If a provider's PA requests are approved 90% or more in a six month period.	(23-99-1111)(c)(3)(A) The requesting provider may contact reviewing physician within one business day of adverse determination for an urgent svc or two days for a nonurgent service.
CA	HSC s 1367.01 to 016 T.28 s 1300.67.2.41	5 business Days, urgent 72 hrs. 24 hrs exigent.		Requires reasonably necessary info.	Licensed physician or health care professional .		Plan must cover 1 therapeutically equivalent drug, device or product for prevention of AIDS/HIV w/o PA or step therapy.
CO	C.R.S. 10- 16-124.5 C.R.S. 10- 16-113	Electronic: 2 business days Nonurgent facsimile or email: 3 business days		PA process should consider national standards for electronic PA, whether to require carriers and PBM firms to use clinical criteria based on medical necessity, and ensure that carriers and PBM firms use evidence-based guidelines in determinations.	Licensed physician familiar with Colorado standards of care. First-level appeals should include consultation of appropriate clinical peer(s) and should not involve any physicians or peers involved in the initial adverse determination.		Carrier shall give the medical facility or health care professional an opportunity to request, orally or in writing, a peer-to-peer conversation about an adverse determination by the reviewer. The conversation shall occur within 5 calendar days of receipt of the request and shall be between the entity rendering the health care service and the reviewer who made the determination or a clinical peer designated by said reviewer if they are not available within those 5 days. If the P2P conversation does not resolve the matter, the determination may be appealed by the covered person. A P2P conversation is not a prerequisite to request a review.

CT	CT Gen Stat § 38a-472g		No retrospective denial if insurer failed to notify the insured's provider at least 3 business days before the date of the procedure whose PA was revoked.				
DE	HB 381 (2016) 18 Del.C.§§ 3373 and 72	Pharmaceuticals: 2 business days Other health care services: 5 business days		Criteria shall be described in language easily understandable by a health care provider in the same clinical area.			
DC	L25-0100 DC Code §§31-3875.03; 31-3875.02; 31-3875.06	Urgent: 24 hours Long-term services: 30 days All others: 3 business days for electronic portal requests and 5 business days for requests submitted via a different medium.	For emergency health care services: only if the utilization review entity shows clear and convincing evidence that the service was not medically necessary.	PA may only be required for a covered service based on determination of medical necessity for different care or that the care is experimental or investigational.	Adverse determination: Current and non-restricted license to practice in D.C., Maryland, or Virginia, and same or similar specialty as a physician who typically manages the relevant service or condition. Reviewing physician: Under direction of one if the entity's directors responsible for providing services to D.C. enrollees and has no financial incentive. Utilization entity appeals: Current and non-restricted license to practice in D.C., Maryland, or Virginia; same or similar specialty as a physician who typically manages the relevant service or condition, knowledgeable in and experienced with the service. Shall not receive any financial incentive and shall not have been involved in making the adverse determination or subordinate of the physician who was.		Enrollee has 15 calendar days to appeal an adverse determination. The utilization review entity shall notify the enrollee's provider before issuing the determination that the medical necessity of the health care service is under question and request additional information on the necessity of the service.
FL	F.S.A. § 627.42392 Ch. 2016- 224 (627.4239 2) and Ch. 16 – 222	Health plans shall provide treatment authorization 24/7 and establish written procedures for requesting and granting authorizations. Medicaid requires expedited PA requests to be processed within 3 business days and standard requests to be processed within 14 days with an average turnaround time within 7 days.					

GA	GA Code Ann. §§33-46-1 to 16; §§ 33-46-20 to 32	Non-urgent: 7 calendar days Urgent: 72 hours		Criteria are based on sound clinical evidence and are evaluated periodically to ensure efficacy. "Medically necessary" means healthcare services that a healthcare provider would provide to a patient for the purpose of treating an illness, injury, or disease or its symptoms in a manner that is in accordance with generally accepted medical standards, clinically appropriate, not primarily for the economic benefit of the insurer or convenience of the patient or provider, and not primarily custodial care.	Healthcare provider with a current and valid nonrestricted license or other appropriate authorization, is currently in active practice in the same or similar specialty, is knowledgeable in and experienced with the service under appeal, is not directly involved in making the adverse determination, and considers all clinical aspects of the service under review.	For unanticipated emergency and urgent services, covered services that are incidental to the primary covered service and medically necessary, and ambulance transportation.	
HI	HB 954	Non-urgent: 5 calendar days before provision of the service. Request is deemed approved after 48 hours if the utilization review entity fails to make a decision, request more information, or notify the provider that PA is being questioned for medical necessity. 24 more hours are given after additional information is given. Provider who fails to submit requested information within 24 hours shall submit a new PA request.	No retrospective denial if care is provided within 45 business days from the date the provider received the PA. A utilization review entity shall pay a provider the contracted rate for a PA unless: the provider intentionally misrepresented the health care service with intent to deceive and obtain an unlawful payment; the provider failed to meet timely filing requirements; the review entity is not liable for the claim; or on the day the service was provided, the service was no longer a covered benefit, the provider was no longer contracted with the patient's insurance plan, or the patient was no longer eligible for coverage.	Any current PA requirements shall be readily available in detailed and easily understandable language on the utilization review entity's website. New PA requirements or amendments must not be implemented until the website is updated to reflect it and until providers have been given written notice within 60 days before the requirement's implementation.	Physician who has a current and valid non-restricted license, is and has been in active practice for at least 5 consecutive years in the same or similar specialty, has knowledge of and experience with the services under appeal, has no financial interest in the appeal's outcome, and was not directly involved in making the determination.	For prehospital transportation or the provision of emergency health care services.	Any utilization review entity questioning a health care service's medical necessity shall notify the enrollee's physician of said questioning. The physician shall have the opportunity to discuss the medical necessity with the physician responsible for determining authorization of said service via telephone.
ID	Title 41, Ch. 39 (41-3930)	Nonemergency: 2 business days No PA for emergencies	In cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits, or if covered person is not enrolled at the time of service.				

IL	Public Act 102-0409 215 ILCS 134/10	Urgent care: Within 48 hours of receiving all required information Non-urgent PA: 5 calendar days of receiving info Appeal: 15 business days of receiving info	No retrospective denial for routine services when an associated health care service has received PA or when PA is not required for said service.	Criteria must be based on national standards except where State law provides its own, be developed in accordance with current national medical accreditation standards, ensure quality of care and access to services, be evidence-based, flexible to allow deviations, and be evaluated and updated at least annually. "Medically necessary" means that a service addresses the needs of a patient for screening, preventing, diagnosing, or treating a condition or its symptoms and comorbidities, in a way that is: in accordance with generally accepted standards of care; clinically appropriate; and not primarily for the economic benefit of the health care plan, purchaser, or utilization review org., or for the convenience of the patient or provider.	Physician with a current and valid nonrestricted license to practice medicine in the U.S., in the same or similar specialty as a physician who manages the condition, have knowledge of and experience providing the health care services under appeal, not directly involved in the adverse determination, and that considers all known clinical aspects of the service.	A health insurance issuer shall periodically review and consider removal of PA requirements where a medication or procedure is customary and properly indicated with support from peer-reviewed medical publications, or for patients currently with an established treatment regimen.	
IN	SB 400 (2023) HR 1143 (2018) SB 73 (2017) 27-1-37.5-1 to 17	Urgent: 48 hours Nonurgent: 5 business days	Health plan shall not deny a claim based solely on lack of PA for the unanticipated health care service. It shall not deny payment for a service rendered in accordance with a PA and all terms and conditions of the provider's agreement with the health plan.			No PA on list of CPT codes for state employees through June '26	The health plan's clinical peer and the covered person's provider or designee shall provide a peer-to-peer review within 7 business days, given that all needed information has been received.
IA	191 IAC 79 IA HF2399 (2022)	Urgent: 72 hours Nonurgent: 5 calendar days When additional needed information is submitted, the applicable time period for a decision starts again. QHP drugs: 24 hours	If fraud, waste, or abuse occurred, or if inaccurate information was provided; If, on the date that the health care service was provided, the service was no longer a covered benefit under the covered person's health plan, or the provider was no longer contracted with the carrier providing the health plan, or the covered person was no longer a participant in the health benefit plan; If the provider failed to meet the carrier's requirements for timely filing of claims; or If the carrier does not have liability for the service due to coordination of benefits.			PA shall be valid for the specific health care service for not less than 90 days from the date of PA receipt, provided that the covered person has the same health benefit plan for those 90 days.	

KS	40-4603	24/7 access to a representative for services provided immediately after treatment of an emergency health condition.				For emergency services if symptoms presented show that an emergency medical condition exists, or for emergency examination and stabilizing services.	
KY	KY Rev Stat § 217.211 SB 54 2019	Urgent review: 24 hours Nonurgent review: 5 days	If the approval was based on fraudulent, materially inaccurate, or misrepresented information.	"Medically necessary health care services" means health care services that a provider would render to a patient to prevent, diagnose, or treat an illness, injury, disease, or its symptoms in a way that is in accordance with generally accepted medical standards and is clinically appropriate.	Licensed physician of the same or similar specialty as the ordering provider		
LA	HB 468 (2023) SB 188 (2023) LSA-RS 22:1006.1 LSA-RS 46:460.33 ASB 348 (2022) LSA-R.S. 22:1139 SB 112 (2022)	Urgent: 2 business days Non-expedited: 5 business days Concurrent: 24 hours of obtaining needed information Retrospective review: 30 business days of obtaining needed info. Insurance issuer has 1 calendar day to inform the provider what additional info. is needed. Provider has 2 business days to provide it.	Denied if: benefit limitations are reached, documentation fails to support the claim, the service is no longer medically necessary, the service would require disapproval in accordance with the enrollee's plan, another payor is responsible for the payment, the provider was already paid for the services, the claim is fraudulent, and/or the recipient of the service was not eligible to receive said service.	Criteria are evidence-based and updated and reviewed by an insurance issuer.	Licensed healthcare practitioner similar in education and background as the requesting provider, or a same or similar specialist who treats the condition and any complications resulting from the health care service.	For invasive procedures for which PA was received from the insurance issuer before the procedure was finished or PA was not required by the issuer.	The health insurance issuer shall appoint a physician to conduct a peer review and shall notify the requesting physician of the determination within 2 business days of the peer review date.
ME	Chapter 273 PL S.P. 218- L.D. 705 2019	Nonemergency: 72 hours or 2 business days, whichever is shorter With outside consultation: 72 hours or 2 business days after initial response, whichever is shorter.	If fraudulent or incorrect information was provided.	Criteria are based on published sound clinical evidence and are evaluated periodically to ensure efficacy.	Clinical peer who may not have been involved in making the initial adverse health care treatment decision unless additional information is provided on appeal.	No PA for first 12 visits of a new episode of care, including for rehabilitative or habilitative services.	
MD	MD Code Ann. 19-108.2 MD Ins Code § 15-851 (2019)	Real time approval for requests that need no additional information and meet the payor's criteria for approval. Otherwise: Nonurgent pharmaceuticals: 1 business day Nonurgent other: 2 business days					

MA	MGL C. 1760, 25	If a payer does not respond within 2 business days, the request is deemed to have been granted.		Guidelines should be developed with input from practicing physicians and participating providers in the carrier's service area, developed in accordance with national accreditation standards, updated at least biennially, evidence based, considerate of individual health care needs of the insured, assessed by the carrier to show compliance with state and federal parity requirements, and compliant with state and federal law.			
MI	Section 500.2212c SB 247 (2022)	Non-urgent: Granted if not decided upon or replied to within 7 calendar days of the request. Urgent: Granted if not decided upon or replied to within 72 hours.		Criteria must be developed by either an entity that works directly with clinicians and does not receive direct payments based on the outcome of the clinical care decision, or a professional medical specialty society. The criteria must take into account the needs of atypical patient populations, ensure quality of care and access to needed services, be evidence-based, be flexible to allow deviations, and be evaluated and updated at least annually.	Licensed physician who is board certified or eligible in the same specialty as a provider who typically manages the condition or service under review. If no such physician can be identified within the applicable time limits, the insurer may use a licensed physician in a similar and appropriate specialty.	An insurer shall adopt a program that promotes the modification of PA requirements based on: The performance of health care providers, involvement of contracted providers to participate in a financial risk-sharing payment plan, and health provider specialty, experience, or other factors.	
MN	M.S.A. § 62M.01 to 19	Standard: 5 business days Expedited: 48 hours, including at least one business day after the initial request Appeal: 15 days + 4 additional days if needed due to circumstances outside the control of the review organization.	If there is evidence that the PA was based on fraud or misinformation, or if a previously approved PA conflicts with state or federal law.	If no independently developed evidence-based standards exist for a particular procedure, an insurer or utilization review organization shall not deny coverage solely based on the ground that the procedure does not meet an evidence-based standard. Clinical criteria must be established with appropriate involvement from actively practicing physicians and must be evaluated and updated annually based on sound clinical principles.	Physician in the same or a similar specialty as typically manages the condition or treatment under discussion who is reasonably available to review the case. Reviewer may not receive any financial incentive based on the number of adverse determinations they make.		
MS	MS Code 2015 83- 9-63	Within 2 business days					
MO	Mo. Rev. Stat.§§ 376.1350-376.1389; SB 982	24 hours electronically or telephonically, plus confirmation within 2 work days Concurrent: 1 work day	The grievance decision is finalized, binding, and subject to judicial review if: review is filed within 30 days of the final decision, judicial review is limited to the record before the director, the enrollee and carrier are real parties in interest, and the scope of judicial review extends only to whether the action is unlawful or in excess of the director's statutory authority.	Based on sound clinical evidence and evaluated periodically. When conducting utilization review, carrier shall only collect necessary information.	Qualified health care professional licensed in Missouri. Compensation for those conducting utilization reviews shall not contain incentives to make medically inappropriate decisions.		Review by the grievance advisory panel follows the same time frames as a first level review. Any grievance decision shall include notice of the right to file an appeal with the director's office.

MT	MT ST. §§ 33-32-101 to 419	Request for ext. review: 120 days of receipt of adverse determination Preliminary review of ext. review request: 5 business days of receipt of request		"Medical necessity" means health care services that a provider would provide to a patient to prevent, diagnose, treat, cure, or relieve a health condition, which are: in accordance with generally accepted standards, clinically appropriate and effective, not primarily for the convenience of the patient or provider, and not more costly than alternative service(s) likely to produce equivalent results.	Physician whose specialty focuses on the diagnosis and treatment of the condition that the Rx drug was prescribed to treat, provided that PA does not require a physician's involvement on the part of a health insurance issuer.	For any generic Rx drug that is not a controlled substance after a person has been continuously prescribed said drug at the same quantity for 6 months, Any generic or brand name Rx drug(s) for therapeutic duplication if the covered person already has PA for therapeutic duplication for the same dosage of the Rx drugs, Any Rx drug with a dosage adjusted within FDA or clinical standards, and Any long-acting injectable antipsychotic Rx drug.	A covered person may request external review when a health insurance issuer fails to adhere to state law involving the resolution of grievances. They are entitled to any available remedies on the basis that the issuer failed to provide a reasonable appeals process.

ND	2280 2025 Session Eff. 8/1/205	**26.1 - 36.12 - 05**. **Prior authorization - Nonurgent circumstances**. Nonurgent - 7 Days **26.1 - 36.12 - 06. Prior Authorization. Urgent Health Care Services**. Urgent - 72 hours **26.1 - 36.12 - 07. Prior Authorization. Emergency Medical Condition.** Emergency - 2 days following admission	**26.1 - 36.12 - 09. Retrospective denial.** May not revoke authorization for 45 days unless there is evidence the prior authorization was based on fraud.	**26.1-36.12-02. Disclosure and review of prior authorization requirements.** A prior authorization review organization shall make any prior authorization requirements and restrictions readily accessible on the organization's website to enrollees, health care professionals, and the general public. Requirements include the written clinical criteria and be described in detail using plain and ordinary language comprehensible by a layperson	**26.1 - 36.12 - 04. Personnel qualified to review appeals.** A prior authorization review organization shall ensure all appeals are reviewed by a physician. The reviewing individual: a. Shall possess a valid nonrestricted license to practice medicine. b. Must be in active practice in the same or similar specialty as the physician who typically manages the medical condition or disease for at least five consecutive years. c. Must be knowledgeable of, and have experience providing, the health care services under appeal. d. May not receive any financial incentive based on the number of adverse determinations made. This subdivision does not apply to financial incentives established between health plan companies and health care providers. e. May not have been directly involved in making the adverse determination. f. Shall consider all known clinical aspects of the health care service under review, including a review of all pertinent medical records provided to the prior authorization review organization by the enrollee's health care provider, any relevant records provided to the prior authorization review organization by a health care facility, and any medical literature provided to the prior authorization review organization by the health care provider.		**26.1-36.12-03. Personnel qualified to make adverse determinations.** A prior authorization review organization shall ensure all adverse determinations are made b y a licensed physician or licensed pharmacist. The reviewing individual: 1. Must have experience treating patients with the condition or illness for which the health care service is being requested; and 2. Shall make the adverse determination under the clinical direction of one of the prior authorization review organization's medical directors who is responsible for the health care services provided to enrollees.
NE	NE ST. §§ 44-5401 to 5431; LB77	Urgent: 12 hours Nonurgent: 3 days		Criteria shall be based on sound clinical evidence and evaluated periodically to ensure efficacy.	A physician that is reasonably available to review the case, unless the health care services were provided or authorized by a provider other than a physician. In this case, the appeal may be reviewed by a nonphysician provider whose scope of practice includes the services under review.		A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

NV	NV ST.§§ 687B.225; 616C.157; 683A.372	Treatment, diagnostic tests, consultation: 5 working days The PA shall be deemed to be given if the insurer fails to respond on time. They may subsequently deny authorization. Other requests: 20 days		Procedures shall include a quality assurance mechanism that ensures that an external review is conducted within the specified time frames, the selection of qualified and impartial clinical reviewers for external reviews, suitable matching of reviewers to specific cases, the independent review organization employs an adequate number of reviewers, the confidentiality of records and review criteria, and that a person employed by the organization adheres to external review requirements.	Physician or other appropriate health care provider who must: be an expert in the treatment of the covered person's medical condition under review; be knowledgeable about the recommended service through recent or current clinical experience treating similar patients with the same or similar medical condition; hold a nonrestricted license in the U.S. and, if a physician, hold a current certification byt a specialty board of the American Board of Medical Specialties in the area(s) appropriate to the subject of review; and have no history of disciplinary actions or sanctions that question the reviewer's physical, mental, or professional competence or moral character.		
NH	NHRSA §§ 420-J: 5, 420-J:6, I (c) 420-J:6, III 420-J:6, X 420-7-b; 415-A:4-a; 415-A:4-b	Urgent care appeals: 72 hours Confirmation of expedited decision: 2 business days Non-urgent: 14 calendar days Request for more info: 7 calendar days		Criteria shall be developed with input from practitioners with relevant knowledge, updated at least biennially, compliant with national accreditation entity standards, based on current and nationally accepted standards, and evidence-based.	Has appropriate medical and pro. expertise and credentials to apply clinical criteria. Med. necessity determination is made by one of the carrier's or UR entity's medical directors who is responsible for reviewing health care services provided to covered NH residents.	For interfacility transports related to treatment of certain mental illnesses. For at least one medication-based treatment option for substance use disorders without renewal more frequently than every 12 months.	Urgent determinations in 72 hours, additional information given at least 48 hours. The determination shall be made within 48 hours after the add'l information is received or the claimant misses the deadline to provide it. Peer-to-peer reviews can be requested before PA determination or after denial and before grievance, and shall be available within 2 days.

NJ	NJ Uncodified AB 1255	Urgent req: 24 hours Non-urgent req: 72 hours Current inpatient or emergency care services: 24 hours Urgent care: 72 hours Emergency care: 150 min.; services approved if determination is not made within this time	Payer shall honor a PA granted by a previous payer for at least the first 60 days of coverage under a new health plan. Payer shall reimburse a hospital or provider for all medically necessary emergency and urgent health care services covered under the health benefits plan.	"Medical necessity" means or describes a health care service that a health care provider would provide to a covered person to evaluate, diagnose, or treat a condition or its symptoms, that is: in accordance with generally accepted standards, clinically appropriate, not primarily for the convenience of the covered person or provider, and not more costly than alternative service(s) likely to produce equivalent results.	PA denials or limitations shall be made by a physician who shall: make the adverse determination under the clinical direction of a medical director be licensed in NJ, not be paid based on their approval or denial rate, and not be provided preferential treatment by a payer in requests for PA of the reviewing physician if that physician is also a network provider for the payer. Adverse determinations of appeals shall be made by a physician with the same requirements as reviewing physicians for PA denials, and additionally shall: be board certified in a same or similar specialty relevant to the condition or service under review, or has experience with said condition within the last 5 years; not have been directly involved in initial adverse determinations for the same claim; consider all clinical aspects of the service under review; and engages in telephone communication with the treating provider when requested.		Payer found to be in violation of those sections shall be liable for a civil penalty up to $10,000 per day that the payer is in violation if reasonable notice is given to levy the penalty. At the discretion of the commissioner, the payer has 30 days to remedy the condition that caused the violation.
NM	59A-22B-5	PA is granted for determinations not made within 7 days. When a health care professional requests an expedited PA and submits a statement that delay in treatment could cause permanent harm, an adjudication shall be made within 24 hours or deemed granted if no determination is made.	No retrospective denial for mental health or substance use disorder services after the provider renders the services, except in cases of fraud or violation of the provider's contract with the insurer.	"Medical necessity" means health care services determined by a health care provider, in consultation with the insurer, to be necessary according to: generally accepted principles of good medical care; practice guidelines from the federal government or professional associations; or applicable clinical protocols developed by the insurer consistent with federal, national, and professional practice guidelines.	"Medical peer review" means review by a health care professional from the same or similar specialty that typically manages the condition or procedure under review for PA.		An auto-adjudicated PA request based on medical necessity that is pended or denied shall be reviewed by a health care professional who: has knowledge of the medical condition of the covered person for whom the auth is requested, or consults with a specialist who has said knowledge. The health care professional shall make a final determination of the request; if denied, notice of the denial shall be provided to the covered person and their provider with: the grounds for denial, a notice of the right to appeal, and a description of how to file an appeal.

NY	N.Y. Ins. Law §§ 4902; 4903;4904	Appeal of initial UR determination: 30 days Expedited appeals: 2 business days Expedited appeal for substance abuse treatment: 24 hours Step therapy protocol override: 72 hours Step therapy protocol override for urgently needed Rx drug: 24 hours Allow at least 40 hours a week during normal business hours to discuss care and allow telephone requests		Utilization review agent shall use an evidence-based and peer reviewed review tool to determine coverage for substance use disorder treatment, which is designated by the office of alcoholism and substance abuse services. Agent shall use evidence-based and peer reviewed criteria to determine coverage for a mental health condition, which is approved by the commissioner of the office of mental health.	Both standard and expedited appeals shall only be conducted by clinical peer reviewers other than those who rendered the adverse determination.		Expedited appeals: 2 business days of receipt of necessary information, except those for substance use disorder treatment, which shall be determined within 24 hours. Notice of the appeal determination shall include rationale for the determination.
NC	N.C Gen. Stat.§§ 58-50-61; 58-3-200	"Necessary information" includes the results of any patient exam, evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to the provider within 3 business days of obtaining all necessary information.	If an insurer determines that items are covered under its health benefit plan, the insurer shall not subsequently retract its determination after the items have been provided or reduce payments unless the determination was based on an intentional misrepresentation about the insured's health condition.	Criteria are based on sound clinical evidence and are periodically evaluated to ensure efficacy. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall either be: the diagnostic criteria in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders, or criteria adopted by the insurer or its URO.	Medical doctor licensed to practice in NC with no incentives to make a particular decision.		Insurer shall clearly and comprehensively describe its UR procedures, and include availability of assistance and contact information for Health Insurance Smart NC, in the certificate of coverage and member handbook that it provides to covered persons. UR procedure information should also be included in materials for prospective covered persons.
OH	Ohio Rev. Code § 1751.72	Urgent: 48 hours Non-urgent: 10 calendar days (Both for PA requests and appeals)	If the service is related to another service that has already received PA approval and been performed, the new service was not known to be needed when the original service was performed, and the need for the new service was revealed when the original service was performed.		Appeal shall be between the health care practitioner requesting the service and a clinical peer.		Committing a series of violations that constitute a pattern shall be considered an unfair and deceptive practice. If the appeal does not resolve the disagreement, covered person or a representative may request external review. If the health care practitioner submits a claim including an unintentional error which results in a claim that does not match the information in the originally submitted approved PA request, the practitioner may resubmit the claim upon receiving a denial of services.

OK	Okla. Stat. Tit. 36, § 6907			Procedures shall ensure that health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of practice, and shall include mechanisms to assure availability, accessibility, and continuity of care.			
OR	O.R.S. §§ 743B.001; 743B.256; 743B.420; 743B.423	Nonemergency: within 2 business days If more information is requested, by the later of: 2 business days after receipt of a response or 15 days after the request	Determinations related to benefit coverage are binding on the insurer if obtained within 60 days before date of service Determinations related to eligibility are binding on the insurer if obtained within 5 business days before date of service	Must be evidence-based and continuously updated based on new research, and take into account new treatment developments.	Physician licensed under ORS 677.100–677.228 for all final recommendations regarding treatments subject to UR. Independent review org. shall appoint reviewer(s) with at least one clinician in the same or similar specialty as the provider who prescribed the treatment.	"Managed health insurance" means any health benefit plan that requires enrollee to use specified network(s) of providers managed by the insurer to receive benefits, except for emergency service.	Insurer must give any provider who requested treatment or payment of services but was denied on the basis of being medically unnecessary or experimental the opportunity for a timely appeal with a medical consultant or peer review committee.
PA	Statutes 40 P.S.§§991.2154; 991.2155-2156; 991.2161	Urgent: Within 72 hours if not yet initiated, otherwise 24 hours MA or CHIP: 2 business days All others: 15 days	No denial for closely related services if the provider notifies the insurer within 3 business days of completion and before submitting a claim for payment, including all clinical information to evaluate medical necessity.	Criteria must be based on national medical standards, be applicable with govt. guidelines, provide for appropriate health care service and reflect current medical and scientific evidence.	Licensed provider with appropriate training and knowledge of the same or similar specialty related to the service, OR a licensed provider in consultation with a third-party provider with said qualifications.		For denied PA requests, insurer shall make a licensed professional available for a peer-to-peer review to the requesting provider. The peer-to-peer review procedure shall be available on the insurer's public website and portal. An MA or CHIP plan shall maintain an external grievance process, that includes expedited grievances, to appeal internal grievance denials.
PR	PR St T. 26 § 9005					For emergency services when such services are included in the health plan, and for obstetrical and gynecological care.	
RI	27-18.9 et seq.; 42-14.5-3	Urgent: 72 hours Non-urgent: 15 days (non-administrative)	Only if the initial approval was based on inaccurate information or the healthcare services provided did not follow the provider's care plan and/or prior approval restrictions.	ABD determinations must be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering provider.	Licensed practitioner with the same licensure status as the ordering provider.	The insurance commissioner shall establish and assist an advisory council subcommittee made up of healthcare providers and RI licensed health plans.	A non-administrative ABD reconsideration decision shall not be made until the UR agent's provider has engaged in two-way, direct communication with the provider who is responsible for providing the treatment.

SC	§§ 38-71-144; 44-6-1050					Rx PA extends to all refills allowed by the o.g. prescription and subsequent prescriptions for the same drug at the same dose.	If a benefit plan that covers treatment of stage 4 advanced, metastatic breast cancer denies a PA request or claim for diagnostic imaging based on an adverse medical necessity determination, the covered person shall have a right to expedited external review. A Medicaid recipient who has been denied PA for a Rx drug is entitled to an appeal.
SD	SDCL § 58-17H et seq.	Determinations shall be issued in a timely manner in compliance with SD code. Carriers shall ensure utilization reviewers apply review criteria consistently.	Carrier shall make the determination within a reasonable time period not exceeding 30 days, but can be extended once for up to 15.	Criteria are based on clinical evidence and are evaluated periodically to ensure efficacy.	Reviewer must be a clinically qualified and appropriately licensed health care professional.		
TN	Tenn. Code Sections 56-7-3701-22; (56-61-102)	Urgent: 72 hours + 1 business day if applicable Nonurgent: 7 calendar days		Criteria must be: based on national standards except where state law provides its own, non-arbitrary and cited by the UR org., evidence-based, flexible to allow deviations, and evaluated and updated in accordance with state law.	Licensed healthcare pro. with the same or similar specialty as the physician requesting the PA. For appeals, same or similar specialty as the physician who requested initial PA, and is also currently licensed in the U.S. without restrictions and is knowledgeable and experienced with the services under appeal.	PA requirements shall be reviewed at least annually, during which PA for prescriptions & medical service checks is considered for removal.	Non-urgent requests are approved within 7 calendar days if the provider is not notified that PA is being questioned for med. necessity (except Rx drugs). If notice is provided, it must include a phone # to the UR org., hours of business operation of the physician reviewing the PA, and a statement that there is an opportunity to discuss the medical necessity of the service with the healthcare pro. who will approve or deny the PA. Must request PA at least 5 calendar days before providing service for non-urgent PAs.

TX	Ins. Section 843.3483; Ins. Section 4201.151; Ins. Section 4201.356; Ins. Section 4201.357; 28 TAC Section 19.1730;	A health maintenance org. that uses a PA process that violates TX law, including failing to comply with applicable deadlines, must provide an expedited appeal for any health care service affected by the violation.			Physician licensed to practice medicine in TX and must follow standards developed and approved by health care providers.	At least 90% approval for a particular service during the most recent 6 mo. eval period. No more than one PA annually for Rx drugs for autoimmune diseases, hemophilia, or Von Willebrand disease.	If a provider requests within 10 days that a specialty provider reviews the claim, a provider with the same or similar applicable specialty shall complete a review within 15 days. Appeal process must include procedures for expedited appeals for denials of: emergency care, continued hospitalization, or another service with documentation from the requesting provider proving that the service is needed to prevent death or serious harm to the patient.
UT	Utah Code Annotated § 31A-22- 650; §§ 31A-22-613(4), 31A-22-613.5(2)(d), 31A-22-625(4), 31A-22-627, 31A-22-639		No retrospective denial if the enrollee is eligible for coverage under their insurance policy, their circumstances related to care haven't changed, the provider submits an accurate claim, and no fraudulent or incorrect information was given by the provider.		Currently licensed as a physician and surgeon in a U.S. state, district, or territory.		
VT	18 V.S.A. § 9418, 18 V.S.A. § 9418b, DFR Rule H-2009-03	Urgent: 24 hours Nonurgent: 2 business days with acknowledgement given within 24 hours	Only if the health plan has provided at least 30 days' notice, including the proposed adjustment and explanation of the adjustment. Must be within 12 months of payment of the previously paid claim unless fraud occurred, provider was already paid, services were not provided, or the claim is the subject of legal action.	Based on medical and scientific evidence, and should be updated periodically. "Medically necessary" means appropriate in type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. It must be informed by medical and scientific evidence.	Physician under a medical director responsible for treating the MCO's members except when denial is based on eligibility for coverage.	For treatments ordered by a primary care provider.	The grievance process must allow members at least 180 calendar days following receipt of an ABD notification to request a first level appeal and at least 90 calendar days for a second level appeal. Members can submit and view copies of information related to the grievance. Reviewers must not have any prior involvement with the grievance and shall include at least 1 clinical peer of the treating provider in deciding on an ABD that is based on a medical judgement.
VI	No Provision						

VA	VA Code § 38.2-3407.15 VA Code § 38.2-3407.15:2 14VAC 5-216-40 A, C,E 14VAC5-216-50	Urgent requests via telephone within 24 hours, including weekends. Otherwise, within 2 business days.	In an invasive procedure, if the provider discovers the need to perform a less or more extensive procedure than was authorized, which is medically necessary and not investigative in nature, the carrier will pay the claim.	Carrier shall designate a clinical peer reviewer for the appeal of any adverse benefit determination. The reviewer shall not have been involved in any previous determination with regard to the claim.	An appropriate person designated by the carrier. They shall not have made any previous ABD of the subject under appeal nor shall they defer to any prior ABD.	No PA for at least one drug prescribed for substance abuse treatment.	Each covered person is entitled to a full review of an ABD and may file an appeal orally or in writing within 180 days. Pre-service claims: 30 days Post-service claims: 60 days Urgent appeals/requests to extend: 72 hours (any needed add'l info should be requested within 24 hr) Notification of an urgent care ABD shall describe the appeal process. Carrier shall provide coverage pending the appeal of a review decision. Reductions or terminations of an approved course of treatment shall constitute an ABD.

WA	Wash. Rev. Code § 48.43.830; § 48.43.537; § 48.165.050 Wash. Admin. Code § 284-43-2050	Electronic Standard PA request: 3 calendar days Expedited request: 1 day Request for more info: 1 day Nonelectronic Standard request: 5 days Expedited request: 2 days Request for more info: 5 days		Detailed, easily understandable, based on evidence-based clinical review criteria, and accommodating to underserved populations. Criteria should be updated at least annually.	Licensed in Washington or a state with comparable standards and should have substantial, recent clinical experience with the same or similar health conditions.	No automatic denial when it is impossible for the provider to obtain PA before performing services or notify payor within 24 hours.	Carrier or its representative must allow specialists to request PA for diagnostic or lab service in advance.
WV	W. Va. Code Ann. §33-15-4s et.seq.	Initial Review in 2 days, Additional Information given 3 days, with a follow up of 2 days for final decision.		Inpatient prescriptions written at time of discharge no PA if not over $5000 per day. After three days a PA may be required.	If PA is rejected, the physician can then request for an appeal by a physician with same specialty, background, and education.	If a health care practitioner has performed 30 procedures in 6 mos w/90% approval received Gold Card for 6 mos.	Appeals shall take no longer than 5 business days. Appeal on a PA shall take no more than 10 days.
WI	Wis. Admin. Code § 632.855	For PA requests of experimental procedures, within 5 work. days.					
WY	W.S. 1977 § 26-55-101 et seq.	PA requirements and restrictions must be easily accessible and in detailed yet simple language within 24 hours of being requested by a provider.	Only at the end of a 12 mo. period if the provider would not have met the 90% authorization criteria.	After issuing an adverse determination, insurer must determine authorization of the service and schedule a discussion about its medical necessity within 5 business days of the provider's request.	Provider with knowledge in an applicable specialty, knowledge in the coverage criteria, a current and unrestricted license, and the patient's med history and diagnosis.	For opioid abuse medications or for the first 12 visits of rehab or habilitative services for a new condition or treatment.	Appealing provider must have sufficient knowledge in an applicable specialty, knowledge in the coverage criteria, and a current and unrestricted license; must not have been employed or contracted by the insurer or otherwise have a financial interest in the appeal's outcome; must not have been involved in the initial determination; and must have considered all clinical aspects of the service.

Agenda Item #4

Hear a Presentation from the National Committee for Quality Assurance (NCQA) on Updates to its 2026 Utilization Management (UM) Standards—*Alan Immelman (NCQA) and Kristine Toppe (NCQA)*

NCQA: Utilization Management and Prior Authorization

Kristine Thurston Toppe, VP of State Affairs
Alan Immelman, Deputy Director of State Affairs

Who We Are

For 35 years, NCQA has advanced transparency and accountability in health care through accreditation, certification, and performance measurement to improve the quality of health care for all.

Key Facts

- Founded in 1990
- Is an independent non-profit
- Offers more than 20 accreditation, certification and recognition programs.
- Has the most widely used performance measurement tool in health care (HEDIS®)

What We Do to Help Organizations

NCQA's key levers for improvement

Measure

Assess health care quality, promote transparency and guide performance improvement.

HEDIS, Quality Measurement Programs

Accredit

Evaluate organizations against standards for health care structures, processes and systems.

Health Plan Accreditation, Credentialing Accreditation & Certification, Utilization Management Accreditation

Recognize

Highlight providers and practices that deliver high-quality care by meeting performance criteria.

Patient-Centered Specialty Care, Diabetes, Heart/Stroke

Modernize

Digitally enable quality measurement that reduces administrative burden and produces real-time quality data.

Digital quality measures (dQM), Data Aggregator Validation, Digital Content Services

NCQA's Utilization Management Programs Suite

Reach of NCQA's program

Composition of NCQA's UM Requirements

Policies and Procedures for Prior Authorization

UM requirements include policies for prior authorization and medical necessity to ensure justified treatment decisions.

Timely Decision Making

Standards mandate specific timeframes for decisions and communication to provide prompt responses to UM requests.

Appeals and Grievance Process

UM includes appeals and grievance mechanisms allowing challenges to adverse determinations by patients and providers.

Qualified Clinical Staff Involvement

Qualified clinical staff are involved in UM decisions to ensure medical expertise in the review process.

NCQA UM Standards Guiding Principles

Patients are given access to clinically appropriate, equitable and timely care within the scope of their benefit design

Payers offer an efficient prior authorization process to enable optimal patient outcomes

The standards enable continuous quality improvement and burden reduction for physicians and patients

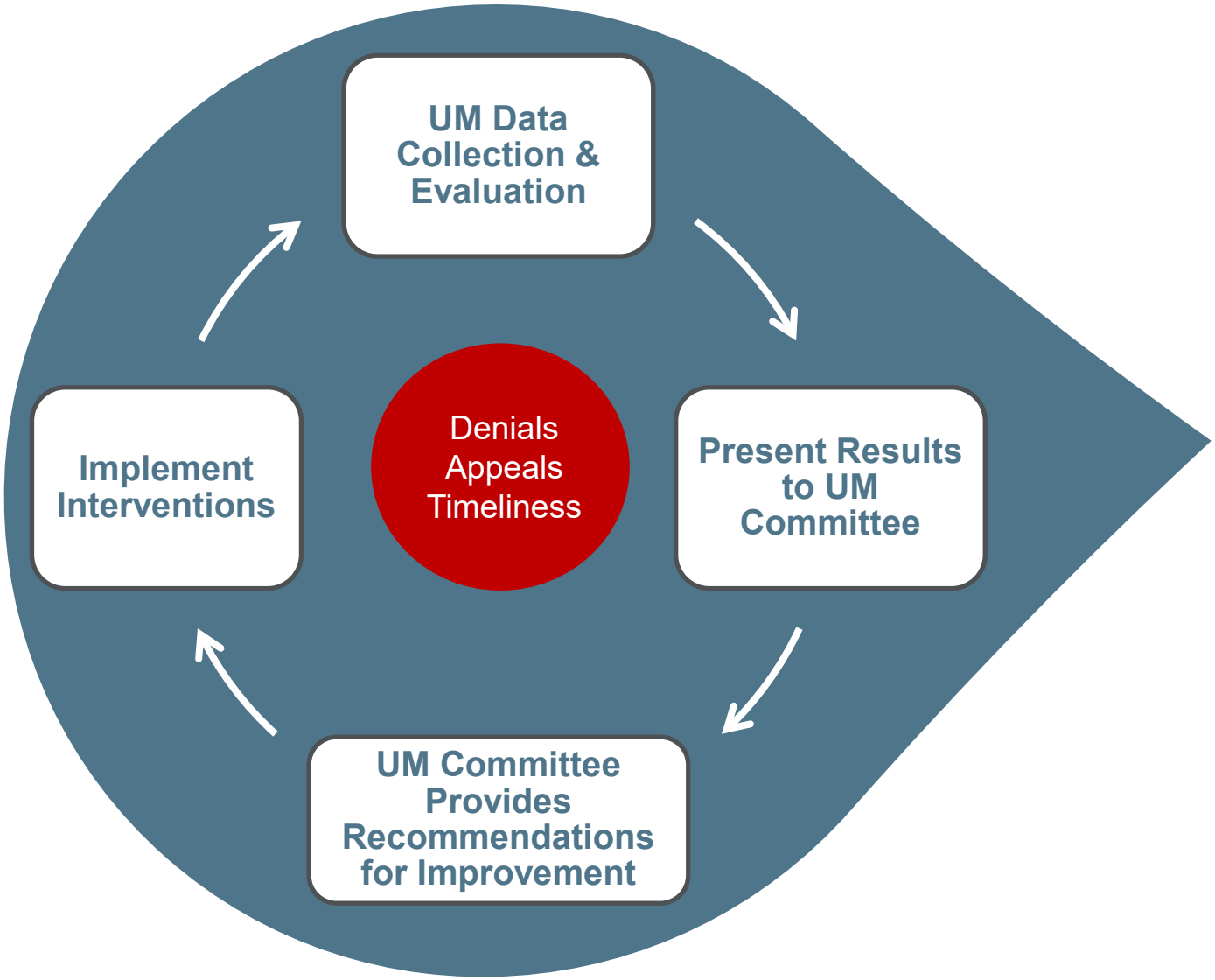
Updates at a Glance

Across UM, HPA and MBHO Accreditation

Key Standards & Updates	
UM Data Collection and Analysis	✓ ***Annually*** *collect* ***UM indicators*** *for improved decision making and identify areas that need improvement* ✓ *Identify* ***trends*** *in rates for continuous* ***quality*** *improvement*
UM Committee & Improvement Actions	✓ *The* ***UM Committee*** *provides* ***recommendations*** *based on data analysis of UM indicators* ✓ ***Annually*** *implement follow-up actions and interventions*
Measurement of Effectiveness	✓ *Organizations must evaluate the effectiveness of the interventions implemented*
UM Criteria	✓ *Make* ***UM criteria*** *available to practitioners at the* ***point of care***
Align with industry best practice	✓ *Update nonurgent request decision making from 14 to 7 calendar days for all lines of business across non-BH, BH, and pharmacy.*

Data Driven Quality Improvement

A Framework to Actively Build Trust, Accountability and Transparency



These activities collectively…

- **Build Trust with Providers:** Focusing on provider perception positions the health plan as a valuable partner.
- **Build Trust with Members***:* Leveraging data to prioritize member experience improves satisfaction and reputation.
- **Mitigate Risk:** Identifying issues helps prevent legal disputes and adverse health outcomes.
- **Facilitate Process Improvement:** Clear metrics create a foundation for quality, leading to systemic improvements over time.
- **Strengthen Internal Benchmarking:** Standardizing data structures and breaking down silos improve benchmarking.
- **Demonstrate Value:** Showcasing the clinical value of UM and commitment to quality care.

NCQA

UM Rates: Non-Behavioral, Behavioral, and Pharmacy

For requests requiring authorization, the organization annually reports:	
1.	Overall approval rate.
2.	Overall denial rate.
3.	Overall timeliness of notification rate for denials.
4.	Timeliness of notification rate for urgent concurrent denials.
5.	Timeliness of notification rate for urgent preservice denials.
6.	Timeliness of notification rate for non-urgent preservice denials.
7.	Timeliness of notification rate for post-service denials.

Take Note

- NCQA reviews evidence submitted but does not score performance based on the rates.
- NCQA does not publicly report the information.

**NCQA is collecting the same data as outlined in NAIC's Draft Prior Authorization White Paper.*

UM Rates: Appeals

The organization annually reports:	
1.	Overall appeal rate.
2.	Appeal overturn rate.

- NCQA reviews evidence of how often appeals are overturned.
- NCQA does not publicly report the information.

Non-NCQA Accredited Delegate Review

For delegation arrangements that have been in effect for more than 12 months with non-NCQA Accredited organizations, the organization:	
1.	Completes an annual audit for each delegate.
2.	Identifies corrective actions, as applicable.
3.	Implements, or plans to implement, corrective actions, as applicable.

Questions


NCQA
Thank you

Agenda Item #5

Receive a Status Report on the ERISA (B) Working Group's Work to Develop Guidance on Pharmacy Benefit Manager (PBM) ERISA Issues and Develop Guidance on Level-Funded Plans and Other Alternative Arrangements as Related to the Small Group Market
—Robert Wake (ME)

Agenda Item #6

Discuss Any Other Matters Brought Before the Task Force
—Commissioner Grace Arnold (MN)