Revised date: 8/4/25

2025 Summer National Meeting
Minneapolis, Minnesota

REGULATORY FRAMEWORK (B) TASK FORCE
Tuesday, August 12, 2025
12:00 – 1:00 p.m.
Hilton Minneapolis—Grand Ballroom D—Level 3

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
Andrew N. Mais	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 VanAalst	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. Hear Opening Remarks—*Commissioner Grace Arnold (MN)*

2. Consider Adoption of its Spring National Meeting Minutes
   —*Commissioner Grace Arnold (MN)*

3. 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 (ME)*
   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)*

4. Hear an Update on Health Plans' Commitment to Streamlining and Simplifying Prior Authorization—*Jeanette Thornton (AHIP) and Monica Auciello (BlueCross and BlueShield Association—BCBSA)*

5. Hear a Discussion on the Federal Deregulation Initiative
   —*Katie Keith (Center for Health Policy and the Law at the O'Neill Institute, Georgetown Law) and Brian Blase (Paragon Health Institute)*

6. Hear an Update on Work to Develop a Prior Authorization Framework White Paper—*Commissioner Grace Arnold (MN)*

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

8. Adjournment

Agenda Item #1

Hear Opening Remarks—*Commissioner Grace Arnold (MN)*

Agenda Item #2

Consider Adoption of its Spring National Meeting Minutes
—Commissioner Grace Arnold (MN)

Draft Pending Adoption

Draft: 3/31/25

Regulatory Framework (B) Task Force
Indianapolis, Indiana
March 25, 2025

The Regulatory Framework (B) Task Force met in Indianapolis, IN, March 25, 2025. The following Task Force members participated: Grace Arnold, Chair (MN); Allan L. McVey, Vice Chair, represented by Joylynn Fix (WV); Lori K. Wing-Heier represented by Sarah Bailey (AK); Peter M. Fuimaono (AS); Barbara D. Richardson 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 Sheryl Parker (FL); Doug Ommen represented by Andria Seip (IA); Dean L. Cameron represented by Weston Trexler (ID); Holly W. Lambert represented by Meggan Brumbaugh (IN); Vicki Schmidt represented by Julie Holmes (KS); Sharon P. Clark represented by Shaun Orme (KY); Michael T. Caljouw represented by Kevin P. Beagan (MA); Robert L. Carey represented by Marti Hooper (ME); Angela L. Nelson represented by Jo A. LeDuc and Amy Hoyt (MO); Mike Causey represented by Robert Croom (NC); Jon Godfread represented by Chrystal Bartuska (ND); Eric Dunning represented by Martin Swanson (NE); Scott Kipper represented by Alexia Emmermann (NV); Judith L. French represented by Laura Miller (OH); Glen Mulready represented by Ashley Scott (OK); Andrew R. Stolfi represented by Alex Cheng (OR); Michael Humphreys (PA); Larry D. Deiter represented by Jill Kruger (SD); Cassie Brown represented by Randall Evans (TX); Jon Pike represented by Tanji J. Northrup (UT); Scott A. White represented by Julie Blauvelt (VA); Patty Kuderer represented by Jane Beyer (WA); and Nathan Houdek represented by Rebecca Rebholz (WI).

1. Adopted its March 10, 2025; Feb. 28, 2025; and 2024 Fall National Meeting Minutes

The Task Force met March 10 and Feb. 28. During these meetings, the Task Force took the following action: 1) jointly adopted with the Health Insurance and Managed Care (B) Committee a motion to rename the Pharmaceutical Benefit Management Regulatory Issues (B) Working Group to the Prescription Drug Coverage (B) Working Group; and 2) adopted 2025 revised charges for the Prescription Drug Coverage (B) Working Group reflecting the Working Group's new name and its focus on prescription drug coverage issues and the recently established Pharmacy Benefit Management (D) Working Group focusing on pharmacy benefit management enforcement.

Swanson made a motion, seconded by Trexler, to adopt the Task Force's March 10, 2025 (Attachment One) minutes; Feb. 28, 2025 (*see NAIC Proceedings – Spring 2025, Health Insurance and Managed Care (B) Committee, Attachment One)*, minutes; and Nov. 17, 2024 *(see NAIC Proceedings – Fall 2024, Regulatory Framework (B) Task Force)* minutes. The motion passed unanimously.

2. Adopted its Working Group Reports

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

3. Heard a Summary of State PA Laws and Presentations on PA from the Provider, Patient and Consumer, and Insurer Perspectives

Commissioner Arnold said the Task Force has been tasked with developing a white paper on prior authorization (PA) arrangements. She said that given this, the Task Force decided to jump-start that work by having its meeting

at the Spring National Meeting focus on the PA issue, starting with an overview of state PA laws and then hearing presentations on the issue from the provider, consumer and patient, and insurer perspectives.

Olivea Myers (NAIC) said the NAIC Research Library and the NAIC Legal Division jointly searched state PA laws and compiled them into a chart included in the Task Force's meeting materials. She said state laws regulating PA fall into several categories, including response times, retrospective denials, clinical criteria, medical necessity, reviewer qualifications, gold carding, and peer-to-peer/appeal process. Myers also discussed state bulletins on PA. She highlighted existing research on the impact of PA reform, such as the federal Centers for Medicare & Medicaid Services (CMS) estimate that $15 billion in savings is due to the implementation of electronic PA (ePA) requirements.

Heather McComas (American Medical Association—AMA) discussed the impact of PA on stakeholders from a physician's perspective. She described AMA member survey responses indicating that PA harms patients. She said 29% of physicians reported that PA has led to a serious adverse event for a patient in their care. She said PA also wastes practice and health care resources. McComas highlighted potential solutions to solve identified problems with the PA process, such as: 1) requiring faster response times; 2) reducing the need for PA for care with high approval rates; and 3) preventing repeated PA requests for already approved treatment. She discussed current PA state and federal reform efforts seeking to implement some of these potential solutions. McComas discussed opportunities for state insurance regulators to address issues with PA, such as: 1) implementing state legislation; 2) enforcing existing laws; 3) pursuing additional data collection; and 4) monitoring and evaluating the impact of the use of artificial intelligence (AI) in PA on patients.

Carl Schmid (HIV+Hepatitis Policy Institute) and Lucy Culp (The Leukemia & Lymphoma Society—LLS) discussed the impact of PA from a patient and consumer perspective. Schmid said consumers and patients impacted by prioritization are frustrated. He said they are having a lot of difficulty and frustration in accessing covered health care services and prescription drugs that they or their employer have paid for in their premiums. Schmid discussed several research studies tracking claim denials and appeals and how difficult it is for consumers to appeal claim denials. He discussed the claim denial rates compiled by HealthCare.gov issuers by state for 2023, noting that the highest percentage of denials did not provide a specific reason for the denial. Schmid also discussed recently enacted state PA laws and states considering passing new PA laws. He also discussed how insurers, such as Blue Cross Blue Shield of Michigan, Cigna, and UnitedHealthcare, are seeking to reduce PA. The federal government has also implemented changes to PA that impact state reform efforts, such as the federal CMS Prior Authorization and Interoperability Final Rule and the federal CMS 2024 Medicare Advantage and Part D Final Rule. Schmid also discussed suggestions for increased transparency of the NAIC Market Conduct Annual Statement (MCAS) health data, such as sharing the full MCAS health data with all stakeholders, not just state insurance regulators.

Culp discussed the NAIC consumer representatives' recommendations for the Task Force as it begins work on the PA white paper. She suggested that the Task Force first identify the challenges that consumers are facing and the policies that states are implementing to solve them. She said the Task Force could identify and include best practices other states could adopt in the white paper. Culp discussed a few challenges consumers face with PA, including misaligned PA criteria. She said such misalignment can be seen in several forms, from excessive and mid-course treatment PA requirements to repeated PA requirements for people with chronic conditions who are stable on the already approved treatment. Culp discussed the implications of such misalignment, including treatment delays or the inability to receive treatment altogether. She also noted that using AI for utilization management creates unique challenges and numerous risks to consumers concerning improper denials, data accuracy, quality testing, governance, and transparency. Culp acknowledged the work happening in the states related to PA reform. She said she anticipates there will be a lot of opportunities for the states to learn from each other and other stakeholders as the Task Force works through the white paper drafting process.

Amanda Motter (America's Health Insurance Plans—AHIP) and Danielle Lloyd (AHIP) discussed the PA issue from an insurer perspective. Motter said PA provides a vital check and balance to ensure patients receive safe, evidence-based care and to reduce low-value and inappropriate services so that coverage is as affordable as possible. She said low-value care significantly impacts the U.S. healthcare system, and more importantly, low-value care impacts patients by exposing them to harm and additional out-of-pocket healthcare costs. Motter said the U.S. spends more on healthcare than any other country in the world, and many experts agree that up to 25% of care is wasteful at best and harmful at worst. She described AHIP's work with physicians and other stakeholders to address this issue. Motter said health plans, doctors, and hospitals all need to work together to reduce the amount of low-value care and protect patients from unnecessary, potentially harmful care and those costs.

Motter explained that health plans use PA selectively and are working to improve the process. She identified efforts health plans are taking to improve PA, including: 1) selective use; 2) ensuring it is evidence-based; 3) utilizing ePA; and 4) waiving or reducing PA for providers with a track record. Lloyd discussed how ePA is improving the process, but there are still challenges with its use and opportunities for improvement. She detailed how ePA is being used and will be required to be used by certain payers by Jan. 1, 2027, as required under the federal CMS Prior Authorization and Interoperability Final Rule. Lloyd also discussed how AI could further streamline and simplify ePA.

Commissioner Arnold asked if there were questions for the presenters. Commissioner Humphreys discussed the work that Pennsylvania has done with respect to PA reform. He asked McComas if the AMA has determined what types of procedures are appropriate for PA. McComas said she would have to check with her colleagues and follow up with him. She noted, however, that right-sizing PA is the key rather than requiring PA for all procedures or eliminating PA altogether. She said there needs to be a sensible approach to its use.

Commissioner Arnold said NAIC staff have already solicited interest from Task Force members and interested regulators to serve on the drafting group that will develop an initial white paper draft. She said that if any Task Force members are interested but have not yet volunteered, they should reach out to her, Fix, or NAIC staff.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/RFTF/National Meetings/2025 Spring National Meeting/RFTF 3-25-25 MtgMin.docx

Agenda Item #3

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)*

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Minneapolis, Minnesota

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) (B) WORKING GROUP
Tuesday, August 12, 2025
10:00 – 11:00 a.m.

Meeting Summary Report

The Employee Retirement Income Security Act (ERISA) (B) Working Group met Aug. 12, 2025. During this meeting, the Working Group:

1. Heard an update on ERISA preemption of pharmacy benefit manager (PBM) laws.

2. Heard a presentation on level-funded plans from the National Association of Benefits and Insurance Professionals (NABIP).

2025 Summer National Meeting
Minneapolis, Minnesota

PRESCRIPTION DRUG COVERAGE (B) WORKING GROUP
Monday, August 11, 2025
11:30 a.m. – 12:30 p.m.

Meeting Summary Report

The Prescription Drug Coverage (B) Working Group met Aug. 11, 2025. During this meeting, the Working Group:

1. Adopted its Spring National Meeting minutes.

2. Adopted its May 19 minutes. During this meeting, the Working Group took the following action:
   A. Heard presentations from AHIP, the HIV+Hepatitis Policy Institute, and The AIDS Institute on copay accumulators.

3. Heard presentations from the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Cystic Fibrosis Foundation (CFF) on alternative funding programs (AFPs). The PhRMA presentation highlighted the differences between AFPs and other types of prescription drug patient assistance programs, such as accumulator adjustment programs and copay maximizer programs, and how such differences negatively impact consumers. The PhRMA presentation also discussed the hidden impacts of AFPs and how the states are beginning to address them, with two states recently banning them. The CFF presentation discussed APFs, their relationship with international drug importation, and consumer experience with navigating APFs—particularly consumers needing specialty drugs, such as those with cystic fibrosis. The CFF presentation also highlighted the potential for consumers to be at risk for unregulated importation and discussed how state insurance regulators and other state policymakers can address this issue.

Agenda Item #4

Hear an Update on Health Plans' Commitment to Streamlining and Simplifying Prior Authorization—*Jeanette Thornton (AHIP) and Monica Auciello (BlueCross and BlueShield Association—BCBSA)*

Voluntary Plan Commitments Have Positive Member and Provider Impact

BlueCross BlueShield Association | AHIP

Solution	Reduce Scope	Reduce Time	Increase Transparency	Lower Member Burden	Lower Provider Burden
Standardizing Electronic Prior Authorization		☑	☑		☑
Reducing the Scope of Claims Subject to PA	☑			☑	☑
Ensuring Continuity of Care When Patients Change Plans				☑	☑
Enhancing Communication and Transparency on Determinations			☑	☑	
Expanding Real-Time Responses		☑			☑
Ensuring Medical Review of Non-Approved Requests			☑		

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BlueCross BlueShield Association

AHIP

August 12, 2025

July 8, 2025

National Health Law Program: Voluntary Industry Prior Authorization Commitments: Empty Promises, Little Accountability

AHIP, the national trade association representing the health insurance industry, and the Blue Cross Blue Shield Association recently announced a set of "voluntary commitments" to "streamline" prior authorization and "improve patient outcomes." Major insurers including Aetna, Centene, Cigna, Elevance Health, Humana, and UnitedHealthcare have signed on.

These commitments appear to put more guardrails on how insurers use prior authorization. In reality, they largely repeat existing obligations and may simply be a strategic attempt to deflect growing public criticism of insurers' abuse of prior authorization to deny or delay care.

These commitments were developed during a roundtable hosted by Dr. Mehmet Oz. Notably, it's unclear whether any consumers, consumer groups, or provider associations participated in shaping them. Any lack of broad stakeholder representation raises concerns about whether the commitments reflect the interests of the people most affected by prior authorization policies.

AHIP also released a policy brief to accompany the announcement, reasserting the importance of prior authorization as a tool for reducing "unnecessary" health care spending and as a "critical safeguard in patient care." Yet, a large and growing body of research shows that prior authorization is a primary way insurers control costs while tripping up beneficiaries in red tape. This misrepresentation of harm calls into question the credibility of the initiative as whole.

Against that backdrop, a closer look at the commitments reveals that several simply echo the existing requirements already baked into federal regulation, including in the CMS Interoperability and Prior Authorization Rule ("Rule") finalized in January 2024. For example, the pledge to adopt FHIR-based technology for electronic submission by January 1, 2027, is not new. That deadline is already mandated under the Rule for many plans. Likewise, the promise to improve transparency by explaining denials in plain language and providing appeal guidance simply restates baseline requirements found in the Rule and required by the Affordable Care Act.

While some commitments mirror existing requirements that lend a degree of accountability (if enforced), other so-called "new" commitments totally lack meaningful oversight or accountability, relying entirely on voluntary compliance. For example, the pledge to reduce prior authorization volume by 2026 only "as appropriate" for each plan's local market lets insurers set their own goals without standards, oversight, or consequences. These kinds of statements may sound patient-centered, but are meaningless without regulatory oversight. Another commitment – to have clinicians review denials – is already described by AHIP as an industry-wide "existing norm." Even if that is true, there is no standard requiring plans to disclose who is making

decisions, leaving consumers in the dark and unable to know whether the promise is actually being followed.

These same corporations made similar promises in 2018 and again in 2023. At the time, they vowed to reduce prior authorization and increase transparency. But without any enforcement, those promises went nowhere and the volume of prior authorization increased.

Other commitments are more limited than they appear. The pledge to honor existing authorizations for 90 days when a member switches plans only applies if the person has already started the approved course of treatment and only if the benefit is covered and provider is in-network under the new plan. That's far from a robust continuity of care guarantee.

The commitment to process 80% of prior authorization requests in "real time" by 2027 also raises concerns. It lacks a clear definition of "real time" and creates incentives for speed over careful, individualized review. In practice, efforts to accelerate processing often rely on overworked clinicians or algorithmic tools that cut corners. A former Cigna medical director, for example, said that she and other doctors were pressured to rush through claim reviews without fully examining patient records. Her superiors were "more concerned about being fast than being right." We have already seen how automation and AI tools can contribute to opaque, inconsistent, and clinically inappropriate denials. AHIP claims AI isn't used to deny care without clinician input, but mounting evidence shows otherwise. Without meaningful guardrails, transparency, or independent oversight, this pledge risks increased reliance on the very technologies that have undermined trust in prior authorization.

Ultimately, this voluntary framework follows the same playbook and seems more focused on protecting insurers than helping patients. HHS praised the "flexibility" of the initiative, framing it as a balanced approach to reducing burden while maintaining care quality. HHS and Dr. Oz "applaud[ed] these voluntary actions by the private sector," noting that this "is how these types of issues should be solved." This framing misses the point. We don't need more flexibility for insurers. We need enforceable rules – real tools like auditing, independent oversight, external medical reviews, and public reporting requirements – and penalties for noncompliance when delays or denials cause harm. Otherwise, all we have are toothless commitments. Empty promises with no bite.

July 1, 2025

NAIC President Jon Godfread
North Dakota Insurance Commissioner
1101 K Street, N.W., Suite 650
Washington, DC 20005

Dear Commissioner Godfread,

On behalf of AHIP and BCBSA, we are pleased to share with you a series of commitments health plans recently announced to streamline and simplify prior authorization. Our mission is to advance our members' health and ensure that health care resources are used appropriately. Prior authorization is a critical safeguard to confirm that treatments and services our members receive are covered, evidence-based and not redundant, advancing our mission to ensure that every health care dollar is spent wisely.

Building on health plans' existing efforts, these improvements to prior authorization are focused on connecting patients more quickly to the care they need while minimizing administrative burdens on providers.

These commitments are being implemented across insurance markets, including for those with Commercial coverage, Medicare Advantage and Medicaid managed care consistent with state and federal regulations, and will benefit the vast majority of covered Americans.

For patients, these commitments will result in faster, more direct access to appropriate treatments and medical services with fewer challenges navigating the health system. For providers, these commitments will streamline prior authorization workflows, allowing for a more efficient and transparent process overall, while ensuring evidence-based care for their patients.

We all know that the health care system remains fragmented and burdened by outdated manual processes, resulting in frustration for patients and providers alike. The prior authorization process can cause friction, which is why health plans are making voluntary commitments to deliver a more seamless patient experience and enable providers to focus on patient care, while also helping to modernize the system.

Participating health plans commit to:

- **Standardizing Electronic Prior Authorization.** Participating health plans will work toward implementing common, transparent submissions for electronic prior authorization. This commitment includes the development of standardized data and submission requirements (using FHIR® APIs) that will support seamless, streamlined processes and

faster turn-around times. The goal is for the new framework to be operational and available to plans and providers by January 1, 2027.

- **Reducing the Scope of Claims Subject to Prior Authorization.** Individual plans will commit to specific reductions to medical prior authorization as appropriate for the local market each plan serves, with demonstrated reductions by January 1, 2026.
- **Ensuring Continuity of Care When Patients Change Plans.** Beginning January 1, 2026, when a patient changes insurance companies during a course of treatment, the new plan will honor existing prior authorizations for benefit-equivalent in-network services as part of a 90-day transition period. This action is designed to help patients avoid delays and maintain continuity of care during insurance transitions.
- **Enhancing Communication and Transparency on Determinations.** Health plans will provide clear, easy-to-understand explanations of prior authorization determinations, including support for appeals and guidance on next steps. These changes will be operational for fully insured and commercial coverage by January 1, 2026, with a focus on supporting regulatory changes for expansion to additional coverage types.
- **Expanding Real-Time Responses.** In 2027, at least 80 percent of electronic prior authorization approvals (with all needed clinical documentation) will be answered in real-time. This commitment includes adoption of FHIR® APIs across all markets to further accelerate real-time responses.
- **Ensuring Medical Review of Non-Approved Requests.** Participating health plans affirm that all non-approved requests based on clinical reasons will continue to be reviewed by medical professionals – a standard already in place. This commitment is in effect now.

Plan progress will be tracked and reported. A full list of participating health plans and additional information are available here.

If you or your team would like to learn more about this broad industry initiative, please do not hesitate to reach out to either one of us.

Sincerely,

Mike Tuffin
President and CEO, AHIP

Kim A. Keck
President and CEO, BCBSA

Improving Prior Authorization for Patients & Providers

Prior Authorization – A Critical Safeguard in Patient Care

Addressing the cost of health care is a top priority for Americans. Recent surveys reinforce that the overwhelming majority of Americans view health care affordability as a significant problem facing the country.[1] There is also broad recognition that a significant portion of U.S. health care spending is inefficient or of low value. An estimated 25% of health care spending is considered unnecessary due to overtreatment, use of low-value care, lack of care coordination, outdated technology and fraud.[2]

Variation in provider practice often contributes to instances in which care deviates from evidence-based guidelines and recommendations. While the majority of physicians follow the appropriate and evidence-based standards of care, as defined by their respective specialty societies, a number of physicians do not.[3]

Prior authorization is an important safeguard used by both public and private payers to ensure patient care follows clinical guidelines. It helps reduce patients' exposure to low-value, unsafe or inappropriate care by making sure services and/or prescriptions align with the latest research and guidelines for effectiveness. This leads to better health outcomes for patients.

At the same time, health plans recognize patients are often frustrated when their prescription medications or doctor-recommended procedures are not promptly approved or are denied following prior authorization review. Health plans are voluntarily taking steps to improve prior authorization for patients and providers by:

- Standardizing electronic prior authorization;
- Reducing the scope of claims subject to prior authorization;
- Ensuring continuity of care on benefit-equivalent prior authorizations when patients switch health plans;
- Enhancing communication and transparency on prior authorization determinations;
- Expanding near real-time response on prior authorization requests submitted electronically; and
- Ensuring continued medical review of non-approved requests.

An estimated 25%

of health care spending is considered unnecessary due to overtreatment, use of low-value care, lack of care coordination, outdated technology and fraud.[2]

1 https://www.pewresearch.org/politics/2024/05/23/top-problems-facing-the-u-s/
2 https://jamanetwork.com/journals/jama/article-abstract/2752664#
3 https://ahiporg-production.s3.amazonaws.com/documents/AHIP_AppropriatenessMeasures_2022.pdf

In a 2024 survey of AHIP's members, health plans reported that the vast majority of Commercial claims – 96% of prescription drug claims and 93% of medical claims – are not subject to prior authorization.

Use of Prior Authorization

When developing prior authorization, health plans follow the clinical standards established by leading medical organizations and supported by peer-reviewed research. Medical professionals employed by health plans and with expertise in specific areas of medicine, such as cardiology, oncology or psychiatry, are central to developing the prior authorization requirements.

Importantly, prior authorization is only selectively used. In a 2024 survey of AHIP's members, health plans reported that the vast majority of Commercial claims – 96% of prescription drug claims and 93% of medical claims – are not subject to prior authorization.

Prior authorization serves as an important patient safety check, helping to prevent dangerous drug interactions and inappropriate use of certain treatments. In these instances, prior authorization acts as a guardrail to ensure medications and/or treatments are not used in a manner inconsistent with established medical guidelines. Or, when appropriate alternatives are available, prior authorization can ensure patients have the option to obtain affordable alternatives that are consistent with evidence-based guidelines, such as generic medicines.

Benefits of Electronic Prior Authorization

Electronic prior authorization offers significant benefits to the health care system by streamlining the traditionally manual and time-consuming process of obtaining prior approvals for medications and services. Electronic prior authorization reduces administrative burden for providers, accelerates patient access to necessary treatments and minimizes delays in care.

Health plans have recognized these advantages and continue to invest in the infrastructure needed to drive adoption. These investments include integrating electronic prior authorization capabilities into electronic health record (EHR) systems, partnering with technology vendors and providing training and incentives for providers. Such efforts not only improve operational efficiency but also enhance the overall patient experience by ensuring timely and appropriate care delivery.

To ensure electronic prior authorization works effectively end-to-end, hospitals and doctors must also invest in modern electronic systems and operations. According to AHIP's 2024 survey, nearly half of prior authorization requests for medical services (45%) and prescription drugs (47%) are currently submitted by providers manually, using phone, fax or traditional mail.

Without the greater use of modern technologies, continued reliance on manual processes negate the efficiencies electronic prior authorization is designed to deliver. A coordinated effort from both health plans and providers is essential to fully streamline the prior authorization process and improve patient outcomes.

Prior Authorization: A Critical Safeguard in Patient Care

Improves Health Care Outcomes

Reduces Patient Costs

Developed By Medical Professionals

Based on Evidence-Based Clinical Standards

Prior Authorization Reduces Exposure to Low-Value Care

Instead of an expensive CT scan for abdominal pain, which can expose patients to unnecessary radiation and higher costs, prior authorization can direct a patient to a more affordable ultrasound as a better first line of diagnosis, consistent with evidence-based medical guidelines.

Instead of inpatient treatments for joint procedures requiring extended hospital stays, prior authorization can direct a patient to outpatient treatment resulting in the same or better health outcomes and lower costs for patients.

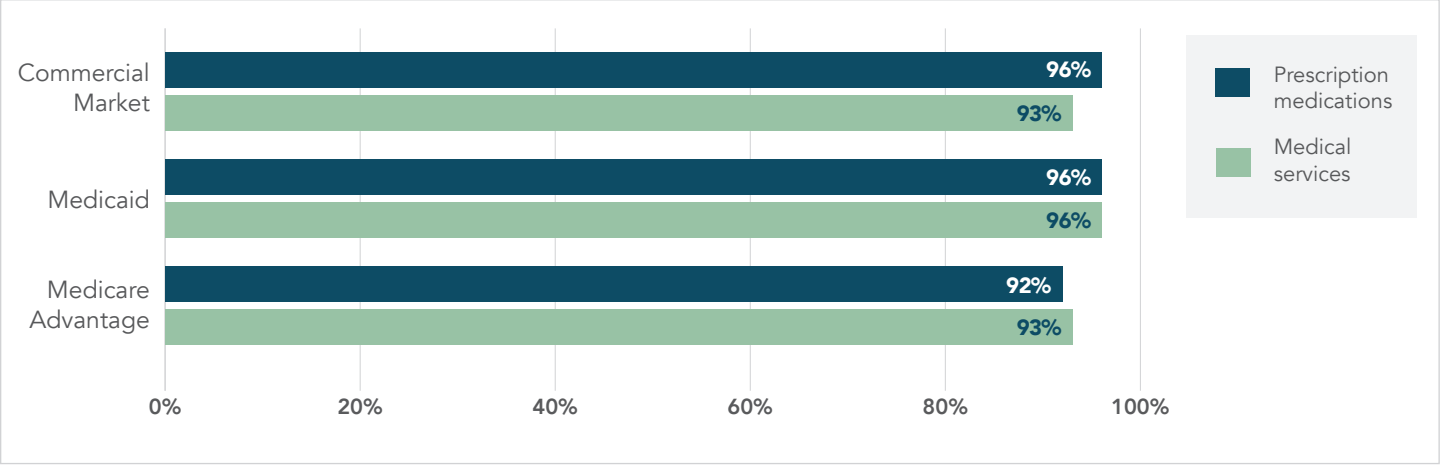
AHIP Survey on Prior Authorization in the Commercial Market, Medicaid, and Medicare Advantage Programs

AHIP conducted a survey of its member companies in October 2024. The survey asked respondents to provide information on the prior authorization processes used in the Commercial, Medicaid, and Medicare Advantage markets. For the Commercial market, 32 health plans responded, representing 109 million lives or 51% of national Commercial market enrollment. For Medicaid, 21 health plans responded, representing 53% of Medicaid managed care enrollment. For Medicare Advantage, 21 health plans responded, representing 42% of MA enrollment.

AHIP's survey found:

- Prior authorization is **evidence-based**. Health plans develop prior authorization programs based on clinical literature, professional treatment guidelines and other evidence-based resources on safety, efficacy and quality.
- Prior authorization relies on and incorporates **provider input**, including Pharmacy and Therapeutics (P&T) committees, utilization management committees and clinical experts.
- The **vast majority of medical services** are not subject to prior authorization review.
  - In the Commercial market, approximately **96% of prescription medication claims** and **93% of medical service claims** are not subject to prior authorization review.
  - For Medicaid, **96% of prescription medication claims** and **96% of medical service claims** are not subject to prior authorization review.
  - For Medicare Advantage, **92% of prescription medication claims** and **93% of medical service claims** are not subject to prior authorization review.

Figure 1: Portion of Claims Not Subject to Prior Authorization Review

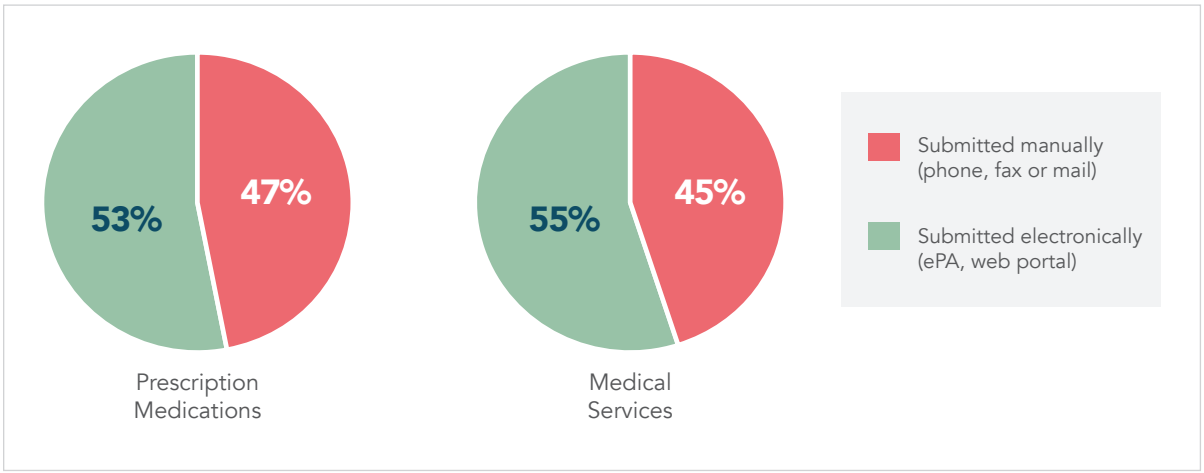


- The **vast majority of prior authorization requests are approved** following final review.
  - In the Commercial market, approximately **90% of prescription medications** and **97% of medical services** are approved.
  - For Medicaid, approximately **91% of prescription medications** and **97% of medical services** are approved.
  - For Medicare Advantage, approximately **90% of prescription medications** and **98% of medical services** are approved.
  - Approximately **20% of prior authorizations** for medical services are **approved in real-time.**
- Today, **almost half of prior authorization requests are submitted manually by phone, fax or mail**. On average, 47% of requests for prescription medications and 45% of requests for medical services are submitted manually.

All responding health plans reported that AI is not used to deny prior authorization requests that involve medical necessity or clinical considerations.

- Cases in which prior authorization requests are initially denied in the Commercial market, Medicaid, and Medicare Advantage, are often a result of incomplete information from providers. Ultimately, most prior authorization requests are approved, with average final denial rates for Commercial plans of only **3% for medical services and 10% for prescription medicines.**
- All responding health plans (100%) reported that **AI or algorithms without clinician or practitioner review are not used to deny prior authorization requests** that involve medical necessity or clinical considerations.

Figure 2: Portion of Prior Authorization Requests Submitted Manually vs. Electronically



Health Plan Commitments to Improve Prior Authorization

In an effort to improve the overall experience for patients and providers, participating health plans have voluntarily committed to a set of reforms aimed at increasing transparency, reducing administrative burden and accelerating access to care. These commitments represent important steps forward and allow for flexibility in order for health plans and providers to implement each one successfully. The commitments outline a shared vision among health plans to streamline prior authorization, support faster and fully integrated electronic processing and strengthen communication and engagement with patients and providers. To view the list of participating health plans, visit www.ahip.org.

1. Standardizing Electronic Prior Authorization

Greater standardization and harmonization of the clinical data utilized to process prior authorization requests has the potential to benefit patients and providers by achieving greater consistency and clarity on the criteria and data elements and reducing variability. Health plans are exploring opportunities for greater standardization. The goal is for the new framework to be operational and available to plans and providers by January 1, 2027.

Commitment: Signatory Plans will work toward the development and implementation of common, transparent submissions for electronic prior authorization. This commitment includes the development of standardized data and submission elements (using FHIR® APIs) that will support seamless, streamlined processes and faster turn-around times.

2. Reducing the Scope of Claims Subject to Prior Authorization

To ensure prior authorization continues to be applied to services most prone to variation, health plans providing fully insured, ACA marketplace and Medicare Advantage coverage commit to specific specific reductions to prior authorization as appropriate for the local market each health plan serves, with demonstrated reductions by January 1, 2026. This commitment is consistent with health plans' ongoing efforts to regularly review and adjust their prior authorization lists based on current data and their enrollees' needs.

Commitment: Signatory Plans providing fully insured, ACA marketplace coverage and Medicare Advantage coverage commit that they will individually reduce the volume of in-network medical prior authorizations by January 1, 2026. Signatory Plans further commit that they will provide data to allow industry reporting of the extent of such reductions reflecting actions taken since January 2024.

3. Ensuring Continuity of Care When Patients Change Health Plans

Continuity of patient care is essential, particularly for patients undergoing an active course of treatment or who have a chronic condition. When a patient has been approved for a particular item, service or medication and then switches health plans, honoring the previous health plan's authorization for a specified period of time, provided that item, service or medication is a covered benefit under the new health plan with an in-network provider, will help smooth the care transition for patients.

Commitment: By January 1, 2026, Signatory Plans commit to support continuity of care by honoring a previous health plan's prior authorization for the same service, under the same type of benefit in network for a 90-day transition period when a member changes health plans after starting a course of treatment.

4. Enhancing Communication and Transparency on Determinations

Health plans continue to improve the readability of their member communications, which are often dictated by specific state and federal requirements. In cases for which a request for a prior authorization is not approved, notices and letters must be easy to understand and clearly explain available next steps for assistance, including simple instructions for how to appeal the decision. To ensure all communications are actionable, Signatory Plans commit to a meaningful improvement of these communications. Existing member support services will provide specific assistance designed to help members navigate the prior authorization process.

These commitments include providing simple explanations and easy-to-access assistance for prior authorization determinations, including clear information about next steps and support for appeals processes if needed.

Commitment: By January 1, 2026, for fully insured and self-insured Commercial coverage and ACA marketplace coverage, Signatory Plans commit to explaining with clear and personalized language about any prior authorization denials, including information about next steps and available appeals processes. Signatory Plans also will explore seeking regulatory changes to facilitate expansion of this commitment. Signatory Plans serving Medicare Advantage beneficiaries will work with CMS to improve existing mandatory member communications on prior authorization denials and appeals.

Commitment: By January 1, 2026, for fully insured and self-insured Commercial coverage and ACA marketplace coverage, Signatory Plans commit to providing staff to help members understand the prior authorization process and their options after a prior authorization determination is made.

5. Expanding Real-Time Responses

Health plans continue to make significant investments in capabilities that enable real-time or near real-time prior authorizations – as have many providers. Today, millions of electronic prior authorizations are approved in real-time or near real-time (i.e., within minutes). To speed approvals for patients and providers and to encourage broader provider adoption of electronic prior authorization, Signatory Plans commit to meaningful acceleration of these capabilities. Adoption of new technical standards (FHIR® APIs) by health plans and providers will accelerate real-time responses.

Commitment: Signatory Plans commit to an acceleration of the percentage of prior authorization requests for medical services answered in real-time if submitted electronically by providers with all necessary clinical documentation. By 2027, for all coverage types at least 80% of prior authorization approvals will be answered in real-time.

Commitment: While existing regulations require new technical standards for electronic prior authorization for certain health plans in federal programs beginning January 1, 2027, health plans subject to these forthcoming rules will support these standards (FHIR® APIs) for all lines of business.

6. Ensuring Medical Review of Non-Approved Requests

AI automation can improve the prior authorization process for patients, providers and health plans. This will accelerate timely approvals, promote access to care, improve the patient experience, minimize administrative burden and reduce costs. AI will only be used to facilitate quicker approvals, not for denials based on medical necessity without a clinician review.

Commitment: For all coverage types, Signatory Plans commit that all prior authorization denials based on medical necessity for clinical factors will be reviewed by a licensed and qualified clinician. This commitment reflects existing practices and is in effect now.

Agenda Item #5

Hear a Discussion on the Federal Deregulation Initiative—*Katie Keith (Center for Health Policy and the Law at the O'Neill Institute, Georgetown Law) and Brian Blase (Paragon Health Institute)*

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Federal Deregulation: A Six-Month Review

Katie Keith, JD, MPH

Center for Health Policy and the Law

Deregulatory Directives

President Trump issued at least 9 deregulatory directives in first six months

General directives

- Jan. 2025: 10-for-1 rule
- Feb. 2025: Legal and policy review process
- Apr. 2025: Skip notice and comment process

Examples of specific directives

- Water pressure, sunset provisions at DOE
- Eliminate disparate impact liability for civil rights protections

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THE WALL STREET JOURNAL.

Trump Set to Start Slashing Regulations Across Government in Bonfire of Red Tape

DOGE and Republicans allies in Congress want to help the incoming president cut 10 rules for every new one

POLITICO

Trump directs agencies to quietly repeal regulations — without public notice

The New York Times

Trump Seeks to Strip Away Legal Tool Key to Civil Rights Enforcement

President Trump has ordered federal agencies to halt their use of "disparate-impact liability," which has been used to assess whether policies discriminate against different groups.

Deregulatory Action at HHS

Less deregulatory action at HHS to date

- Revocation of the "Richardson waiver"
- Single notice to revoke four policies on opioids, Sec. 1557, and COVID-19
- Revocation of guidance under EMTALA
- Revocation of Medicaid/CHIP guidance on health-related social needs and 1115 waivers
- Interim final rule to revoke data policy for unaccompanied minors
- Nonenforcement of short-term plan rule

Health Care Deregulatory Action at Other Agencies

Other agencies have rescinded health care-related requirements:

- CFPB issued a single notice to revoke nearly 70 guidance documents, including on No Surprises Act reporting requirements and deceptive medical debt collection practices
- IRS revoked series of prior guidance on since-repealed taxes
- DOJ rescinded long-standing guidance on language access under Title VI

APA & Richardson Waiver

The Administrative Procedure Act exempts certain agency actions from notice-and-comment procedures:

- Agency management, personnel, public property, loans, grants, benefits, or contracts; or
- For "good cause" if notice and comment is "impracticable, unnecessary, or contrary to the public interest."

Richardson waiver (1971) required HHS to use notice-and-comment rulemaking for these categories of agency action and to use the good cause exception "sparingly."

Revoking the Waiver

Feb. 2025: Sec. Kennedy, Jr. rescinds the Richardson waiver, noting that the prior policy was contrary to the text of the APA and imposed extra-statutory obligations on HHS. The 2025 notice:

- Exempts matters relating to agency management, personnel, public property, loans, grants, benefits, or contracts from notice-and-comment requirements; and
- Allows use of the "good cause" exception "in appropriate circumstances."

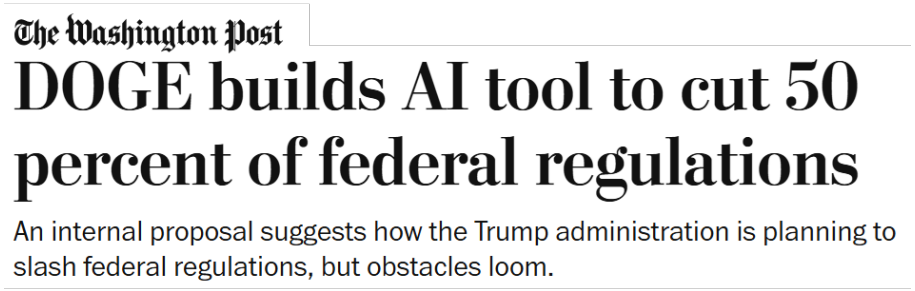
To date, HHS has continued to use notice-and-comment procedures for many health care rules.

Implications for Consumers and Stakeholders

- Broad deregulation could **disrupt the complex, highly regulated health care system** that consumers and patients rely on through abrupt changes to consumer protection laws, federal programs, the regulation of drugs and devices, etc.
- Notice and public comment are critical for **transparency** and to **allow those most affected** to explain how proposed changes would support or limit access to care—or impose new burdens on health care providers, insurers, state officials, and more.
- Public feedback should **inform agency action**, especially when policy or operational changes to programs affect millions of people and billions of dollars.
- Deregulatory changes will contribute to **chaos and confusion** at the same time as agency staffing reductions, agency reorganizations, and funding freezes.

Issues to Watch and Considerations for Regulators

Will HHS turn to more aggressive deregulatory action this fall? If so, will HHS try to invoke the Richardson waiver or use notice-and-comment processes?


The Washington Post

DOGE builds AI tool to cut 50 percent of federal regulations

An internal proposal suggests how the Trump administration is planning to slash federal regulations, but obstacles loom.

- RFIs on deregulatory actions closed in July
- One Big Beautiful Bill Act implementation is the opposite of *de*regulatory
- Potential for significant disruption, esp. without the benefit of transparency or comment

Will agencies use AI to accelerate the deregulatory process?

How much litigation will there be and how will it change how courts interpret the Administrative Procedure Act and its requirements?

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Thank you

Katie Keith
Katie.Keith@georgetown.edu

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HEALTH INSTITUTE

NAIC Presentation

August 12, 2025

PARAGON
HEALTH INSTITUTE

Topics of Relevance to State Insurance Commissioners

1) Short-term, limited-duration health insurance
2) Farm Bureau health coverage plans
3) Association Health Plans
4) Individual Coverage HRAs
5) Enhanced Affordable Care Act subsidies

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Federal Agencies Pause Enforcement of Biden's Short-Term Plan Rule (August 7th directive)

- Departments of Labor, HHS, and Treasury announced suspension of enforcement for 2024 short-term insurance rules.
- Action taken under Executive Order 14219 directing review of regulations that burden small businesses.
- Federal agencies will not prioritize enforcement of Biden-era restrictions during rulemaking review.
- HHS encourages states to adopt similar non-enforcement approach.

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Policy Recommendation

- The federal agencies should restore policy under President's Trump's 2018 rule, permitting a plan up to 364 days and to be renewed for up to 3 years.
- States should use CMS's guidance to decline enforcement of Biden-era restrictions.
- There is NO evidence that permitting short -term plans harmed the ACA market. In fact, the ACA market strengthened in states that fully permitted short -term plans.

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Individual Market Enrollment, by State STLDI Approach

State Grouping	2018	2023	% Change
STLDI Favorable States	9.22m	13.97m	51.4%
Exchange	7.07m	11.45m	62.0%
Off-exchange	2.20m	2.54m	15.1%
STLDI Unfavorable States	6.53m	6.41m	-1.9%
Exchange	4.68m	4.90m	4.7%
Off-exchange	1.90m	1.50m	-20.7%

NOTE: The exchange enrollment figures are the numbers reported by the Centers for Medicare and Medicaid Services as the number of sign-ups at the end of open enrollment. The total enrollment figures represent the total individual enrollment reported by carriers to state insurance regulators as compiled by Mark Farrah Associates (MFA). The off-exchange row is the individual market enrollment minus exchange enrollment. For three states—Maine, Missouri, and Virginia—MFA reported negative off exchange enrollment in 2018, and these states were excluded from the 2018–2023 data for off-exchange enrollment, as negative enrollment is impossible. Five states were excluded for off-exchange enrollment for the year 2023 (Alabama, Alaska, New Mexico, North Carolina, and Wyoming.). All states were included for on-exchange enrollment and total individual market enrollment. For this reason, the total individual market enrollment is not the sum of the exchange and off-exchange enrollment numbers. There were 29 states categorized as STLDI favorable states and 22 states (including the District of Columbia) categorized as STLDI unfavorable states. Enrollment is reported in millions, denoted by an m.

Exchange Plan Premium Changes from 2018-2024, by State STLDI Approach

State Grouping	Average Lowest-Cost Bronze	Average Lowest-Cost Silver	Average Benchmark	Average Lowest-Cost Gold
STLDI Favorable States	2.6%	-0.2%	-4.7%	-12.2%
STLDI Unfavorable States	13.2%	5.9%	4.8%	2.4%

SOURCE: KFF, "Average Marketplace Premiums by Metal Tier, 2018-2025," https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/. NOTE: These are weighted averages by exchange enrollment at the end of the first quarter of each calendar year.

Number of Insurers Offering ACA Exchange Coverage, by State STLDI Approach

State Grouping	2018	2024	% Change
STLDI Favorable States	86	179	108.1%
STLDI Unfavorable States	95	126	32.6%

SOURCE: KFF, "Number of Insurers Participating in the Individual Health Insurance Marketplaces, 2014-2025," https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/.

Farm Bureau Health Benefit Plans

- More than a dozen states exempt Farm Bureau health benefit plans from the definition of insurance.
- As a result, these plans are not subject to state and federal insurance regulation, including the Affordable Care Act.
- In some states, there is initial underwriting, but once people are enrolled they are not subject to cancellation, non - renewal, modification, or increase in premium due to a medical event.
- States often contract with a large, reputable insurer to sell the coverage.

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Farm Bureau Health Benefit Plans: The Numbers

- **Kansas Farm Bureau:** Health plans have an average monthly premium of $383 and can save most families between $1,000 and $1,500 per month.

- **Missouri Farm Bureau:** Health plans are projected to cost 30% less than comparable unsubsidized plans on the individual health insurance marketplace.

- **Nebraska Farm Bureau:** Health plans offer comprehensive, benefit -rich options at rates that can be 30% to 50% less than unsubsidized plans offered under the ACA.

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Farm Bureau Health Benefit Plans: State Status

State	Year Coverage Permitted, per Legislation
Alabama	2025
Arkansas	2023
Florida	2025
Indiana	2020
Iowa	2018
Kansas	2019
Mississippi	2024
Missouri	2025
Nebraska	2024
North Dakota	2024
Ohio	2025
South Dakota	2021
Tennessee	1993
Texas	2021

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Association Health Plans

- 2018 Labor Dept. rule to create another pathway for small businesses to join together.
- Permitted any businesses within a state to join together, regardless of type of business.
- Struck down by a judge in 2019 and reversed by Biden administration.

What could second Trump administration do?

- Rulemaking on AHPs that addresses the court's concerns

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Individual Coverage HRAs

- Another way for employers to offer health insurance created through a Trump administration rule in 2019.
- Employer provides a tax -preferred contribution for employees to use toward purchasing an ACA -compliant individual market plan.
- There are a large set of rules for how employers can structure ICHRAs.

What could second Trump administration do to build on ICHRAs?

1. permit employers more flexibility in offering coverage
2. permit employees more flexibility over how to use the ICHRA

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Issues with Enhanced ACA subsidies

- Paragon research estimates 6.4 million enrollees were enrolled in the 100 -150% of the federal poverty level category who do not have that income. This equates to $27 billion of improper federal spending in 2025.

- More than one -in-three individual market enrollees used $0 of medical care in 2024 —a huge increase from 2020.

- Extending the enhanced subsidies would cost around $40 billion per year, including interest costs on additional deficits.

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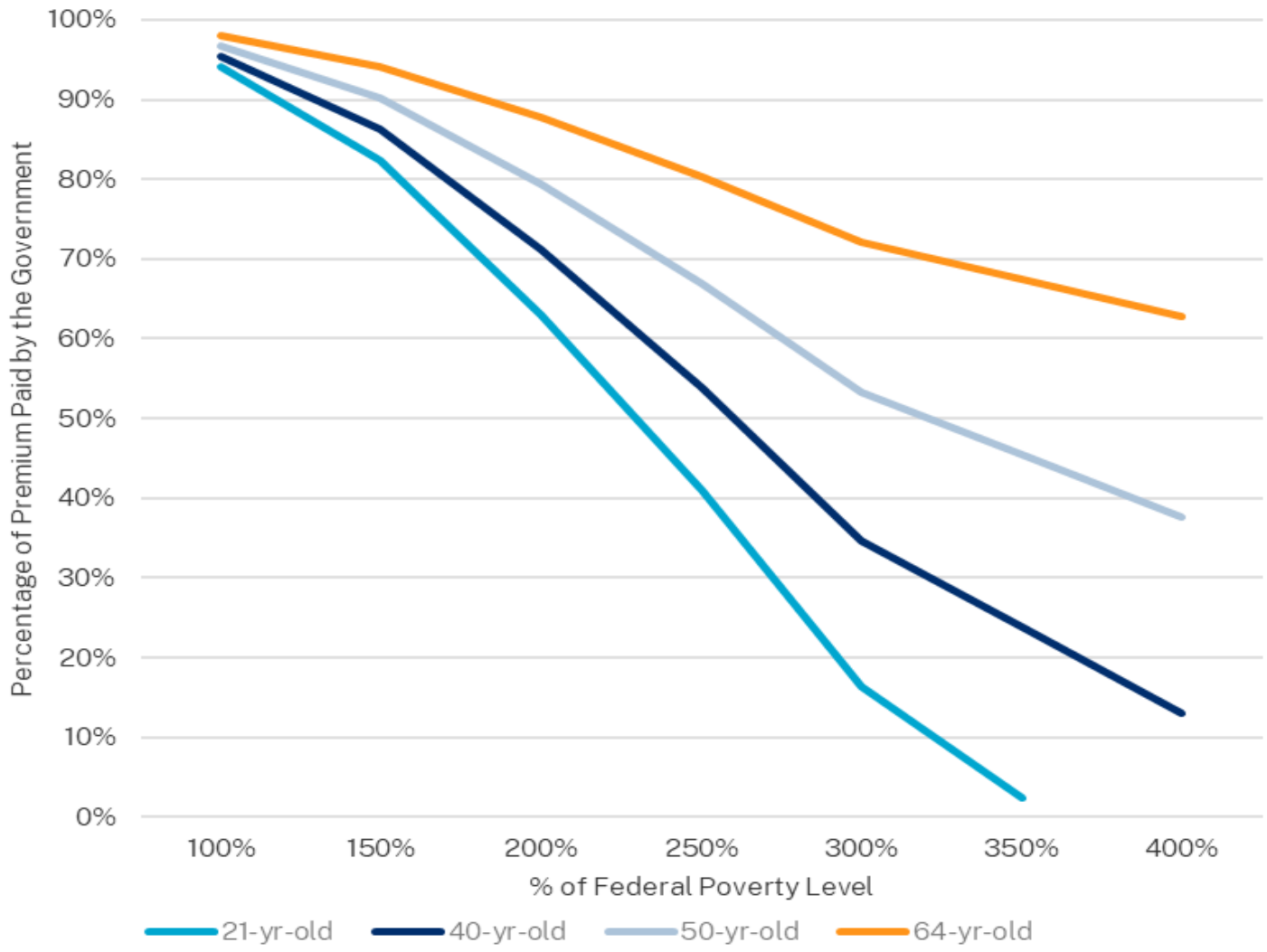
Percentage of Premium Paid by Government for 2026 Silver Plan Under Current Law



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and Congress about the program, and to estimate program impact.

Type of respondent: Annual reporting; respondents are all grantees that receive Title X funding from OPA.

Type of respondent	Number of respondents	Number responses per respondent	Average burden per response (in hours)	Total burden hours
Grantees	88	1	72	6,336
Total	88	1	72	6,336

Susan R. Little,

Department Information Collection Clearance Officer, Paperwork Reduction Act Program, Department of Health and Human Services.

[FR Doc. 2025–08415 Filed 5–13–25; 8:45 am]

BILLING CODE 4150–34–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Document Identifier: OS 4040–0011]

Agency Information Collection Request. 30-Day Public Comment Request

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: In compliance with the requirement of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of a proposed collection for public comment.

DATES: Comments on the ICR must be received on or before June 13, 2025.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: Sagal Musa, *sagal.musa@hhs.gov,* or call (202) 578–5441. When submitting comments or requesting information, please include the document identifier 4040–0011–30D and project title for reference.

SUPPLEMENTARY INFORMATION: Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Title of the Collections: SF–271 Outlay Report and Request for Reimbursement for Construction Programs.

Type of Collection: Reinstatement.

OMB No. 4040–0011.

Abstract: The SF–271 Outlay Report and Request for Reimbursement for Construction Programs form is an OMB-approved collection (4040–0011). This information collection is used by grant awardees to report on their construction grant award. This IC expired on January 31, 2025. *Grants.gov* is seeking reinstatement without change of this information collection and a three-year clearance.

ANNUALIZED BURDEN HOUR TABLE

Forms (if necessary)	Respondents (if necessary)	Number of respondents	Number of responses per respondents	Average burden per response	Total burden hours
SF–271 Outlay Report and Request for Reimbursement for Construction Programs.	Grant Applicants	40,000	1	1	40,000
Total		40,000	1	1	40,000

Susan R. Little,

Department Information Collection Clearance Officer, Paperwork Reduction Act Program, Department of Health and Human Services.

[FR Doc. 2025–08420 Filed 5–13–25; 8:45 am]

BILLING CODE 4151–AE–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Request for Information (RFI): Ensuring Lawful Regulation and Unleashing Innovation To Make American Healthy Again

AGENCY: Department of Health and Human Services.

ACTION: Notice; request for information.

SUMMARY: To implement the President's Deregulatory Initiatives, including Department of Government Efficiency Deregulatory Agenda, and to better promote the health and well-being of the American people, the U.S. Department of Health and Human Services (HHS) is planning the largest deregulatory effort in the history of the Department. To facilitate this effort, HHS seeks input from all interested parties on how to dramatically deregulate across all areas the Department touches. HHS also welcomes other submissions explaining how regulations, guidance, paperwork requirements, and other regulatory obligations can be repealed.

DATES: To be assured consideration, comments must be received no later than 11:59 p.m. Eastern Time (ET) on July 14, 2025. HHS will not reply individually to responders but will consider all comments submitted by the deadline.

ADDRESSES:

RFI Docket: You may examine the RFI docket at *regulations.gov* under Docket ID. AHRQ–2025–0001. The docket contains this RFI and all comments received to date. To submit a response, click the ''Comment'' button inside Docket: AHRQ–2025–0001 and follow all instructions.

Regulations.gov: The public can also send HHS-specific deregulatory submissions for publication in the **Federal Register** at the following site: *https://www.regulations.gov/deregulation.*

FOR FURTHER INFORMATION CONTACT: For additional information, direct questions to Jennifer Burnszynski or Laina Bush in the HHS Office of the Assistant Secretary for Planning and Evaluation at *osaspeinfo@hhs.gov* or (202) 690–7858.

SUPPLEMENTARY INFORMATION:

Background: The President has issued two major, cross government Deregulatory Initiatives. First, on January 31, 2025, he issued E.O. 14192, ''Unleashing Prosperity Through Deregulation'' (90 FR 9065; February 6, 2025). This E.O. directs agencies to eliminate 10 regulations for each new regulation issued (''10-for-1''), as well as the direction that deregulation leads to significant cost savings. In addition, on February 19, 2025, the President issued Executive Order 14219, ''Ensuring Lawful Regulation and Implementing the President's 'Department of Government Efficiency' Deregulatory Agenda'' (90 FR 10583; February 25, 2025). That order stated the policy of the Trump Administration is to focus the executive branch's limited enforcement resources on regulations squarely authorized by constitutional Federal statutes and commence the deconstruction of the overbearing and burdensome administrative state.

To implement the President's Deregulatory Initiatives, and to better promote the health and well-being of the American people, HHS is planning the largest deregulatory effort in its history. However, HHS cannot accomplish this feat alone. As Secretary, I believe that an important component of Making America Healthy Again is making sure that providers and caretakers can focus on preventing and treating chronic diseases instead of having to do unnecessary or burdensome paperwork and otherwise comply with Administrative burdensome requirements with no clear health benefit. As such, HHS is seeking input from the American public on how to dramatically deregulate across all the areas the Department touches. Specifically, HHS welcomes submissions explaining how regulations, guidance, paperwork requirements, and other regulatory obligations can be repealed. Those submissions may be entered in response to this RFI.

Ensuring Lawful Regulation

Pursuant to E.O.14219, agencies are required to identify and report to the Office of Information and Regulatory Affairs (OIRA) within the Office of Management and Budget on regulations in one or more of the following categories:

(i) Unconstitutional regulations and regulations that raise serious constitutional difficulties, such as exceeding the scope of the power vested in the Federal Government by the Constitution;

(ii) Regulations that are based on unlawful delegations of legislative power;

(iii) Regulations that are based on anything other than the best reading of the underlying statutory authority or prohibition;

(iv) Regulations that implicate matters of social, political, or economic significance that are not authorized by clear statutory authority;

(v) Regulations that impose significant costs upon private parties that are not outweighed by public benefits;

(vi) Regulations that harm the national interest by significantly and unjustifiably impeding technological innovation, infrastructure development, disaster response, inflation reduction, research and development, economic development, energy production, land use, and foreign policy objectives; and

(vii) Regulations that impose undue burdens on small business and impede private enterprise and entrepreneurship.

After receiving this report, OIRA is instructed to consult with agency heads to develop a Unified Regulatory Agenda to rescind or modify identified regulations as appropriate and consider these factors when evaluating potential new regulations.

Unleashing Prosperity Through Deregulation

Pursuant to E.O. 14192, agencies have been charged with the following requirements:

(a) Unless prohibited by law, whenever an agency proposes for notice and comment or otherwise promulgates a new regulation, it shall identify at least 10 existing regulations to be repealed.

(b) For fiscal year 2025, all agencies must ensure that the total incremental cost of all new regulations, including repealed regulations, being finalized is significantly less than zero, as determined by the Director of the Office of Management and Budget (OMB), unless otherwise required by law or instructions from OMB.

(c) Any new incremental costs associated with new regulations must, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations. Further, Executive Order 14192 requires that for fiscal year 2026, and each fiscal year thereafter, the head of each agency identify, on an aggregated basis, for regulations that increase incremental cost, offsetting regulations and provide the agency's best approximation of the total costs or savings associated with each new regulation or repealed regulation. During the Presidential budget process, the Director of the Office of Management and Budget will identify for each agency a total amount of incremental costs that will be allowed for such agency in issuing new regulations and repealing regulations for each fiscal year after fiscal year 2025. No regulations exceeding the agency's total incremental cost allowance will be permitted in that fiscal year, unless required by law or approved in writing by the Director. The total incremental cost allowance may allow an increase or require a reduction in total regulatory cost. Subsequent OMB Guidance Implementing section 3 of Executive Order 14192 provides the following definitions:

An ''E.O. 14192 regulatory action'' is: (i) A significant regulatory action as defined in section 3(f) of E.O. 12866 that has been finalized and that imposes total costs greater than zero; or (ii) A significant guidance document, broadly conceived, (*e.g.,* significant interpretive guidance) reviewed by OIRA under the procedures of E.O. 12866 that has been finalized and that imposes total costs greater than zero. For example, E.O. 14192 regulatory actions include negotiated rulemakings that are significant as defined in section 3(f) of E.O. 12866, that have been finalized, and that impose total costs greater than zero.

An ''E.O. 14192 deregulatory action'' is an action that has been finalized and has total costs less than zero. An E.O. 14192 deregulatory action qualifies as both: (1) one of the actions used to satisfy the provision to repeal or revise

at least 10 existing regulations for each regulation issued, and (2) a cost savings for purposes of the total incremental cost allowance. E.O. 14192 deregulatory actions are not limited to those defined as significant under E.O. 12866 or OMB's *Final Bulletin on Good Guidance Practices.* An E.O. 14192 deregulatory action may be issued in the form of an action in a wide range of categories of actions, including, but not limited to: Informal, formal, and negotiated rulemaking; Guidance and interpretive/interpretative documents; Some actions related to international regulatory cooperation; and Information collection requests that repeal or streamline recordkeeping, reporting, or disclosure requirements. Significant proposed rules issued before noon on January 20, 2025, that are formally withdrawn by notice in the **Federal Register** and removed from the *Unified Agenda of Regulatory and Deregulatory Actions* may also qualify as repeal actions, but do not qualify for cost savings.

Request for Information

During President Trump's first administration, HHS undertook nearly 400 deregulatory actions to increase efficiency and reduce burden on the healthcare system. These efforts were facilitated by public comment received in response to HHS's Regulatory Relief To Support Economic Recovery; RFI (85 FR 75720, November 25, 2020) and HHS's RFI on Redundant, Overlapping, or Inconsistent Regulations (85 FR 76003, November 27, 2020).

Although that was a good start, HHS intends to dramatically expand its deregulatory efforts. The public should help HHS identify any opportunities to produce cost savings, increase efficiency, and stoke health and economic innovation through deregulation.

HHS's goal is to address regulations that are unnecessary, inconsistent with the law, overly burdensome, outdated, out of alignment with current Executive orders, or otherwise unsound. Consistent with Secretary Kennedy's commitment to radical transparency, HHS will involve the public in this process and values the perspectives and knowledge of those outside of the Federal Government, particularly those served by HHS and those who help carry out its mission. As HHS conducts a thorough review of all regulations in its purview pursuant to the Executive orders described above, HHS is seeking input from a full range of stakeholders, including health care providers and suppliers; State, local, territorial, and Tribal governments; health and drug plans and payers; human services agencies; public health agencies; community- and faith-based organizations; long term care facilities; pharmacist and pharmacy associations; health and human services professional organizations; farmers and food producers; patient advocacy groups and organizations; people living with chronic disease and their family members; researchers; health technology organizations; and other businesses.

The most helpful submissions are those that HHS can publish in the **Federal Register** with minimal revision—whether as notices of proposed rulemaking (NPRMs), direct final rules (DFRs), or other notices—rescinding previous rulemakings or provisions in the Code of Federal Regulations. These submissions should be entered at *https://www.regulations.gov/deregulation.*

Instructions

Responses submitted at *regulations.gov/deregulation* should follow the format provided there. You may respond to one or more of the questions listed below and please include question numbers provided in the response. Each responding entity (person or organization) is requested to submit only one response per regulation or guidance. Unless submitted anonymously, responses should include the name(s) of the person(s) or organization(s) submitting the comment. If a comment is submitted on behalf of an organization, the individual respondent's role in the organization may also be provided.

In a clear and concise manner, please describe how the recommendation would lead to cost savings, how much savings are anticipated, and the statutory authority that would permit HHS to act on the recommendation. Respondents should identify the specific regulation, guidance, or requirement at issue along with its administering HHS division. Where practical, please also include data, legal citations, quantitative estimates, and recommended actions. Economic data to demonstrate costs and savings are strongly encouraged, with an emphasis on the especially ambitious deregulatory ideas that may require a stronger evidentiary basis. Analyses that conform to OMB guidance to Federal agencies on the development of regulatory analysis, Circular A–4 (2003), and to the HHS Guidelines for Regulatory Impact Analysis (2016), are similarly encouraged. Comments containing references, studies, research, or other empirical data that are not widely published should include electronic links or copies of the referenced materials attached as an appendix.

This RFI is voluntary, and responses may be submitted anonymously. Comments submitted in response to this RFI may be posted on HHS websites or otherwise released publicly. Please do not submit proprietary, classified, confidential, or sensitive information, to include personally identifiable (PII) or personal health information (PHI), in response to this RFI.

This RFI is for information and planning purposes only and should not be construed as a policy, solicitation for applications, or as an obligation on the part of the government to provide support for any ideas in response to it. HHS will use the information submitted at its discretion and will not comment on any respondent's submission. Respondents are advised that the government is not obligated to acknowledge receipt of the information received or provide feedback to respondents concerning any information submitted. Those submitting responses are solely responsible for all expenses associated with response preparation.

Questions

1. What HHS regulations and/or guidance meet one or more of the following seven criteria identified in E.O. 14219? Should they be modified or repealed? What would be the impact of this change, especially the costs and savings?

* Unconstitutional regulations and regulations that raise serious constitutional difficulties, such as exceeding the scope of the power vested in the Federal Government by the Constitution;

* Regulations that are based on unlawful delegations of legislative power;

* Regulations that are based on anything other than the best reading of the underlying statutory authority or prohibition;

* Regulations that implicate matters of social, political, or economic significance that are not authorized by clear statutory authority;

* Regulations that impose significant costs upon private parties that are not outweighed by public benefits;

* Regulations that harm the national interest by significantly and unjustifiably impeding technological innovation, infrastructure development, disaster response, inflation reduction, research and development, economic development, energy production, land use, and foreign policy objectives; or

* Regulations that impose undue burdens on small business and impede private enterprise and entrepreneurship

2. What regulations should we reconsider as we look to achieve some of the policy objectives outlined in Executive Order 14212, ''Establishing the President's Make America Healthy Again Commission,'' to focus on reversing chronic disease?

3. For more general deregulatory consideration under E.O. 14192, are there additional HHS regulations and/or guidance that:

* Are confusing or unnecessarily complicated;
* Require an excessive number of reports or unreasonable record keeping, or information that is not needed or used effectively;
* Impose requirements on the wrong individual or group;
* Carry excessive penalties;
* Are conflicting (examples include but are not limited to conflicts between HHS and State regulations, public and private sectors);
* Impede access to or delivery of care or services;
* Impede efforts to innovate
* Are obsolete; and/or
* Otherwise interfere with the public or private sector's ability to address chronic health conditions or otherwise promote the health and wellbeing of Americans?

Should they be modified or repealed? What would be the impact of this change, especially the costs and savings?

4. What alternative approaches could be taken to achieve or accomplish the same goal with a lesser burden? For example, are there less burdensome approaches that are used by other entities such as State governments or private companies that could be adopted by HHS to achieve its goal with less burdensome requirements? What would be the impact on costs and savings?

5. Are there HHS regulations, guidance, or reporting requirements that are rooted in outdated technology? Can new technologies be leveraged to allow for rescinding or updating these policies? What are the cost implications?

6. Are there HHS regulations, guidance, or reporting requirements that are inconsistent with Executive Orders 14151, 14154, 14168, and 14213 or others issued by the President? Should they be modified or rescinded to make them consistent?

Robert F. Kennedy, Jr.,

Secretary, United States Department of Health and Human Services.

[FR Doc. 2025–08384 Filed 5–13–25; 8:45 am]

BILLING CODE 4150–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Document Identifier: OS 4040–0012]

Agency Information Collection Request. 30-Day Public Comment Request

AGENCY: Office of the Secretary, HHS.

ACTION: Notice.

SUMMARY: In compliance with the requirement of the Paperwork Reduction Act of 1995, the Office of the Secretary (OS), Department of Health and Human Services, is publishing the following summary of a proposed collection for public comment.

DATES: Comments on the ICR must be received on or before June 13, 2025.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain*. Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: Sagal Musa, *sagal.musa@hhs.gov,* or call (202) 578–5441. When submitting comments or requesting information, please include the document identifier 4040–0012–30D and project title for reference.

SUPPLEMENTARY INFORMATION: Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Title of the Collections: SF–270 Request for Advance or Reimbursement.

Type of Collection: Reinstatement.

OMB No. 4040–0012.

Abstract: The SF–270 Request for Advance or Reimbursement is a federal form used by grant awardees to request funds either in advance or as reimbursement for project expenses. This IC expired on January 31, 2025. *Grants.gov* is seeking reinstatement without change of this information collection and a three-year clearance.

ANNUALIZED BURDEN HOUR TABLE

Forms (if necessary)	Respondents (if necessary)	Number of respondents	Number of responses per respondents	Average burden per response	Total burden hours
SF–270 Request for Advance or Reimbursement.	Grant Applicants	100,000	1	1	100,000
Total		100,000	1	1	100,000

Susan R. Little,

Department Information Collection Clearance Officer, Paperwork Reduction Act Program, Department of Health and Human Services.

[FR Doc. 2025–08418 Filed 5–13–25; 8:45 am]

BILLING CODE 4151–AE–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 1009 of the Federal Advisory Committee Act, as amended, notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which

Agenda Item #6

Hear an Update on Work to Develop a Prior Authorization Framework White Paper
—Commissioner Grace Arnold (MN)

Draft: 7/18/25

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

Prior Authorization White Paper

Contents

What is prior authorization?

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

How this document can help regulators

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

Please note that this document will not elaborate on the use of artificial intelligence (AI) in the PA space. The topic would more appropriately be addressed in detail by the NAIC Innovation, Cybersecurity, and Technology (H) Committee, though we would be comfortable assisting the H Committee in any endeavors to better understand the use AI in prior authorizations in any forthcoming materials.

The prior authorization process

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

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

Common medical services subject to prior authorization

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

- ***High-Cost and Specialty Drugs:*** Medications that are expensive or require careful monitoring, such as biologics or high-dose chemotherapy drugs.
- ***Advanced Imaging:*** Tests like MRI, CT scans, or PET scans.
- ***Surgical Procedures:*** Surgeries that are elective or involve the use of experimental techniques.
- ***Durable Medical Equipment:*** Items like wheelchairs or hospital beds.

Prior authorization issue perspectives

The provider perspective

Administrative burden and expense

Prior authorization can create substantial administrative burdens, costs, and inefficiencies. According to a recent American Medical Association (AMA) survey[2], physicians spend 13 hours per week requesting PAs. To mitigate this, health care providers must also employ and maintain knowledgeable staff who can help monitor the PA process. According to the same AMA survey[3], 40% of participating physicians have staff who work exclusively on PAs. Providers' electronic health records generally do not integrate with insurer

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

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

[3] Id.

systems, so staff must manually enter data into these systems. Furthermore, incorrect or missing patient demographic and insurance information can delay PA or result in unexplained denials.

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

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

Lack of consistency and transparency

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

Denial letters often lack transparency and provide no information on how the denial was determined. Health care providers are forced to guess why the denial occurred and how to appeal the decision. Some health care providers completely avoid the PA process by not accepting insurance.

Outdated and inefficient technology

Oftentimes, the technologies (including software, web portals, fax machines, and even communication by phone) used by insurer PA systems are outdated and cumbersome. The PA process can be significantly delayed or result in denials if an insurer has not updated its utilization management processes or has not communicated changes to processes or codes. Though some insurer portals make it easy to look up required PA information by simply inputting a procedure's current procedural terminology code, other insurers will not provide information until a provider contacts them. When medical offices are required to contact a health benefit plan by phone, staff experience long hold times. Providers often need to create documentation of their communications by phone or fax in case such information is later needed to prove contact was made.

Misalignment with clinical standards of care

In addition to determining whether a requested service is recommended according to research-based evidence, insurers also consider whether the service is the most cost-effective way to treat a patient.

[4] https://arkleg.state.ar.us/Bills/Detail?id=sb83&ddBienniumSession=2025%2F2025R

Clinical standards used by providers do not necessarily consider cost and are intended to provide the most efficient and effective care depending on a patient's particular needs. Rather than treating a patient with what the health care provider considers to be most appropriate treatment using their knowledge of clinical standards of care, a PA request denial may force a health care provider to prescribe a different therapy, not considered to be in the patient's best interests, but that is covered by the patient's insurer. The provider must choose whether to pursue a lengthy and possibly futile appeal process related to their preferred therapy that will further delay treatment or choose a different therapy less likely to provide optimal results.

The consumer perspective

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

Disruptions in care

According to a KFF survey, approximately six in 10 insured adults are not able to use their insurance without experiencing a problem.[5] Of those insured adults that report having an issue with using their insurance, 16% reported experiencing problems specifically with PA processes.[6] Additionally, a KFF analysis of CMS' 2023 Transparency in Coverage data demonstrated that prior authorization accounted for 9% – more than six million - of in-network claim denials. Separately, a physician survey conducted by the AMA in 2023, found that 94% of the patients of participant physicians experienced delays in care that they would not have otherwise experienced.[7] Moreover, the same survey found that 78% of the patients abandoned treatment because of the PA processes.[8]

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

Higher costs in the long run

Federal law prohibits plans from requiring PA for coverage of emergency services. As a result, some individuals seek care directly from an emergency room rather than engaging with their health insurer to help coordinate care prior to a medical issue becoming emergent. According to a survey from the AMA, insured adults who received health care in an emergency room would have been twice as likely to encounter PA problems when trying to seek care in a non-emergency setting when compared to those who did not otherwise use the emergency room.[9]

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

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

Adverse and inequitable outcomes

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

The appeals process

It is important to note that most PA requests are approved. For example, for Medicare Advantage plans in 2023, 90% of PA determinations were fully favorable.[15] In the event of a PA denial, there are mechanisms to appeal. These processes are often byzantine and difficult to access and discourage consumers who receive a denial from appealing. In Pennsylvania, for example, of the 2,135,041 claims denied by Qualified Health Plans in the state's individual health insurance market, just 3,156 internal appeals were filed. Of those internal appeals, nearly half (48%) were overturned in favor of providing coverage for the requested service.[16] The pattern is repeated at the national level. Qualified Health Plans offering individual health insurance coverage through the Federally Facilitated Exchange in 2022 denied 69,315,868 claims. Less than one percent of those denials was appealed, and 42% of the appeals filed were overturned.[17] Staking the availability of coverage for medical services on the ability to navigate administrative processes can have negative impacts on health outcomes.

The insurer perspective

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

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

[11] Id.

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

[13] Id.

[14] Id.

[15] https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/#:~:text=Of%20the%2049.8%20million%20prior,of%2014%20requested%20therapy%20sessions.

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

[17] Id.

- Flagging newer and better treatments for patients to improve the quality of care;
- Preventing excessive, unnecessary, harmful or fraudulent health care utilization; and
- Containing claims costs.

Patient Safety

Health insurers often cite examples of clearly harmful activity by providers, such as providing inappropriate cancer treatments to patients who may not even suffer from cancer, to demonstrate how PA supports patient safety.[18] It is difficult to determine how frequently these forms of consumer harm are prevented by PA, but there is no reason to doubt that such harms are a legitimate concern.

Cost containment

Insurers claim that PA prevents the use of low-value health care services, saving insurer and member dollars without adverse health consequences.[19] While the research on the value proposition of health care services may be clear in some cases, it is disputed in others. Especially for newer modes of treatment that may lack a large evidence base. This can lead to disputes, appeals and complaints to regulators. There is not yet definitive research to determine the overall economic value of PA for insurers. However, insurer representatives consistently articulate the centrality of PA for their efforts to contain costs and improve quality of care.

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

Friction with providers and members

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

Electronic prior authorization

Health insurance carriers have been broadly supportive of moving away from manual and "paper" processes for PA and toward more uniform electronic submission standards. For example, carriers

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

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

supported federal adoption of a rule on PA interoperability in 2024.[20] Carrier advocates have typically argued that state activity in this area should focus on aligning state requirements for insurers with these federal rules, and that states should consider more proactively implementing requirements for health care providers.[21] Carriers have suggested that more rapid adoption and effective implementation of electronic PA on the part of health care providers can resolve some of their concerns about administrative burdens.

Selective use

Selective use, also called gold carding, means applying different PA processes and expectations based on provider performance.[22] Health insurers have typically opposed statutory or regulatory mandates in the area of selective use, preferring to be permitted the flexibility to explore a range of options to strike a favorable balance between administrative simplification, patient protection and cost containment. However, many health insurers voluntarily apply selective use policies as part of their PA programs.

Questions regarding the evidence base

One of the key purposes of PA cited by insurers is to ensure that covered services are evidence-based and effective. Some insurers have expressed concerns about the evidence base behind PA and have pushed for stricter requirements in this area.[23] Insurers are unlikely to be supportive of restricting their flexibility in this area for a variety of reasons. For example:

- PA denials are typically subject to appeal and external review requirements that provide the opportunity for an independent check on practices not aligned with clinical evidence.
- Questions about the value proposition of particular health care services may not be entirely resolvable by clinical evidence. For example, there may be cases where two therapies with significant cost differences have similar effectiveness in treating a health condition but may have differential effects on the patient experience in other respects, such as comfort or aesthetic considerations.[24]

Solutions and examples

States

Gold carding

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

[20] https://www.ahip.org/news/press-releases/ahip-statement-on-the-cms-interoperability-and-prior-authorization-final-rule
[21] https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states
[22] See e.g., https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf
[23] For example, Congress has considered legislation that would push Medicare Advantage issuers to consult with health care providers on evidence-based best practices for prior authorization: https://delbene.house.gov/news/documentsingle.aspx?DocumentID=3221
[24] Potential examples could include proton beam therapy for cancer treatment or autologous breast reconstruction following mastectomy.

service will not be required to obtain PA before performing that service. Once implemented, these programs are intended to simplify health care for consumers, providers, and insurers.

Under state gold carding programs, a health insurer is required by the state to evaluate a health care provider's history of requesting PA for a particular health care service to determine whether the provider qualifies for an exemption from PA for that particular service. The insurer examines medical records to determine the number of times a health care provider requested PA for a particular service and compare that number to the number of times the provider's request for that service was approved. If the percentage of approved requests meets the number mandated by the state legislature, the insurer will be required to issue the provider a gold card exemption for that service.

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

Arkansas

Arkansas has extended its gold card programs to PAs for prescription drugs. Insurers in Arkansas examine the health care provider's history of all PAs requested for all health care services, which Arkansas defines to include prescription drugs.[25] A health care provider's gold card exemption privilege extends to any health care service for which they received approval of the PA request at least 90%) of the time within a six-month evaluation period.[26] An insurer may rescind a health care provider's exemption if the provider performs five or fewer of the health care service for which they obtained an exemption.[27]

Arkansas has also established a process that allows an insurer to continue requiring PA for a particular drug if the insurer obtains approval from the state's boards of pharmacy and medicine to continue requiring PA.[28] When an insurer receives approval to continue requiring PA for a particular drug, the approval is good for two years, and the insurer may continue requiring PAs for that drug from all health care providers, regardless of any gold card exemption privilege a health care provider would have otherwise had.

Texas

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

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

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

1. Submitted five or more eligible PA requests for the particular health care service in the most recent evaluation period; and
2. At least 90% of the eligible PA requests for a particular service were approved. [29]

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

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

West Virginia

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

Wyoming

The Wyoming legislature passed legislation regarding provider exemptions from PA requirements (Gold Carding).[30] The law will go into effect January 2026. The legislation establishes guidelines for a provider to be exempted from completing PAs for health care services that have been authorized 90% of the time in the proceeding twelve months. The provider must have submitted no fewer than five PAs for the procedure during that time. The insurer can review the exemption every twelve months, but they may establish a longer exemption period. In addition, an exemption cannot be revoked before twelve months have passed.

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

[29] Texas Administrative Code https://texas-sos.appianportalsgov.com/rules-and-meetings?$locale=en_US&interface=VIEW_TAC_SUMMARY&recordId=209986 and Texas Insurance Code Title 14, Ch. 4201 https://statutes.capitol.texas.gov/Docs/IN/htm/IN.4201.htm#4201.653

[30] Wyo. Stat. Ann. § 26-55-112

Addressing continuity concerns

District of Columbia

The District of Columbia requires a PA to be valid for at least one year or for the course of the treatment, including any dosage changes.[31]

Illinois

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

Oklahoma

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

Tennessee

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

Texas

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

Wyoming

The Wyoming Insurance Code, titled *Ensuring Transparency in PA Act* was passed in 2024[32] and addresses continuity of care and step therapy. If an individual changes health care coverage and has an approved PA with their prior insurer, and the health care service is a covered benefit under the new plan, the new insurer must honor the PA for at least 90 days.

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

Reducing response times

Oklahoma

House Bill 3190[33], which took effect on January 1, 2025, requires utilization review entities to respond more promptly to PA requests. After a utilization review entity has obtained all necessary information to make a

[31] https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-we-must-ensure-continuity-care#:~:text=Georgia%2C%20Kentucky%2C%20Louisiana%2C%20Michigan,hemophilia%20or%20Von%20Willebrand%20disease.

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

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

decision, the entity must respond within 72 hours for urgent requests and within seven days for non-urgent requests. These expedited timelines are intended to facilitate timely care for patients.

Texas

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

Washington

The Evergreen State has implemented shorter turnaround times for PA approvals[34], ranging from one to five calendar days, aiming for timely patient access to care. The required turnaround times differ depending on how the request is submitted to the carrier (non-electronic versus electronic) and whether the request is urgent. For electronic PA requests, carriers must make a decision and notify the provider and facility of the decision within three calendar days for a standard request and within one calendar day for an urgent request. The turnaround times are a little longer for non-electronic requests - within five calendar days for a standard request and two calendar days for an urgent request.

West Virginia

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

Wyoming

The *Ensuring Transparency in PA Act* relied heavily on the American Medical Association model and established response times for PA requests.[35] PA response times for non-emergent responses are to be within five calendar days of obtaining all necessary information to complete the review. Urgent authorizations are to be completed within 72 hours of obtaining all necessary information. Health insurers and contracted utilization review entities shall not require PA for medications used for opioid use disorder. In addition, a health insurer or contracted utilization review entity shall not require PA for rehabilitative or habilitative services including, but not limited to, physical therapy service or occupations therapy services for the first twelve visits for each new episode of care.

Updating technology and systems

Texas

In 2014, Texas mandated standardized PA request forms for health care services and prescription drug benefits.[36] The code, which took effect on September 1, 2015, established an advisory committee tasked

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

with updating the forms every two years. Its primary goal was to streamline the PA process, making it more efficient and transparent for both providers and patients. By standardizing the forms and ensuring their accessibility, the code aimed to reduce confusion and facilitate a smoother authorization process for necessary health care services. The forms must be provided in both paper and electronic formats and made accessible on health plan websites. Medicaid and CHIP are required to accept these forms.

Washington

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

With the passage of Engrossed Second Substitute House Bill (ESSHB)1357[37] in 2023, each carrier is required to build and maintain a PA application programming interface (API) that automates the process for in-network providers to determine whether a PA is required for health care services, identify PA information and documentation requirements, and facilitate the exchange of PA requests and determinations from its EHR or practice management system by January 1, 2025. Carriers would also be required to automate the process to determine whether a PA is required for durable medical equipment or a health care service, streamlining the process. The API requirements were modified by Substitute House Bill (SHB) 1706[38] in 2025 to align the API requirements codified in Washington's RCW with the guidance and timelines in the CMS Interoperability and PA Final Rule[39].

West Virginia

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

Improving transparency

Oklahoma

House Bill 3190[41] requires health insurers to publish their PA requirements online, ensuring they are accessible to patients and providers. If a utilization review entity—defined as an individual or organization that performs PA for a health benefit plan—plans to implement a new requirement or change an existing one, they cannot do so until their website reflects the updated information.

Furthermore, utilization review entities are required to enhance communication opportunities during the PA process. They must have staff available for phone calls regarding PA issues at least eight hours a day during normal business hours. In addition, they must allow staff to address communications about PA

[37] Washington ESSHB 1357 https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/House/1357-S2.SL.pdf?cite=2023%20c%20382%20s%201
[38] Washington SHB 1706 https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/House/1706-S.SL.pdf
[39] CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) https://www.cms.gov/priorities/burden-reduction/overview/interoperability/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f
[40] W. Va. Code Ann. §33-15-4s et.seq.
[41] Oklahoma HB 3190 https://www.oklegislature.gov/BillInfo.aspx?Bill=hb%203190&Session=2400

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

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

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

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

Pennsylvania

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

Texas

If a PA exemption is denied, the insurer is required to provide a notice to the provider describing why the exemption was denied, directions on how to appeal the denial and information on how to file a complaint with TDI.[42] Determinations must be made by an individual licensed to practice medicine in Texas who has the same or similar specialty as that physician. The physician or provider has the right to a review regarding a PA exemption to be conducted by an independent review organization.[43]

Washington

Starting October 1, 2020, and annually thereafter, carriers in Washington must include in their annual report to the OIC aggregated and deidentified data related to their PA practices and experience for the prior plan year.[44] For each category (inpatient medical or surgical, outpatient medical or surgical, mental health and substance use disorder, durable medical equipment, diabetes, and prescription), carriers must list the ten codes with the:

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

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

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

West Virginia

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

Wyoming

The *Ensuring Transparency in PA Act* and established guidelines for review of adverse determinations.[45] Individuals qualified to make adverse determinations need sufficient knowledge in the applicable practice area or specialty, knowledge of coverage criteria, have an unrestricted license to practice within the scope of their profession recognized in the United States or District of Columbia, and knowledge of the person's medical history and diagnosis. The health insurer or contracted utilization review entity shall provide the opportunity for the provider to discuss the medical necessity of the service. An attempt to schedule the discussion should take place within five days of the provider's request.

Finally, the insurer or contracted utilization review entity shall make any PA requirements and restrictions easily accessible on their website to enrollees, health providers and the public. Should a provider ask for the PA requirements or restrictions from an insurer, the insurer must provide the list to the requesting party within 24 hours. [46] Furthermore, any changes to the requirements must be posted 60 days in advance of the change's enactment.[47] These deadlines have to do with the disclosure and review of prior authorization requirements, not a specific patient PA.

Provider Associations

American Medical Association Model Legislation

The goal of the AMA model legislation[48] is to improve transparency and limit interruptions to patient care. The following states have taken language directly from the model legislation: Delaware, Georgia, Illinois, Mississippi, New Jersey, Oklahoma, and Wyoming.

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

The legislation recommends:

- Establishing quick response times (24 hours for urgent, 48 hours for non-urgent care).
- Requiring adverse determinations to be made only by a physician licensed in the state and of the same specialty that typically manages the patient's condition.
- Prohibiting retroactive denials if care is preauthorized.
- Requiring authorizations to be valid for at least 1 year, regardless of dose changes, and for those with chronic conditions, to be valid for the length of treatment.
- Requiring the public release of insurers' PA data by drug and service as it relates to approvals, denials, appeals, wait times and more.
- Requiring new plans to honor a patient's PA for at least 60 days; and
- Reducing volume using PA exemptions or gold-carding programs.

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

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

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

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

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

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

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

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

American Psychiatric Association Model Legislation

In 2022, the American Psychiatric Association (APA) developed model legislation[49] aimed at reforming the PA process to reduce unnecessary administrative burdens and improve patient access to care. This legislation focuses on streamlining the authorization process, increasing transparency, and ensuring timely decision-making. It protects the rights of patients with mental health conditions, preventing unfair denial of coverage or excessive delays in accessing necessary care.

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

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

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

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

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

5) Any long-acting injectable prescription drug.

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

The legislation outlines expedited internal appeal processes with quick response times for denials. It requires decisions to be made within 48 hours for expedited appeals. If the prescriber believes that the insured or enrollee will suffer serious harm without access to the prescribed drug, the denial becomes

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

eligible for an expedited internal appeal. Once the expedited appeal process is initiated, the insurance carrier must render a decision within 48 hours and provide written notice. If a decision is not made within this timeframe, the initial denial is automatically overturned, and the insured or enrollee receives immediate coverage approval for the prescription drug.

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

The federal government

In addition to state legislative action, the Centers for Medicaid and Medicare Services (CMS) within the federal Department of Health and Human Services (HHS), issued a CMS Interoperability and PA Final Rule[50] in 2024 in an effort to set uniform national PA standards for the federal health coverage programs under its jurisdiction, as well as for Qualified Health Plans offering ACA compliant coverage through Federally Facilitated Exchanges. The rule created uniform timeframes for PA decisions, data exchange requirements, transparency requirements, and other digitization efforts. While this rule does not reach health insurers operating in states with State-Based Exchanges, having a federal baseline may help encourage national uniformity as states continue to grapple with the issue.

Private industry

In June 2025, AHIP announced efforts by its member health insurance providers to simplify prior authorization, with a focus on "connecting patients more quickly to the care they need while minimizing administrative burdens on providers."[51] The pledge is the outcome of a survey of AHIP's members[52] and applies to insurance markets including Commercial coverage, Medicare Advantage, and Medicaid managed care. The participating member health plans commit to:

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

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

- **Enhance communication and transparency on determinations,** operational for fully insured and commercial coverage by January 1, 2026, with a focus on supporting regulatory changes for expansion to additional coverage types.
- **Expand real-time responses.** In 2027, at least 80% of complete electronic prior authorization requests will be answered in real-time.
- **Ensure medical review of denied requests**, a standard that is already in place

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

Takeaways

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

Take advantage of data calls

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

Incorporating flexibility in legislation

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

Build relationships with state partners

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

Implementation processes

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

Develop provider and consumer education

States may pursue public awareness campaigns so that health insurance consumers and their physicians become familiar with PA processes and the attendant appeal rights. States may also highlight rules currently in effect designed to significantly increase transparency of health insurer processes. Bringing

more focus to the health insurance consumer experience with PA will greatly benefit those depending on the coverage they purchased to help navigate and address complex health concerns.

Create structure for enforcement

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

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

Agenda Item #7

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