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PRIOR AUTHORIZATIONS UNDER THE GUN

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1.0 The Problem*

Long present as a feature of commercial health insurance, prior authorizations for specific services have, since their inception, been decried by the providers subject to them. The use of prior authorization is a utilization control technique for plans: “Also known as preauthorization, prior approval, or precertification, it is a tool requiring providers to establish and justify the clinical eligibility of a treatment before care can be delivered or often, continued.”¹ The plans have claimed their decisions are based on clinical evidence. Typically the authorizations apply to treatments or medications deemed unsafe, of low value or with too high a cost. Some services may be denied or deferred until alternative treatment has been tried (“step therapy”). Still, the processes are not uniform in their content, nor in how to submit a request. Insurers argue that imposing prior authorization requirements prevents fraud, reduces overspending and guards against potential harm to patients. It has been fundamental in gatekeeping HMO arrangements where the primary care physician (PCP) has to authorize specialty care.

Lambasted for years as burdensome to physician practices, recent data demonstrate that physicians continue to denounce the effects of prior authorization requirements.²

- 24 % of physicians say prior authorization led to an adverse event for a patient
- 90% said it has a negative impact on patient outcomes
- 94% said it delays access to care
- 27% said requests are often or always denied
- 87% said it leads to higher overall use of resources resulting in unnecessary waste
- 92% of surveyed practices reported hiring or reassigning staff solely to handle PAs³

* Much of the initial thinking supporting this article was originally set forth in a March 2026 presentation at the Health Law Institute of the Pennsylvania Bar Association

¹ Bernstein et al, “The Impact of Prior Authorization on Clinical Practice and Patient Care Outcomes: A Work Group Report of the AAAAI Prior Authorization Task Force” (July 2024)
<https://pubmed.ncbi.nlm.nih.gov/38819354/>

² “AMA survey shows physicians, patients heavily burdened by prior authorization”, AHA (June 20, 2024)
<https://www.aha.org/news/headline/2024-06-20-ama-survey-shows-physicians-patients-heavily-burdened-prior-authorization>

³ MGMA Govt Affairs Staff: “The prior authorization landscape in 2025”, MGMA Connection (Oct 2025) pp 20-25

- 60% indicated that at least three employees are typically involved in completing one PA request
- 35% reported spending more than 35 minutes on average per request

New concerns have arisen that artificial intelligence increases prior authorization (PA) denials, often with little or no human review.⁴

- Physicians report completing an average of 39 PAs a week
- They lament that it increases physician burnout
- 75% of physicians report the number of denials has increased over the last five years
- For a single physician, PA consumes 13 hours of physician and staff time each week
- 40% of physicians employ staff members just to work on PAs
- 88% of physicians report that PAs lead to higher overall utilization resulting in unnecessary waste by requiring ineffective prior treatment, additional office visits, urgent or emergency care and hospitalizations

The problematic effects are not restricted to physicians. Patients report exacerbated conditions and additional procedures necessitated because of delays.⁵ Patients who use more health services (e.g. more than 10 physician visits in a year) have more problems with PAs.⁶

- 26% of patients with a mental health condition had problems compared to 13% of insured adults who did not seek such treatment
- 23% of patients with diabetes had problems compared to 14% of others

⁴ AMA, “Physicians concerned AI increases prior authorization denials” (Feb 24, 2025) <https://www.ama-assn.org/press-center/ama-press-releases/physicians-concerned-ai-increases-prior-authorization-denials>

⁵ Sausser, “Stuck in Prior Authorization, Some Patients Run Out of Options”, *NBC News* (June 22, 2025) <https://www.nbcnews.com/health/health-care/prior-authorization-insurance-denials-patients-treatment-rcna212068>; see also Bendix and Barber, “Her spine surgery was denied. Doctors say it is all too common” *NBC news* (Aug 20, 2025) <https://www.nbcnews.com/health/health-care/spine-surgery-was-denied-doctors-say-s-common-rcna226100>

⁶ Lopes et al, “Consumer Problems with Prior Authorization: Evidence from KFF Survey,” (Sept 29, 2023) <https://www.kff.org/affordable-care-act/consumer-problems-with-prior-authorization-evidence-from-kff-survey/>

- 19% of adults with one prescription medication had problems compared to 8% of those who do not take prescription medication
- 25% of those who got health care in an emergency room were twice as likely to have PA problems compared to those who did not use the ER (13%)⁷

Consumers whose insurance problems include PA were more likely to experience serious consequences than those who did not use PA. These problems have included an inability to receive recommended medical care, significant delays in receiving care, a decline in their health, or they ended up paying more for treatment or services than they expected to pay.⁸ The complaints and problems are so widespread that a sub-industry of companies intended to help providers streamline the PA processes has emerged.⁹ Some products are being marketed by existing vendors such as Epic, Waystar and Salesforce. Others are newly created to focus on PA specifically.

Taken together the concerns regarding how PA has been implemented has led to significant focus on it in a variety of ways. Understanding who is engaged in commercial PA and the controversies there, plus what is present in Medicare Advantage and traditional Medicare is essential to understanding the current context for medical care delivery and payment. A major development is that state regulation has entered the fray in a highly detailed manner, And finally, despite the maelstrom surrounding this aspect of payment, CMS is launching a new pilot program for fee for service Medicare only. All of these issues are addressed in this article.

1.2 Medicare Advantage

In 2024, researchers found¹⁰ that between 2009-2019, 3 out of 4 enrollees were subjected to some form of PA. Across all plans the extent of PA's use increased over those ten years. There was variability regarding the extent and to what services PA applied. The most frequent applications were for DME, Part B drugs and skilled nursing care. The greatest increases over ten years were for diagnostic services, diabetic supplies and services, and

⁷ Patients who experienced problems with PA had other insurance problems as well. Id.

⁸ Id.

⁹ Perna, "The prior authorization companies ready to take on insurers", *Modern Healthcare* (October 2025) pp 12-14; <https://www.modernhealthcare.com/health-tech/ai/mh-prior-authorization-companies-cohere-health-eliseai/>

¹⁰ Neprash et al, "The Extent and Growth of Prior Authorization in Medicare Advantage", *Am J Mgd Care* (March 7, 2024) <https://www.ajmc.com/view/the-extent-and-growth-of-prior-authorization-in-medicare-advantage>

psychiatric services. Medicare Advantage insurers made nearly 50 million PA determinations in 2023 reflecting steady year over year increases from 2021 (37 million) and 2022 (46 million).¹¹ They fully or partially denied 6.4% of the requests. Amazingly, only 11.7% of those denials were appealed. That means of the 46 million reviews, almost 3 million entailed denials and only a little more than 344,000 were appealed. Given that most appeals (91.7%) were partially or fully overturned, the real viability of Medicare Advantage PA is called into question compared to less than one third of appeals overturned for traditional Medicare in 2022. PA in Medicare Advantage is most common among Humana and Anthem plans.

And still, controversies abound. Centene's PA denials, in 2022, were overturned 95.3% of the time and Aetna's were overturned 90.8%.¹² The companies apply predictive algorithms to make determinations, although the plans claim they are suggestive only.¹³ As part of the rampant consolidation everywhere in health care, not to anyone's advantage except the resulting behemoths, insurers are now buying the companies that create the algorithms. The biggest, NaviHealth, is owned by United Health and was created by Tom Scully with money from an original investment of \$56 million from Ascension, Select Medical and his private equity firm. He sold it for \$2.5B. To make matters worse, reportedly the plans deny care routinely covered in traditional Medicare

1.1 Commercial –The Rise of PBMs and RBMs

Pharmacy Benefit Managers (PBMs) emerged in the 1960s as intermediaries between insurers and providers when drug coverage was included with health insurance¹⁴. Their initial tasks were to help set reimbursement rates, process claims and pay pharmacies. As with many aspects of health care, they are increasingly vertically integrated so they are part

¹¹ Biniak et al, "Medicare Advantage Insurers Made Nearly 50 million Prior Authorization Determinations in 2023", KFF (Jan 23, 2025) <https://www.kff.org/medicare/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/>

¹² Wilson, "Medicare Advantage insurers ranked by prior authorization denial rates | 2023", , Becker's Payer Issues (Jan 30, 2025) <https://www.beckerspayer.com/payer/medicare-advantage-prior-authorization-how-insurers-stack-up/>

¹³ Ross and Herman, "Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need", (March 13, 2023) <https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/>

¹⁴ For a good review of the development and transitioning of PBMs see, Mattingly et al, "Pharmacy Benefit Managers: History, Business Practices, Economics and Policy," *JAMA Health Forum online* (Nov 3, 2023) <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2811344>

of the plans themselves. Today they do much more than their three basic tasks.¹⁵ They negotiate with drug manufacturers and pharmacies to set prices. They set formularies. They establish requirements for step therapies, where different medications must be tried before the targeted medication may be delivered and covered. Fundamentally, they determine patients' access to medications. They contract with pharmacies to participate in networks. They get a share of the drug rebates they negotiate and also collect the difference between what insurers are reimbursed and the amount pharmacies are paid. They steer business to affiliated pharmacies. Three PBMs account for more than 85% of drug spending : CVS Caremark, Express Scripts/CIGNA and Optum.

The power they hold has led to a host of controversies. Retention of negotiated rebates is seen as a conflict of interest with respect to what science would dictate regarding proper medication. Their tiering of formularies to create preferred medications has been fraught with criticisms. The retention of the difference between amounts paid by health plans and employers which are higher than what the PBMs pay to pharmacies has also been disparaged. Other complaints include that vertical integration limits competition. Not surprisingly, pharmacists are as dissatisfied with PBMs as physicians are with medical PA.¹⁶

Radiology Business Managers (RBMs) arose more recently than PBMs, and emerged with the advent of high end imaging in the late 1990s and early 2000s.¹⁷ Like PBMs they have engaged in vertical integration and consolidation of providers. In their roles, they often require proof of prior efforts at conservative treatment (See Evolent Conservative Treatment History Form).¹⁸ Where questions have been raised regarding the effectiveness of RBM compared to none in place, at least one study found commercial plans with PA had the same utilization rates as Medicare FFS with no PA.¹⁹

¹⁵ Martin. "What Pharmacy Benefit Managers Do, and How They Contribute to Drug Spending," Explainer (March 17, 2025) <https://www.commonwealthfund.org/publications/explainer/2025/mar/what-pharmacy-benefit-managers-do-how-they-contribute-drug-spending>

¹⁶ "New Surescripts Survey Reveals Prescriber and Pharmacist Frustration with Prior Authorization, Raising Concerns About Impact on Patient Access to Care" (Aug 12, 2025) <https://surescripts.com/press-releases/new-surescripts-survey-reveals-prescriber-and-pharmacist-frustrations-prior-authorization-raising-concerns-about-impact-patient-access-care>

¹⁷ Wiley " RBMs: The Debate Heats Up", Radiology Business (July 1, 2009)

¹⁸ https://cms.radmd.com/sites/default/files/2024-01/Conservative%20Treatment%20Form%20-%20Back_Neck%202023%20Evolent.pdf

¹⁹ Stempniak, "Data cast doubts on effectiveness of radiology benefits management, experts say". Radiology Business (Jan 3, 2020)

Other companies have expanded beyond imaging to a range of other services following the same principles.²⁰ EviCore, which is owned by CIGNA, promises insurers a 3 to 1 return on investing in their services. They are used by United, Aetna and Blues plans, issuing recommendations for imaging, oncology, cardiology, gastroenterology, sleep problems and more. The validity of their guidelines has been criticized by the American College of Cardiology, the Society for Vascular Surgery and the American Society for Radiation Oncology. They use an algorithm they tinker with to produce fewer or more denials in accordance with the desires of their insurance company customers. They were fined \$16,000 in 2024 by the Connecticut Insurance Department for more than 77 violations in a review of 196 files. The second largest company is Carelon Medical Benefits Management, a subsidiary of Elevance Health (formerly Anthem).

“In 2022, Carelon settled a lawsuit for \$13 million that alleged the company, then called AIM, had used a variety of techniques to avoid approving coverage requests. Among them: The company set its fax machines to receive only 5 to 10 pages. When doctors faxed prior authorization requests longer than the limit, company representatives would deny them for failing to have enough documentation.”²¹

Both PBMs and RBMs have become both more widely condemned and subject to greater scrutiny and reporting about them.

1.3 Traditional Medicare

Prior authorization has been limited in traditional Medicare, focused primarily on certain outpatient hospital services which list expanded from 2020 through 2024) (blepharoplasty, botulinum toxin injection, rhinoplasty, panniculectomy, vein ablation, cervical fusion with disc removal and implanted spinal neurostimulators and facet joint interventions), non-emergency ambulance transport and DMEPOS (List currently contains 67 Healthcare Common Procedure Coding System (HCPCS) items including 46 power mobility devices (PMDs), five pressure reducing support surfaces (PRSSs), six lower limb prosthetics (LLPs), and ten orthoses.)

²⁰ Miller et al, “ “Not Medically Necessary”: Inside the Company Helping America’s Biggest Health Insurers Deny Coverage for Care,” *ProPublica* (Oct.23, 2024) <https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations>

²¹ Id

CMS differentiates between prior authorization and pre-claim review²²

“Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before an item or service is furnished to a Medicare patient. Pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment.”

400,000 PAs were completed for 2023²³. About one quarter of the requests were denied, and like under Medicare Advantage, only 6.4% of denials were appealed in 2022. Of those appeals, just over a quarter overturned the initial denial, but 2/3 of appeals for DMEPOS were successful. CMS says the percentage of claims overturned on level 1 appeal for hospital outpatient department services in 2024 was 18.4%, while for non-emergent transport it was 45.1% and for DMEPOS was 38.4%,²⁴ a sharp drop from the previous year. Given the rate of success on appeal, why aren't more appealed?²⁵ CMS argues the pre-service reviews are a benefit to providers: “In an effort to reduce provider burden, these programs do not change any medical necessity or documentation requirements. They require the same information currently needed to support Medicare payment, just earlier in the process. This helps providers and suppliers address claim issues early and avoid denials and appeals.”

2.0 CMS Reform Regulations

The ongoing complaints about PA as applied in Medicare have been heard. Beginning in 2024, CMS has issued regulations addressing a range of issues in Medicare Advantage (MA) implementation of PA. These include coverage determinations, processes for handling PA requests, transparency of data and communication regarding accessibility.

2.1 Coverage Decisions

Effective Jan 1, 2024, confronting a much lamented element, MA plans must follow traditional Medicare National Coverage Determinations (NCDs), local coverage

²² “Prior Authorization and Pre-Claim Review Program Stats for Fiscal Year 2024” (Sept 16, 2025) [pre-claim-review-program-statistics-document-fy-24.pdf](#)

²³ See fn 19

²⁴ See fn 20

²⁵ AMA Wire, “Over 80% of prior auth appeals succeed. Why aren't there more?” (Oct 3, 2024) <https://www.ama-assn.org/practice-management/prior-authorization/over-80-prior-auth-appeals-succeed-why-aren-t-there-more>

determinations (LCDs), and basic coverage statutes and regulations when making medical necessity determinations. MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statute, regulation, NCD or LCD. Coverage criteria are not fully established when additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently. When additional, unspecified criteria are needed to interpret or supplement general provisions, the MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.²⁶ The MA plans must post their internal coverage criteria and provide public summary of the evidence that was considered in creating the criteria.

The plan's approval granted through PA processes must be valid for as long as medically necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history and the treating provider's recommendations. If a service is initially approved, it may not be later disapproved on medical necessity grounds, except for good cause defined in regulations or credible evidence of fraud. The plan must provide a minimum 90 day transition period when an enrollee who is currently undergoing treatment switches to a new MA plan, from Traditional Medicare to an MA plan or is new to Medicare; the MA organization must not disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days. MA organizations must establish a committee (similar to a Pharmacy and Therapeutics (P&T) committee, led by a plan's Medical Director, that reviews utilization management policies, including PA, annually and keeps current with LCDs, NCDs and other Traditional Medicare coverage policies. The majority of the committee's membership must be physicians. One must be independent.

“Beginning January 1, 2025, [the committee must] include at least one member with expertise in health equity. Expertise in health equity includes educational degrees or credentials with an emphasis on health equity; experience conducting studies identifying disparities amongst different population groups; experience leading organization-wide policies, programs, or services to achieve health equity; or experience leading advocacy efforts to achieve health equity.”²⁷

²⁶ 42 CFR §422.101

²⁷ 42 CFR §422.137(c)(5)

The regulations assign the committee 7 specific responsibilities²⁸ among which, after January 1, 2025, include conducting a health equity analysis for their utilization management policies including those pertaining to PA.

2.2 *Prior Authorization Processes*

Here CMS has adopted an omnibus rule for multiple programs it regulates, including Medicare and Medicaid, CHIP, MIPS and more.²⁹ Manifesting the substantial concerns in the industry regarding PA, CMS received 900 timely comments and issued 184 pp of responses, plus multiple grids and charts to summarize and focus on the content and impact of the rules.

Significantly, these rules Introduced the concept of "Application Programming Interfaces" (APIs) to respond to the needs of multiple players.

"An API is a set of commands, functions, protocols or tools published by one software developer ("A") that enables other software developers to create programs (applications or ""apps") that can interact with A's software without need to know the internal workings of A's software while maintaining data security and patient privacy (if properly implemented.)"³⁰

The rules call for affected payers to develop and deploy Patient Access API, Provider Access API and Payer to Payer API. They also require a Provider Authorization API to let providers determine whether a specific payer requires prior authorization for a certain item or service, and permit the provider to query the payer's prior authorization documentation requirements directly from the provider's system, to be implemented by January 1, 2027. The Prior Authorization API must³¹ be populated with the MA organization's list of covered items and services (excluding drugs) that require PA; identify all documentation required for approval or any items or services that require PA; support a HIPAA compliant PA request and response (per 45 CFR part 162) and communicate the following about PA

²⁸ 42 CFR §422.137(d)

²⁹ Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program (89 Fed Reg 8758 (Feb 8 2024))

³⁰ Id at 8762

³¹ 42 CFR §422.122(b)

requests: Whether the MA organization approves the PA request and the date or circumstance under which the authorization ends; whether it denies the PA request ;or if the MA organization requires more information. If denied, the MA organization must state the reason for the denial . An MA organization must make publicly accessible, by posting directly on its website or via publicly accessible hyperlink(s), complete accompanying documentation that contains, at a minimum the information listed in this paragraph³²:

- For the purposes of this section, “publicly accessible” means that any person using commonly available technology to browse the internet could access the information without any preconditions or additional steps, such as a fee for access to the documentation;
- a requirement to receive a copy of the material via email;
- a requirement to register or create an account to receive the documentation; or
- a requirement to read promotional material or agree to receive future communications from the organization making the documentation available.

The regulations characterize the decisions made by the MA plan as “Organization Determinations.”³³ These include, (among 3 others not relevant here) a refusal, pre or post service, or in connection with a decision made concurrently with an enrollee’s receipt of services, to provide or pay for services in whole or in part, including the type or level of services that the enrollee believes should be furnished. Also included are a reduction or premature discontinuation of a previously authorized ongoing course of treatment. Those who can request such a determination include an enrollee or their representative or a physician. Organization Determinations must conform with who may review the issues at hand. If the MA organization expects to issue a partially or fully adverse medical necessity (or equivalent) determination, before issuing the decision it must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health appropriate for the services, including knowledge of Medicare coverage criteria. The professional need not be of the same specialty or subspecialty as the treating physician but must have an unrestricted license to practice.

The regulations specify requirements for data accessibility (excluding regarding drugs). An MA organization must make the following information accessible to its current enrollees or

³² 42 CFR §422.119

³³ 42 CFR §422.566

the enrollee's personal representative through the API³⁴ (beginning Jan 1, 2027): the prior authorization request and decision including all of the following as applicable

- The prior authorization status
- The date the PA was approved or denied
- The date or circumstance under which the PA ends
- The items and services approved
- If denied, a specific reason why
- Related structured administration and clinical documentation submitted by a provider

That information must be accessible no later than 1 business day after the MA organization receives a PA request; be updated no later than 1 business day after any status change; and continue to be accessible for the duration that the authorization is active and at least 1 year after the PA's last status change.

Reinforcing the control CMS intends to exercise, the regulations establish timeframes³⁵ for the plans to act. Beginning Jan 1, 2026, if PA is denied, the response to the provider must include the specific reason for the denial. For standard requests, the MA plan must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires but not later than either of the following: for a service or item not subject to the prior authorization rules in 42 CFR §422.122, 14 calendar days after receiving the request; for a service or item subject to prior authorization , 7 calendar days after receiving the request for the standard determination. For expedited requests³⁶, except for a request for a Part B drug, if the MA plan approves the expedited request, it must issue its determination and notify the enrollee and physician, whether adverse or favorable, as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request. If an expedited request for a Part B drug is approved, the determination must be issued no later than 24 hours after receiving the request. The 72 hour notice may be extended up to 14 calendar days if the enrollee requests, the extension is justified and in the enrollee's interest due to need for additional medical evidence or the extension is justified due to extraordinary, exigent or other nonroutine circumstances and is in the enrollee's interest. Notice of the expedited determination must be stated "in understandable language." If not completely favorable, it must inform the enrollee of the right to a reconsideration, describe

³⁴ 42 CFR §422.119

³⁵ 42 CFR §422.568

³⁶ 42 CFR §422.572

both the standard and expedited reconsideration processes, including the enrollee's right to request and conditions for obtaining an expedited reconsideration and the rest of the appeal process. Failure to provide timely notice itself constitutes an adverse organization determination which may be appealed.

The regulators further delineate how an MA organization must process requests for expedited determinations.³⁷ Requests may be made orally or in writing. Support provided may be oral or in writing. The MA plan must document all oral requests in writing and maintain the documentation. The regulations stipulate the proper bases for a plan to decide to expedite: If applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function; or if the physician indicates that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. If the plan denies a request for expedited determination, it must automatically transfer to the standard determination and use that timeframe. It must give oral notice of denial and subsequently deliver, within 3 calendar days, a notice that explains that it will process using the 14 day timeframe and it must inform the enrollee of the right to file an expedited grievance if he disagrees with the decision not to expedite.

With regards to complaints about transparency, the regulations also enumerate a range of requirements pertaining to public reporting. The plan must publicly report these metrics by posting them on the MA plan website.³⁸ These include

- A list of all items and services that require PA;
- The percentage of standard PA requests that were approved, aggregated for all items and services;
- The percentage of standard PA requests that were denied, aggregated for all items and services;
- The percentage of standard PA requests that were approved after appeal, aggregated for all items and services;
- The percentage of PA requests for which the timeframe for review was extended and the request was approved, aggregated for all items and services;
- The percentage of expedited PA requests that were approved, aggregated for all items and services;

³⁷ 42 CFR §422.570

³⁸ 42 CFR §422.122(c)

- The average and median time that elapsed between the submission of a request and a determination by the MA plan, for standard PAs, aggregated for all items and services;
- The average and median time that elapsed between the submission of a request and a decision by the MA plan for expedited prior authorizations, aggregated for all items and services.

The detail in the regulations is highly prescriptive. It demonstrates, to me, a profound distrust of the industry to regulate itself. This raises the question of how plans have behaved with regard to the long-standing criticism of their approaches to PA.

3.0 *Reforms by Plans and to Plans*

3.1 *Background to Consensus*

As we have seen, prior authorization practices by plans have long been a source of annoyance to physicians and a focus of attention by the American Medical Association (AMA). In January, 2017, the AMA convened a workgroup of 17 state and specialty medical societies, national provider associations and patient representatives to develop best practices for prior authorization and other utilization management programs.³⁹ They proposed 21 specific reforms. Then, 100 additional stakeholders signed on in support. It was claimed that the publication led to ‘meaningful discussions’ with the health insurance industry about reducing prior authorization burdens. This, in turn, led the next year to The Consensus Statement.⁴⁰

3.2 *The Consensus Statement*

It was signed by the American Hospital Association (AHA), America’s Health Insurance Plans (AHIP), the AMA, the American Pharmacists’ Association (APhA), the Blue Cross Blue Shield Association, and the Medical Group Management Association (MGMA). The document adopted five areas for improvement to achieve meaningful reform. It is useful to review the extent of the declared efforts at reform in order to evaluate what came later for the industry.

The first promise was for selective application of prior authorization. Plans would encourage the use of programs that selectively implement prior authorization requirements

³⁹ AMA. “Prior Authorization an Utilization Management Reform Principles”, <https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf>

⁴⁰ “Consensus Statement on Improving the Prior Authorization Process” (January 2018) <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>

based on stratification of health care providers' performance and adherence to evidence-based medicine; encourage (1) the development of criteria to select and maintain providers in these selective programs with the input of contracted providers and/or provider organizations; and (2) making these criteria transparent and easily accessible; and create appropriate adjustment when providers participate in risk based payment contracts.

The second topic was program review and volume adjustment. The Statement addressed the need for regular review of the list of services and drugs, on at least an annual basis, with provider input; revision based on data analysis and up-to-date clinical criteria; and sharing of changes to the lists covered via provider accessible websites and at least annual communications to contract providers. With respect to the third topic, transparency and communication regarding prior authorization. The Statement pledged the adoption of effective two way communication channels; transparent and easy accessibility of prior authorization requirements, criteria, rationales and program changes to providers and patients; improvement in communication to support timely submission by providers of the complete information necessary to make a determination as early in the process and possible; timely notification of determinations by plans to impacted providers (both ordering/referring physicians and dispensing pharmacists) and patients/enrollees.

The fourth set of reforms addressed continuity of patient care. Here the pledge was to create sufficient protections for continuity of care during transition for patients undergoing an active course of treatment, when there is a formulary or treatment coverage change or a change of health plan; support continuity of care for medical services and prescriptions for patients on appropriate, chronic, stable therapy through minimizing repetitive prior authorization requirements; and improve communication between providers, plans and patients to facilitate continuity of care and minimize disruptions in needed treatment. Finally, the Statement tackled automation to improve transparency and efficiency. This would include electronic prior authorization processes; making prior authorization requirements and other formulary information electronically accessible to health care providers at the point of care in electronic health records; advocate for adoption of national standards for electronic exchange of clinical documents; encourage communication of up-to-date prior authorization and step therapy requirements, coverage criteria and restrictions, drug tiers, costs, and covered alternatives to EMR, pharmacy systems and other vendors, to promote accessibility of information to health care providers at the point of care via integration, not ordering and dispensing technology interacts, and via easily accessible website for providers. They agreed to advocate that provider and plan trading partners (e.g., intermediaries, clearinghouses and EMR and practice management system vendors) develop and deploy software and processes that facilitate automation using standard electronic transactions. Mind you, all of this was stated as the consensus of the

industry in 2018 when automation and electronic records were nowhere near as widespread as they are today. Was the Statement merely aspirational, given these laudatory goals regarding ‘automation’, as they referred to it? What about the four other topics which did not entail deployment of costly electronic systems, from either side, in order to be implemented? As we shall see, the effort appears to have been a charade. If we examine the data from 2024 in the opening of this article fully six years after the Consensus Statement, it appears there was little follow through or impact. This became manifestly clear when the industry, with great ballyhoo, announced, in June 2025, fully seven years after the Consensus Statement, a new recommitment to reform.

3.3 The 2025 Recommitment

Reportedly CMS chief Mehmet Oz and DHHS Secretary Kennedy secured a new pledge from the industry for six reforms.⁴¹ AHIP announced commitments from 60 plans across benefit programs to streamline, simplify and reduce prior authorizations characterized as ‘measurable commitments’.⁴² Compare the six reforms to the Consensus Statement. In 2025, they assured they would standardize electronic prior authorization but with a goal date of 1/1/27. They agreed to cut the scope of prior authorization, as appropriate to the local market for each health plan with a goal date 1/1/26. Humana said it would eliminate about one third of prior authorizations in the outpatient setting and would remove it for diagnostic services across colonoscopies, transthoracic echocardiograms and select CT scans and MRIs.⁴³ The new reforms would create a new national gold card program for physicians that waives PA requirements for certain items and services for providers with a good track record.⁴⁴ They would boost care continuity including a prior plan’s authorization when patients change plans with a goal date of 1/1/26. That certainly sounds familiar. They promised to improve communication and transparency with clear language, including information about next steps and available appeals with a goal date of 1/1/26. They would expand real-time responses to at least 80% as required in Medicare Advantage but with a goal date of 1/1/27. Humana said it will

⁴¹ DHHS, “HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System,” (June 23, 2025) HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System | HHS.gov

⁴² AHIP, “Health Plans Take Action to Simplify Prior Authorization” (June 23, 2025) <https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization>

⁴³ Lagasse, “Humana pledges to simplify prior authorization process”, Heath Care Finance News (July 24, 2025) <https://www.healthcarefinancenews.com/news/humana-pledges-simplify-prior-authorization-process>

⁴⁴ Id

provide a decision within one business day on at least 95% of requests.⁴⁵ They agreed that medical review of nonapproved requests for denials based on medical necessity for clinical factors would be reviewed by a licensed and qualified clinician and would take effect upon publication of the recommitment --so how is it a reform? The recommitment does not affect prescription drug benefits; and the promises are limited to certain health plan products. The 2025 Statement barely holds a candle to the one in 2018, which they clearly did not live up to. With dissatisfaction with the plans in now way waning, it is no surprise, therefore, that state governments are leaping into the fray with statutes and regulations addressing how insurance plans operating within their borders must conduct prior authorization.

4.0 The States Step In and Up

Against the spotty background of plan initiatives, state regulators have stepped in, where they can regulate plans that are not subject to ERISA. The National Association of Insurance Commissioners (NAIC) has published a white paper on prior authorization specifically to advise state regulators regarding options and activities to date.⁴⁶ They state that 49 states have some form of P law as well as the District of Columbia and Puerto Rico. This section addresses examples of reforms that are imposed by state law. Some of these reflect similar concerns addressed in Medicare Advantage rules.

4.1 Gold Carding

Gold carding is a process by which a provider may qualify for an exemption from some or all of a health insurer's PA requirements. While some plans have introduced these programs voluntarily, in states where regulations address this issue, the plans are required to evaluate providers to be exempt. Some laws further restrict how often the plans can review or revoke the exemptions. The NAIC cites Arkansas, Texas, West Virginia and Wyoming as examples.⁴⁷ All of them require exemption of the provider's PA requests are approved 90% of the time, although over how many requests and what time period varies among those states. NAIC reports that 23 jurisdictions have requirements related to gold carding.

⁴⁵ Id

⁴⁶ NAIC, "Prior Authorization White Paper", 12/4/2025

⁴⁷ Id at pp 13-14.

4.2 *Continuity of Care*

These laws address two types of problems: accepting a PA that was issued by a prior plan when the patient changes coverage, as well as how long a PA must be effective. Illinois, New Hampshire, Tennessee and Wyoming requires the subsequent plan to accept a prior PA approval for 45-90 days after the patient changes coverage. The District of Columbia requires a PA to be valid for at least one year or for the course of treatment, while Oklahoma requires that the PA be valid for at least 45 days or six months in the case of chronic conditions. New Mexico calls out mental health or substance use disorder services for which prior PAs must be honored and further prohibits PA and step therapy requirements for FDA -approved medications prescribed to treat auto-immune disorders, cancer, substance use disorders or rare diseases.⁴⁸

4.3 *Reducing Response Times*

These laws mandate turn around times on responses to PA requests, among at least 7 states. Michigan, New Hampshire, Oklahoma and Wyoming require that urgent requests be addressed within 72 hours. In Texas life-threatening conditions require a response within one hour and for concurrent care within 24 hours, Washington requires a response to an electronic request within three days for a standard request and one day for an urgent request. Timeframes are longer for non-electronic requests -- 2 days for an urgent request, but 5 days for a standard request. A number of states allow 7 days to respond to non-urgent requests: Michigan, New Hampshire, Oklahoma. West Virginia addresses not only the plan's response times but the provider's as well! If the prior authorization request is incomplete, the health insurer must identify all deficiencies in the request within two business days from the date on the electronic request and return the prior authorization request to the health care practitioner. The health care practitioner shall provide the additional, requested information to render the prior authorization request complete within three business days from the time the returned request is received by the health care practitioner. If the completed prior authorization is not returned to the health insurer, the prior authorization request is deemed denied and a new request must be submitted.⁴⁹

4.4 *Updating Technology*

In its 2018 Consensus Statement the health plans said they would move toward electronic PAs. By the 2025 statement they were still projecting their goal date as 1/1/2026. As we

⁴⁸ Id at pp. 15-16

⁴⁹ [https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/IB%2021-08%20Electronic%20PA%20\(1\).pdf](https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/IB%2021-08%20Electronic%20PA%20(1).pdf)

have seen, New Hampshire’s laws incentivize electronic submission by applying shorter timeframes for request submitted electronically. Clearly this benefits the providers. Washington’s laws prioritize and interoperable systems. Like the federal rules their law requires plans to build and maintain an API that automates the process for providers to determine whether a PA is required and sets forth documentation requirements the use of EHR. Since 2014, Texas has mandated standardize PA request forms and has updated its rules to require them in both electronic and paper formats.⁵⁰

4.5 Other Regulatory Reforms.

The NAIC offers a 15 page grid of state controls over PA.⁵¹ Besides the four issues addressed above, they report that half of jurisdictions have provisions relating to retrospective denials, prohibiting them after an approved PA except in cases of fraud. Just over half of jurisdictions have requirements pertaining to clinical criteria and medical necessity focused on evidence-based foundations with transparency requirements for the clinical criteria to be applied. They report that 33 of 56 jurisdictions have requirements relating to the qualifications of reviewers, most of which require that adverse determination be made by a licensed physician or health care professional. Some specify licensure in the state or that the reviewer is of the same or similar specialty as the requestor. Similarly, 26 jurisdictions have provisions for peer-to-peer appeal processes. These often require that providers have an opportunity to discuss with a clinician of the same or similar specialty as the requestor before a decision is final. The state efforts mirror much of what the Medicare Advantage rules did. Some of the state laws are surprisingly detailed. Pennsylvania’s Act 146 which took effect in 2024 has meticulous, wide-ranging features. The conclusion to be drawn from these enactments is that PA is contentious; the plans have not regulated themselves well, the burdens on providers and impact on consumers are appreciated by state legislatures. While the states demonstrated management of PA, PBMs became targets of a recent federal law.

5.0 Federal PBM Reform

The antipathy associated with the functioning of PBMs can be seen in the significant reform provisions adopted in the Consolidated Appropriations Act of 2026⁵², in an otherwise routinely, vastly divided Congress. Signed into law on February 3, 2026, the statute has two

⁵⁰ 28 Tex Admin Code 19.180. See also fn 48 at p 18.

⁵¹ Fn 46 at pp 32-47. Another state law survey which is easier to read, but not summarized was published by the AMA in 2024. AMA, “2024 Prior Authorization (PA) State Law Chart” <https://www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf>

⁵² PL 119-75

substantial sections which confront major criticisms of PBMs. Some of the enactment amends ERISA provisions.⁵³ They are extremely detailed. The basic controls will be effective for plan years beginning or after January 1, 2028. Some of the reporting provisions won't be effective until August 2028 (30 months after enactment). But the demands imposed on the PBMs, are real. They may not bring down drug costs⁵⁴, but they will certainly enhance the transparency of the PBMs' operations.

The first issue of note is the definition of a PBM:

The term `pharmacy benefit manager' means any person or entity that, either directly or through an intermediary, acts as a price negotiator or group purchaser on behalf of a PDP⁵⁵ sponsor or prescription drug plan, or manages the prescription drug benefits provided by such sponsor or plan, including the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered part D drugs, or the provision of related services. Such term includes any person or entity that carries out one or more of the activities described in the preceding sentence, irrespective of whether such person or entity calls itself a `pharmacy benefit manager'!"⁵⁶

The application of the law turns on the functions being performed not the name of the entity or its characterization. The law restricts permissible compensation models prohibiting remuneration on any basis except 'bona fide service fees', thereby eliminating the ability to be paid rebates to PBMs based on the percentage of the drug's price.

⁵³ The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans. ERISA requires plans to provide participants with plan information including important information about plan features and funding; sets minimum standards for participation, vesting, benefit accrual and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; gives participants the right to sue for benefits and breaches of fiduciary duty; and, if a defined benefit plan is terminated, guarantees payment of certain benefits through a federally chartered corporation, known as the Pension Benefit Guaranty Corporation (PBGC).

<https://www.dol.gov/general/topic/retirement/erisa>

⁵⁴ Abelson and Robbinis, "Middlemen Losing Grip on RX Costs", New York Times(Feb 7, 2026) at B1

⁵⁵ PDP stands for prescription drug plan.

⁵⁶ Sec 6224(a)(7)(C)

“The term ‘bona fide service fee’ means a fee that is reflective of the fair market value (as specified by the Secretary, through notice and comment rulemaking) for a bona fide, itemized service actually performed on behalf of an entity, that the entity would otherwise perform (or contract for) in the absence of the service arrangement and that is not passed on in whole or in part to a client or customer, whether or not the entity takes title to the drug. Such fee must be a flat dollar amount and shall not be directly or indirectly based on, or contingent upon—”⁵⁷

price, discounts, coverage or formulary placement decisions or volume or value of referrals. The statute uses the fairly radical term “disgorgement” to refer to the PBM’s obligation to return monies received in violation of the law’s requirements. It establishes transparency regarding guarantees and cost performance evaluations. Effective July 1, 2028, it requires detailed reporting to be provided to the PDP sponsor and the Secretary on no fewer than 18 enumerated data points and then for generic drugs 5 different data points and for biosimilar products another 5. They are required to report their spending, including to any affiliate, broker, consultant advisor and auditor. They are required to submit to the PDP sponsor the details, specified in the statute, regarding any contract or agreement and manufacturer that makes rebates, discounts, payments or their financial incentives. They have to allow at least annual audits, at the request of the PDP sponsor, but they may select their auditor. The statute provides for reporting of alleged violations and establishes anti-retaliation and anti-coercion provisions to protect potential whistleblowers under that provision. In addition the GAO and MedPac are charged with the responsibility to report on agreements with PBMs.

Section 6701 addresses how PBMs, may interact with group health plans or a health insurer offering group health insurance. It establishes detailed reporting requirements pertaining to compensation to the PBM, much of the same reporting as required under 6224. Under this section, each plan year the PBM is to provide to each participant or beneficiary, written notice informing them of the requirement for PBMs to submit reports to group plans as well as a summary document describing what they are doing. By Aug 2027 (18 months after the enactment) the Secretary is to issue regulations regarding reporting. Penalties apply to failure to comply. Failure to provide information is applicable to both the PBM and the plan with a \$10,000 civil money penalty for each day of non-compliance. For providing false information, a \$100,000 civil money penalty pertains. There are ten defined terms that apply generally under this section. For plan years after August 2028 (30 months after enactment) neither the plan nor the PBM may enter into contracts unless they agree

⁵⁷ Id at (a)(7)(b)

to not limit or delay disclosure of information to the health plan and the plan must provide the PBM with relevant information necessary to make the required reports. There are extensive reporting requirements for the PBM to make to the health plan. The law amends the Internal Revenue Code to provide applicable responsibilities.

Taken together, in light of the dearth of management of this sector of the health care industry, the Congressional approach to the host of complaints against PBMs even in a more anti-regulatory administration context is remarkable. Despite the very detailed reporting issues, there are still regulatory challenges awaiting the Secretary and sure to garner attention from the regulated industry. So, while the plans have failed to demonstrate much commitment to change, nor have the PBMs Congress can only go so far. Others have power here too. With all of these controls enacted, many were surprised by a PA initiative launched by CMS in 2025.

6.0 *WISeR or Not So Much?*

Announced in 2025, for implementation in 2026, CMS promulgated a pilot program for original Medicare designated *Wasteful and Inappropriate Service Reduction*⁵⁸, shortened to WISeR, which re-introduced more prior authorization in Medicare. It is applicable in six states: New Jersey, Ohio, Oklahoma, Texas Arizona and Washington. “States and regions were selected based on comparison feasibility, service volume, and geographic diversity and presence or absence of selected services. States included in the model were selected to ensure a broad array of practice environments and geographies. In addition, CMS reviewed Medicare Administrative Contractor (MAC) jurisdiction and LCDs or NCDs within each selected state to ensure that the model could be fully tested.”⁵⁹ The model will be tested over six years in two three year agreement periods. It entails voluntary pre-review or mandatory post review for a specified list of services.⁶⁰ CMS professed that “a primary

⁵⁸ 90 Fed Reg 28749 (July 1, 2025)

⁵⁹ WISer Model FAQs, <https://www.cms.gov/priorities/innovation/files/document/wiser-model-frequently-asked-questions>

⁶⁰ Electrical Nerve Stimulators (NCD 160.7; Sacral Nerve Stimulation for Urinary Incontinence (NCD 230.18); Phrenic Nerve Stimulator (NCD 160.19); Deep Brain Stimulation for Essential Tremor and Parkinson’s Disease (NCD 160.24); Vagus Nerve Stimulation (NCD 160.18); Induced Lesions of Nerve Tracts (NCD 160.1); Epidural Steroid Injections for Pain Management excluding facet joint injections (L39015, L33906, L39036, L39240, L39242, L36920, L38994, L39054); Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF) (L33569, L34106, L34228, L38201, L34976, L35130, L38737, L38213); Cervical Fusion (L39741, L39799, L39770, L39758, L39762, L39793,

goal of WISer is to help patients avoid unnecessary, inappropriate procedures that may cause potential harm such as pain, bleeding, infection, anxiety or other adverse effects and instead promote high-value services aligned with evidence based care guidelines.”⁶¹

6.1 *The Review Process*

The provider (or supplier) must submit his request to the applicable MAC or to the “model participant”. These are companies contracted to perform the PA function⁶². The request must include documentation to support that the services requested meet the requirements of any NCD or LCD. Even if the MAC receives the request, it merely transmits it to the model participant. MACs will not do the PA themselves. Although providers have the choice to voluntarily submit their request for PA, if a request is not submitted, the submitted claim will be subjected to prepayment review. A positive review is “provisional affirmation” for payment. If the request is not affirmed, there is no appeal available, but there is the ability to resubmit, and then peer to peer review becomes available. A non-affirmed prior authorization decision does not prevent the provider from submitting a claim. However, submission of such a claim would be denied by the MAC and would constitute an initial determination, which would be subject to the administrative appeals process. CMS is also exploring implementation of “gold carding” which is a process to exempt compliant providers from the PA process and expanded pre-payment review processes.

L39773, L39788); Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (NCD 150.9); Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea (L38276, L38307, L38398, L38387, L38310, L38312, L38385, L38528); Incontinence Control Devices (NCD 230.10); Diagnosis and Treatment of Impotence (NCD 230.4); Percutaneous Image-Guided Lumbar Decompression for Spinal Stenosis (NCD 150.13); Skin and Tissue Substitutes (LCDs below)—only applicable to MAC jurisdictions and states that have an active LCD in place ++ Application of Bioengineered Skin Substitutes to Lower Extremity Chronic Non-Healing Wounds (L35041) ++ Wound Application of Cellular and/ or Tissue Based Products (CTPs), Lower Extremities (L36690)

⁶¹ WISer Model FAQs, <https://www.cms.gov/priorities/innovation/files/document/wiser-model-frequently-asked-questions>

⁶² Cohere Health Inc., Genzeon Corporation, Humata Health Inc., Innovaccer inc., Virtix Health LLC. Zyter Inc, several noted in fn 9.

The applicable timeframes were not set forth in the Federal Register announcement.⁶³ For prior authorization requests, WISeR model participants are to issue a determination to the requester within 3 days of receiving the initial or resubmitted request. Expedited requests are to be completed within 2 days. Where PA is not requested, for pre-payment medical review, WISeR providers will have 45 days from the date of the request for documentation from the WISeR model participant to submit their clinical documentation. WISeR model participants will issue a determination on medical necessity to the MAC within 3 days of receipt of all documentation.

6.2 Criticisms

Considering all the turmoil with respect to the health plans' Consensus Statement which was so ineffective that it had to be restated in a much diluted form 8 years later, it is hardly surprising that, even before implementation, there was substantial criticism of the WISeR model. Both the hospital industry⁶⁴ and the physician sector⁶⁵ weighed in with regard to the program.

A coalition of 12 medical specialty societies, also including the Medical Group Management Association, formed the Regulatory Relief Coalition seeking to reduce regulatory burdens that interfere with patient care. In their correspondence to CMS they cited two surveys indicating that physicians find PA to be among the most burdensome aspects of practicing medicine. The Coalition challenged the legality of the program stating there is no general authority for PA in Medicare fee for service. They also asserted that the default requirement of prepayment review in the absence of a PA request is in violation of the statute's provisions regarding voluntary prior determinations for physicians' services.⁶⁶

Both the hospital association and the Coalition remonstrated two fundamental aspects of the program. The first was that artificial intelligence will make initial determinations. CMS in its FAQs said the program "is intended to improve speed, accuracy and consistency of

⁶³ See, CMS, "Wasteful and Inappropriate Service Reduction (WISeR) Model Provider and Supplier Operational Guide" (November 6, 2025) <https://www.cms.gov/files/document/wiser-provider-supplier-guide.pdf>

⁶⁴ See, "AHA Comments on CMS WISeR Model" (Oct 23, 2025) <https://www.aha.org/lettercomment/2025-10-23-aha-comments-cms-wiser-model>

⁶⁵ See, RRC letter, Aug 12, 2025. <https://www.aan.com/siteassets/home-page/policy-and-guidelines/advocacy/comment-letters/2025/25-final-rrc.pdf>

⁶⁶ Citing 1869(h)(6)(B)(ii) as contrasted with 42 USC 1395m(a)(15) which was enacted specifically to allow for PA in Medicare only for durable medical equipment, prosthetics, orthotics and supplies

review for adherence to existing coverage policy by leveraging technology to determine whether a claim is payable...”⁶⁷ In the same document they stated that non-affirmations will require the review of a human clinician; and that model participants will be audited to ensure their determinations are consistent with Medicare coverage criteria. Both industry groups were skeptical. A particularly galling feature of the program to them is that the model participants will receive a percentage of savings (10-20%) associated with avoided care. They assert this is a clear financial incentive to the model participants to deny PA for medically necessary services. To this issue the FAQs stated that model participants are responsible for the cost of processing PA requests, including unlimited resubmission of denied (“non-affirmed”) requests; and that they will be paid only once per beneficiary regardless of the number of resubmissions. If a claim is in fact denied, providers, suppliers and beneficiaries retain their appeal rights and CMS asserts that participants will not be paid (or will have payments recouped) for any non-affirmations followed by a successful claims appeals. Finally, both groups have criticized the lack of transparency, accountability, and oversight mechanisms to provide stakeholders with real insight into how PA determinations are made.

7.0 Conclusion

The world of prior authorization has evolved significantly, as it has also been increasingly criticized. Throughout the payment system, more controls are evident at both the federal and state levels. The plan industry failure to prove it could self-regulate, along with the negative performance of the PBMs (although not RBMs), has generated remarkably detailed statutory guardrails and mandates regarding the implementation of PAs at federal and state levels. Whether the patient has commercial insurance, Medicare, Medicaid, or Medicare Advantage, the behavior of those who engage in and require PA is under a spotlight as never before. The plethora of constraints that are now available to manage these activities speak to real dissatisfaction with the history of the operation of this aspect of health care. Whether these controlling efforts will be effective is yet to be seen, but there is no question scrutiny of PA will continue. For the plans and the PBMs, compliance is the real challenge. For providers and patients, how well the plans and PBMs comply will determine access to health care services. Enforcement challenges to and from both sectors will surely ensue.

⁶⁷ See n. 57, supra.

