Prior Authorization Changes and Dilemmas

Written By Laura Carabello

Issues swirling around insurance company Prior Authorizations (PAs) that determine access to care have jumped to prime time. PA is a process that requires healthcare professionals to obtain advance approval from the insurer before a prescription medication or medical service qualifies for payment and can be delivered to the patient.

Amid patient and provider grumblings that PAs leave them in limbo while waiting for approvals, during the recent confirmation hearings on the nomination of Dr. Mehmet Oz to become the administrator of the Centers for Medicare and Medicaid Services (CMS), there was discussion of changes to PA programs. Oz promised that he would make sure that proposed treatments are "safe, effective, affordable, and covered by the plan."

He said the typical health plan subjects about 3,000 procedures to PA, with each plan applying a different set of procedures to the process. That adds up to about 5,000 different procedures that may be subject to review. He suggested one way to improve the system would be to adopt a set of 1,000

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Caryn Rasnick

procedures to be reviewed at all plans and create real-time systems that could let providers know if a proposed course of care will be under review.

Now that Oz was confirmed, Caryn Rasnick, chief operating officer with Boon-Chapman, observes, "We haven't seen a significant rise in PA requirements overall. However, we have seen a sharp increase in the use of specialty drug carve-out organizations, which complicates the process by adding another layer of authorization for both providers and members."

Rasnick also believes PA is appropriate for services like PT, OT, and ST, but only after the standard treatment course is exhausted.

"For example, if 12 to 14 visits are typical, any additional care should go through a medical necessity review. Fraud, waste, and abuse remain a concern," she adds. "Ultimately, PA criteria should be based on both the latest clinical evidence and the individual patient's needs — not every patient fits into the same box."

Offering the PBM and health plan perspectives, Billy Buckles, senior VP of Product and Client Services, RxLogic, asserts, "One of the purposes of the PA process is to help contain drug costs. But the growing complexity and significant escalation in PA requirements have impacted member access to medical care and prescription drugs. As more drugs come to market, more treatment options become available, and

Brandy Maxwell

there may be multiple treatment options available. Additional rules are being developed to guide coverage decisions on all these new entrants, which further complicates the process. "

He also points to the role of clinical teams that are becoming more involved in the decision-making process, designating preferred status for drugs based upon several different criteria: "As much as possible, the PA process funnels approvals toward the plan's preferred drug(s), while still being flexible enough to address member concerns that a prescribed drug is not on formulary. "

As clients pursue more cost-effective care strategies, Brandy Maxwell, Director, Medical Management, Boon-Chapman, observes a gradual increase in PA requirements.

"While PA helps manage utilization, the burden on providers and patients can be significant," she explains. "Delays are especially problematic for members with chronic or complex needs, which is why we work toward 24-hour turnarounds once records are received. PA criteria must reflect the latest clinical evidence while allowing flexibility for individual needs. PBMs play a strong role in drug access, setting coverage rules and negotiating rebates. While this can lower costs, it may also create delays for members."

Amy Tennis

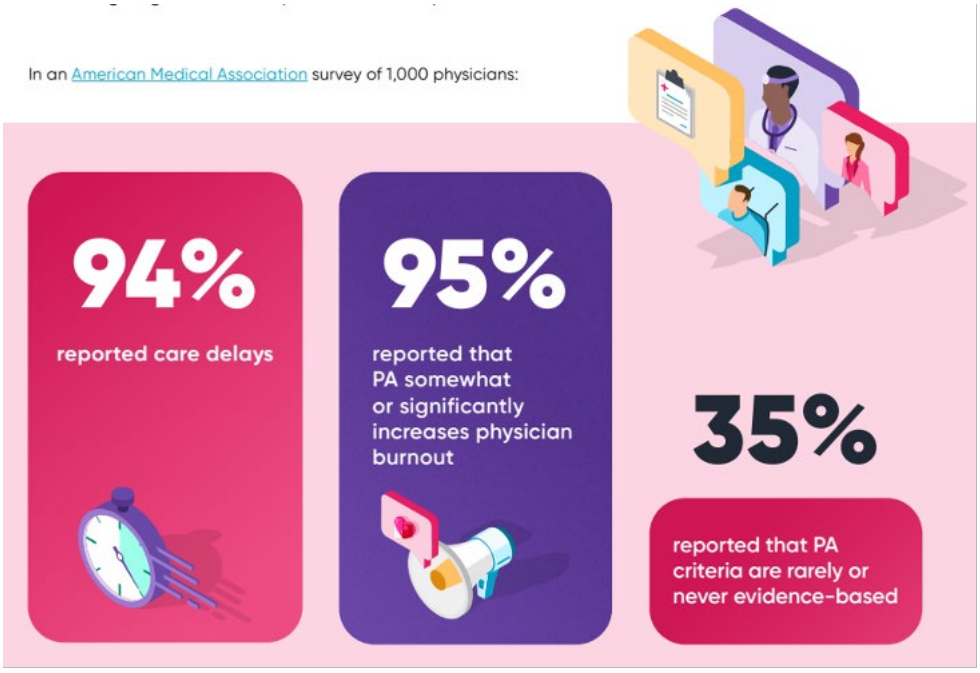
Beyond approvals, PA is deeply connected to broader medical management initiatives, as Amy Tennis, senior vice president of Medical Management, MedWatch, explains, "For example, a structured approach to PA in rehabilitative services ensures a balance between access and appropriate utilization. We take a measured approach to utilization review for physical, occupational, and speech therapy, as well as chiropractic services. Initial outpatient requests for 12 visits are automatically certified, while additional requests undergo Medical Necessity Review to prevent overutilization without meaningful outcomes."

She also points to pharmaceutical oversight as another critical aspect of PA, particularly in the management of high-cost medications.

"MedWatch plays a significant role in pharmaceutical management, particularly with 'J code drugs' covered under medical plans," says Tennis. "We focus on ensuring these medications are appropriate, cost-effective, and the best option for the patient, considering alternatives that traditional PBMs may not utilize."

As PA continues to evolve, its ability to balance clinical standards with individual patient needs remains a focal point, as Tennis continues, "Clinical expertise and judgment are essential in the PA process to ensure care is tailored to each member's needs while also considering the broader treatment plan. For instance, a member may not strictly meet criteria for a skilled nursing facility, but a Case Manager may determine that a denial could lead to hospital readmission or increased health risks, making skilled nursing admission the most appropriate course of action."

PAS UNDER FIRE FROM PROVIDERS



Source: 2025 American Medical Association

The rate of delays and denials due to PA requirements is drawing the ire of providers. According to the Medical Group Management Association's 2023 "Regulatory Burden Report," nearly 97% of providers have seen delays or denials for necessary patient care due to PA requirements. More recently, Medscape's "Physicians and PAs Report 2024" unveiled that more than 7 in 10 physicians believe the costs of PAs are higher, or much higher, than they were three years ago.

The AMA declares that PA is overused, costly, inefficient, opaque, and responsible for patient care delays. The organization is lobbying to eliminate care delays, patient harm and practice hassles, and has made fixing PA a top priority to:

- Cut the overall volume of PAs.
- Increase transparency of requirements.
- Promote automation.
- Ensure timely care for patients.

Calling for further steps to be taken, the AMA has requested that the DOL build on the CMS requirements, including: 1) Impose a 24-hour response time limit on employer plans for urgent PA requests and a 48-hour limit for non-urgent requests. 2) Discourage plans from conducting repeated reviews for patients who are continuing to access care for the same condition.

They contend that while health plans and benefit managers deem PA programs necessary to control costs, physicians and other providers find these programs to be time-consuming barriers to the delivery of necessary treatment:

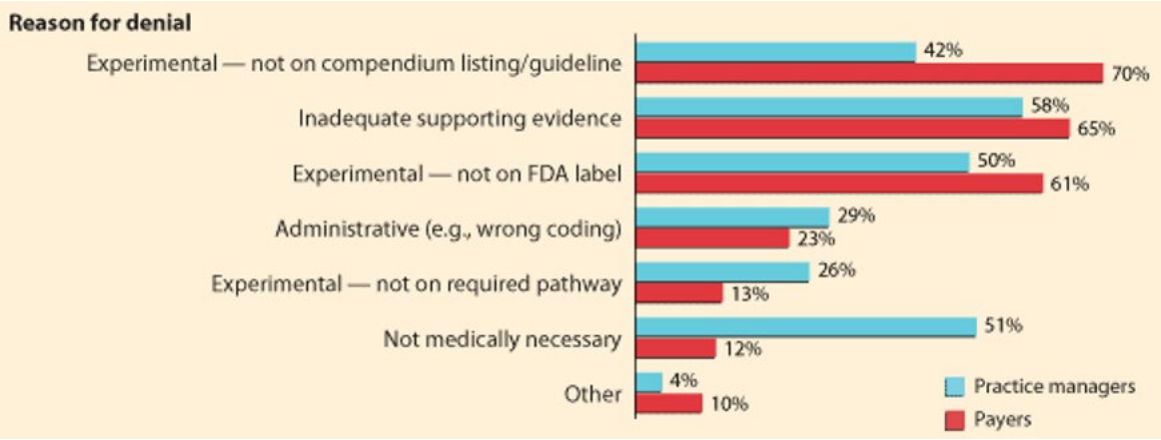
- Patients suffer from care delays and denials associated with PA and often experience poorer health outcomes.
- Patients may clinically deteriorate while they are forced to wait, leading to serious adverse events -- hospitalization, disability, or even death.
- PA implementation for medications to treat diabetes, depression, schizophrenia, and bipolar disorder tied to worsening disease status, increased hospitalization, and higher net medical costs.
- Overuse of the PA process places significant strain on physician practices, with administrative burdens wasting significant practice resources; practices report completing an average of 43 PAs per physician.

PAS CHALLENGE CONSUMERS

Consumers express frustration with the current approach to PA and care denials. An ABC News broadcaster declared, "It's widely acknowledged that prior authorization tends to disproportionately impact some of the sickest people who need the most expensive care."

PAs can affect productivity in the workplace when employees are missing work due to delays in care, leading to prolonged illness or attending rescheduled appointments. In an AMA study, nearly 60% of physicians with patients in the workforce said PA has affected work performance among their patients. These results reflect a KFF survey of adults with health insurance, which found that 16% of all insured adults in the past year experienced PA problems.

REASONS FOR PA DENIALS



Source: Managed Care

Buckles says the PA impacts quality if it is not properly managed, explaining, "Sometimes, inappropriate denials occur, prolonging member access to the medication and absolutely impacting the quality of care and outcomes. The goal is to make faster determinations and approvals that align with the drug formulary. But there's a myriad of reasons why decision-makers will approve drugs off-formulary. For example, if there is a formulary change and the individual has been taking the drug for years prior to the change, the approval will usually be granted."

APPEALS

When a PA is denied, patients can appeal the decision, often with the help of their healthcare providers or other third-party advocates.

There are two main types of appeals:

- Internal: Request health plan review and reconsideration of their decision, often conducted by a different department or reviewer than the one who made the initial denial. If the internal appeal is denied, there is still the right to an external review by an independent third party. Review and response timeframes are set by the insurer, e.g., 30 days for pre-service denials, 60 days for post-service denials. The insurer is obligated to provide the patient with the right to appeal to an external source in the case of a denial.
- External: Request an independent third-party review of the insurance company's decision. An accredited Independent Review Organization (IRO) can assist by providing a neutral third party that is not affiliated with the health plan and makes decisions based upon medical evidence and the coverage in the policy. URAC's Independent Review Organization (IRO) accreditation standards validate that the third-party organizations providing medical determinations are committed to a fair and impartial peer review process for both patients and physicians.

Bruce Roffé

Bruce D. Roffé, president and CEO, H.H.C. Group, a cost containment company using claim negotiation, repricing and independent review solutions, including a URAC-accredited IRO, describes their process, "When we find against performing a procedure, it is usually what is in the best interest of the patient as lesser modes of treatment may not have been tried or the submitted documentation does not support performing the procedure as medically necessary. Still, it may be denied as it is considered an experimental treatment. This does not mean that the procedure may not have to be performed sometime down the line, but at the time of submission, there was not enough information provided to support the procedure being requested."

Roffé further explains that the H.H.C. Group conducts both internal and external reviews with impartial assessments of the patient's condition, adding, "For external reviews, we follow state or federal guidelines, and it's a more balanced, objective type of review. This is critical because we decide based upon the information that's been provided by each party. URAC certification is mandatory in these circumstances because it requires the IRO to meet or exceed certain standards when making these determinations."

He further clarifies that both patients and providers are given the opportunity to submit information, and then the payer is given the opportunity to submit information as to why the PA was denied.

"We look at all of those materials, and then there's an objective assessment made based upon clinical criteria that is used," says Roffé. We primarily use the Official Disability Guidelines (ODG), which provides

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evidence-based guidelines for medical treatment and return-to-work in workers' compensation, non-occupational disability, including impairment guidelines, and drug formularies. The physicians that we work with rely heavily upon ODG."

REGULATORS STEP IN

CMS has already addressed a myriad of issues surrounding PAs. As part of the CMS new rule (CMS-0057) announced in January 2024 and effective January 2026, it is a pledge to streamline and standardize the PA process, reduce administrative load, minimize care delays, and establish industry-wide standards. This essentially promises to bring considerable change to a PA system that, despite its meaningful intentions, has been confusing and challenging for providers, members, and payers alike.

While self-insured employer plans fall under the jurisdiction of the Department of Labor and are not directly regulated by CMS, plan sponsors are starting to pay more attention to what the federal regulators are doing about healthcare PA efforts that impact Medicare Advantage (MA), Medicaid, Children's Health Insurance Program (CHIP), and Marketplace plans.

IMPLEMENTATION OF THE PROPOSED CMS RULES IN JANUARY 2026

Source: 2025 Acentra Health

Now, state insurance regulators are following suit. Constituents of the National Association of Insurance Commissioners (NAIC), a Kansas City, Missouri-based group for state insurance regulators, have assembled 166 pages of PA background materials in a packet for an upcoming in-person session. NAIC cannot set state insurance rules directly, but many states start with NAIC models when creating their insurance laws, regulations, and procedures.

In fact, a growing number of states are imposing new limitations on PA requirements and tighter rules on insurers to address provider and patient complaints that health insurance companies are delaying and

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denying care. According to a National Conference of State Legislatures database, 23 states enacted more than 43 bills related to PA in the last few years, with 18 enacted in 2024.

While California, North Carolina and Hawaii are considering legislation targeting different aspects of the pre-approval process, others have already enacted changes:

- Arkansas banned PAs for many substance use disorder treatments, HIV prevention and certain ambulance services.
- Maine limited PA for breast pumps.
- Louisiana, Oregon, and other states have restricted pre-certification requirements for cancer care.
- NJ legislation mandates insurance companies to render decisions within 24 hours for urgent cases and 72 hours for routine issues. A similar law took effect recently in Washington state.

As these modifications unfold, actuarial and analytical experts at the TERRY Group advise payers to prepare for the changes by investing in technological infrastructure, ensuring timely response to PA requests, standardizing their authorization requirements, and establishing open communication with healthcare providers. Successful adaptation to the new rule involves making new technologies and processes user-friendly, ensuring effective communication among all stakeholders.

PA NOT A GUARANTEE FOR PAYMENT


Mike Lanza

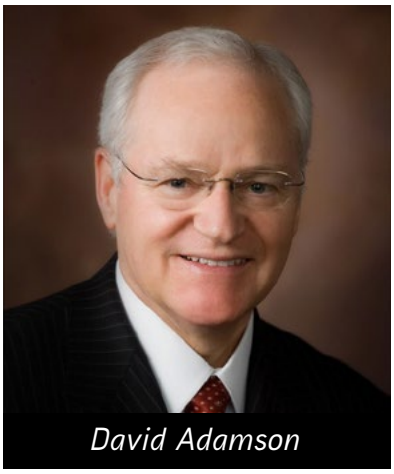
“While PA is meant to help ensure appropriate and cost-effective care, it’s often misunderstood as a guarantee of payment,” says Mike Lanza, senior vice president, USBenefits Insurance Services. "In reality, pre-certification is usually based on limited documentation and still needs to be reviewed against the Plan Document once the claim is submitted."

Lanza observes that from a stop-loss carrier’s perspective, “We’ve seen situations where providers encourage patients to seek care in emergency settings for procedures that aren’t actually emergencies. While these services may receive PA, they can still be denied later if they don't meet the plan's criteria for medical necessity or proper setting. This creates higher costs, possible non-payment, and plenty of confusion."

He cautions that’s why it’s so important to stick closely to what’s outlined in the Plan Document.

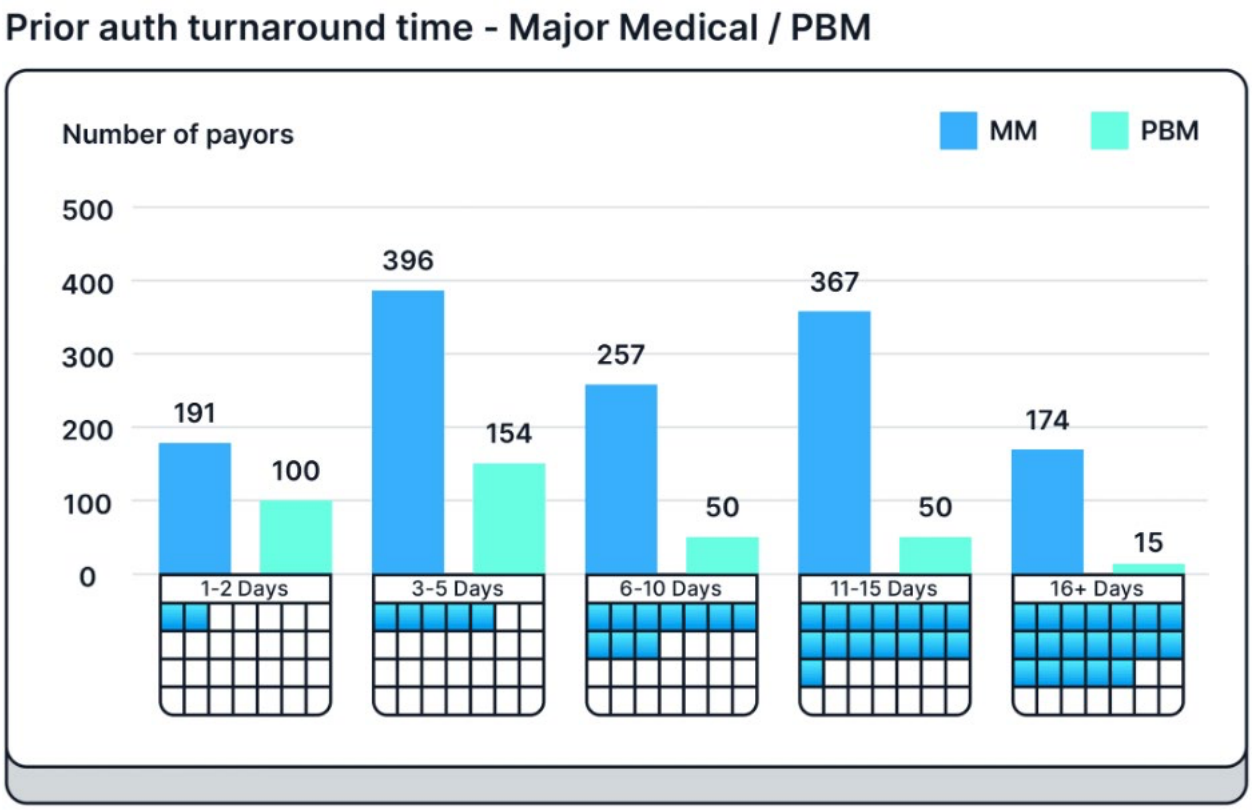
“At the end of the day, the Plan carries fiduciary responsibility—and claims have to be reviewed with that in mind,” continues Lanza. "When TPAs, brokers and carriers work together, it's easier to keep things aligned, avoid unnecessary costs, and do what's best for the employer and the member."

Late last year, however, the AMA adopted a policy that would block insurers and plans from denying payment for claims after approving procedures through PA processes. AMA leaders argue that once


David Adamson

insurers or plans authorize care, that should be enough to guarantee payment. They also plan to encourage physicians to sue insurers and plans that deny payments for care that has already been authorized or that try to get cash back from the physicians or patients.

It is also worth noting that not all services are tied to PA processes. For example, David Adamson, MD, and CEO, ARC Fertility, shares that the ARC business model only requires eligibility information and the amount of subsidy remaining. All care is in pre-authorized packages and approved drugs.



Source: 2025 Infinitis: Report shows that 68.8% of the time, PBMs return PA determinations in five days or less, compared to 42.4% for major medical insurance companies. PBMs return over a quarter of PA determinations in less than 48 hours.

IN DEFENSE OF PAS

Patients and providers alike view PAs as a needless hurdle that payers have inserted into healthcare delivery processes. In defense of PA, many observers say it serves a vital purpose as a gatekeeping tool to ensure that the medication or therapy prescribed aligns with evidence-based guidelines and is necessary for the patient's condition. Health plan managers also acknowledge that while there is a need to improve PA processes, a well-run program can protect patients against unnecessary, overly expensive, or even

dangerous care, such as prescription opioid overdose deaths.

The critical benefit of PA is that it potentially controls costs and keeps them in check, ensuring that prescribed treatments are medically necessary, thereby avoiding unnecessary or overly expensive procedures.

"Prior authorization (PA) has been a cornerstone of healthcare for decades, designed to ensure medical necessity and cost-effectiveness before treatments, procedures, and medications are approved, with its primary goal to promote responsible medical management," says Tennis.

She notes that although the system faces challenges in adapting to the evolving healthcare landscape, PA remains a crucial tool for managing healthcare costs and ensuring evidence-based care. Ongoing advancements are continually refining and modernizing the PA process, making it more efficient and transparent.

Many stakeholders assert that PA also serves as a quality check, ensuring that patients receive the most appropriate care for their specific health circumstances, thereby reducing the incidence of overmedication/adverse drug interactions and inappropriate/ineffective treatments. Experts also say that by evaluating the necessity and suitability of a prescribed test or treatment, PA helps to ensure patient safety.

Caroline Forrester, PharmD, Clinical Specialist, MedImpact, points to some of the benefits of PA for prescription medications, including:

1. Management of prescription drug spend, as part of the toolbox payers use to manage prescription drug costs.

2. Clinically appropriate drug selection and utilization. PAs ensure that a drug is prescribed for patients with the specific FDA-approved indication. The goal is not to restrict appropriate use but rather to promote use in the patient population for whom safety and efficacy have been established.

3. Promotion of safe drug use. PA may help curb the opioid epidemic by providing opportunities for early intervention.

4. To support drug formularies and rebate programs. PAs may be used to support the use of preferred drugs -- because of their cost differences, efficacy and/or safety differences, rebate programs, or alignment with evidence-based treatment guidelines.

America's Health Insurance Plans (AHIP) supports PAs as a "proven tool to ensure patients get the most up-to-date evidence-based care." They insist that health insurance providers continue to collaborate with healthcare providers and other stakeholders to implement innovative solutions to improve the PA process, stating that the targeted use of PA can help ensure patients get care that's not only safe and effective, but also affordable.

An AHIP clinical appropriateness project with Johns Hopkins found:

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CUSTOMIZING PA REQUIREMENTS


Stacy Whalen

"MedWatch has observed an increase in the customization of our Standard Pre-Authorization Requirement Recommendations," says Tennis. "While this approach responds to member concerns, it can also lead to higher costs by failing to contain waste, fraud and overutilization— allowing savings opportunities to slip through the cracks."

She maintains that it may result in missed opportunities to trigger case management for high-cost claims and prevent deviations from standards of care, advising," A strategic, balanced approach ensures PA remains effective without creating unnecessary complexity."

PA criteria facilitate an open line of communication between all parties involved and help objectify what is being requested, why it is being requested, and progress towards the goals, advises Stacy Whalen, senior medical manager, Safety National.

"To best serve patients, take a comprehensive approach towards PA requests," says Whalen. "We have clinical evidence-based guidelines available as a standard of care and foundation to build upon when considering PA requests. From that point, look outside the box and take into consideration the rationale for the request, the patient's progress towards goals, diagnosis, and any unique complexities that might apply to that patient. The PA process provides the foundation that keeps all parties communicating towards the treatment plan's end goal."

WHY PLAN SPONSORS HEED FEDERAL REGULATIONS


Jack Towarnicky

While self-insured health plans fall under the jurisdiction of the U.S. Labor Department, plan sponsors are closely following CMS PA regulations for MA plans.

For example, CMS requires MA plans to review PA requests within seven days and urgent requests within 72 hours. The Employee Benefits Security Administration and the Labor Department simply require employers' self-insured health plans to respond to PA requests "within a reasonable time frame."

Jack Towarnicky, Member, aequum, LLC, explains, "The No Surprises Act regulations confirm that the term 'emergency medical condition' means a

medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain."

He emphasizes that an astute layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in a condition described in the Emergency Medical Treatment & Labor Act (EMTALA), as (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

"The current regulatory standard requires decisions on urgent care claims to be made 'as soon as possible' but no later than 72 hours," he continues. "PA isn't an issue when delivering emergency treatment to stabilize the patient. There is never a delay in those situations, nor a requirement for PA. Conversely, in seeking PA, it suggests that the patient or provider might forego the selected treatment where it isn't covered by the employer-sponsored health plan."

But the AMA protests that ERISA plans' efforts to manage use of care through PA and related programs are "about as burdensome and demoralizing for physicians as the PA efforts at Medicare Advantage plans are." They attest that regulators have made progress at adding tougher rules for MA but claim that little reform progress has impacted employer-sponsored plans regulated by the DOL, and PA programs remain a detriment to physicians' morale. Physicians appear to be furious about reports that some health insurers may be using artificial intelligence (AI) systems to reject PA requests for some types of procedures with little or no live-human oversight.

One AMA spokesperson describes these frustrations with PA as a failure of the insurance company to relegate medical decisions to individuals who are not qualified or trained, and often, do not even know anatomy.

WILL ARTIFICIAL INTELLIGENCE AND AUTOMATION HELP OR HARM THE PA PROCESS?

The answer to this question depends upon who you ask.

Barbara Podzimkova Howell, CEO, True Claim, believes that PA should empower, not obstruct, access to care, a goal that's almost impossible to hit without automation.

"With advancements in AI, health plan administrators shouldn't need to scroll through hundreds of pages of medical records to determine clinical necessity," she says. "A well-designed copilot can lead to almost instantaneous PAs while preserving the opportunity to steer members to better and more affordable care. Without such technology playing a role, prior authorization requirements should be designed carefully so they don't delay access to needed care."

HCAA's Rasnick shares, "Whether AI-powered platforms can transform PA will depend entirely on the technology being introduced. It's important to balance the clinical requirements of the PA process with the integrity of AI systems. Ideally, these modernization efforts, especially with the support of AI, will help reduce turnaround times for procedures that don't require full clinical review. These are often the procedures that help manage large claims, so we believe the PA process needs to stay in place but be handled quickly."

Maxwell says that digital-first tools and AI hold promise, noting, "…particularly with new CMS requirements pushing for electronic PA. But AI isn't a cure-all — clinical oversight is still needed to catch nuances in complex cases and avoid premature or incorrect denials."

When it comes to the use of AI in the PA process, Buckles is "super excited."

"RxLogic actually works with several large PA vendors that offer enterprise-level PA solutions," he explains. "One of those PA vendors, in particular, is on the cutting edge of AI to power their solutions. AI is helping to make the PA much more efficient and less complex. It also helps to bring a lot more transparency to the member."

For instance, when the doctor writes a script for a drug that's not covered or does not have preferred-formulary status, the decision will have to go through the PA process if the physician doesn't want to change the medication.

Buckles continues, "The doctor must submit all this documentation to the PA vendor as to why they want the individual to take the drug and override the formulary. The PA vendor collects and organizes this information as best it can and then allows the designated users to review all the documentation supplied, review the decision criteria, and decide – allow or not allow. Finally, the physician must be notified with a letter of their final disposition."

RxLogic has an MPA (Member Prior Auth) API that different PA vendor teams can access to push and pull data from their system.

"This allows them to extract the members/patients' claim history, run test claims, and update the PA to approve or deny the drug," he says. "This automated approach helps to expedite the PA process, in general, and shortens the timeline for approval."

In addition to RxLogic working with several of the industry-leading PA vendors in the market, the company has its own PA Lite module on its 2025 Product Pipeline.

"This helps our customers make their PA process as efficient as possible," says Buckles. "We intend to leverage an AI tool to assist with the processing and decision-making processes to help streamline the process for our clients and give them complete control over that process, much like the rest of the products in our RxLogic Product Suite. "

REAL-WORLD EXAMPLES

At Florida Blue, AI is intended to speed up the common PAs that are approved, not deny them. Back in 2022, the nonprofit insurance company deployed AI software to automate some pre-approval requests from providers. They have since relied upon AI to review more than 1 million PA requests related to advanced imaging and hip, knee, and other musculoskeletal services for its 6 million Medicare and commercial enrollees.

Software vendor Availity contends that although PAs are critical to ensure that patients receive necessary care, processes are inefficient for providers and payers. They say the root cause of this frustration is manual processes and analog technologies, outdated methods that make PAs one of the most burdensome transactions in healthcare, leading to negative patient impact.

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Availity insists that by automating and streamlining PAs, AI has the capability to extract pertinent and relevant information from clinical records for the PA process and determine whether the specific patient aligns with the criteria previously selected by the payer/plan. They cite the benefits of a system that combines the power of AI with the expertise of human clinicians.

Utilization management company Cohere Health concurs, criticizing many providers and health plans that still rely on outdated methods and fee-for-service models, which can lead to a reactive approach to UM that lacks real-time data and proactive care management. These practices collectively contribute to the prevalence of low-value care and medical services that do not align with evidence-based guidelines and offer minimal clinical benefit.

Cohere says the emergence of intelligent PA solutions represents a pivotal shift. These AI-driven tools are transforming traditional UM methods by providing data-driven insights and a patient-centered approach, significantly reducing low-value care, and improving patient outcomes.

Another example comes from Optum's Surescripts PreCheck PA, designed to reduce physician administrative burden and expedite PA approvals -- from 8.5 hours to under 30 seconds. With an eye on improving such processes and the patient experience, the organization partnered to develop this innovative solution to help automate the PA submission and approval process for select drugs, including GLP-1s for diabetes.

Additionally, Blue Shield of California is teaming up with Salesforce, a cloud-based customer relation management company, to cut down the PA process from days to seconds. The tool queries the patient's electronic health record for relevant clinical information and organizes the data into a pre-populated form for physicians to submit to Blue Shield. If a case requires additional clinical consultation, the submitting physician will receive a message within hours of the initial submission.

Notably, AETNA-owned CVS predicted in 2018 that the insurer saved more than $660 million from denying PA requests for inpatient facilities, saying their internal predictive model designed to "Maximize Approvals" was deemed too catastrophic for the bottom line. In 2021, hoping to save money in MA, CVS deployed AI to reduce spend in skilled nursing facilities. Though the company expected savings to total $4 million per year, leadership later raised the estimates to $77 million over the next three years.

Most recently, Surescripts, a health information network, unveiled Touchless PA technology intended to help automate existing manual workflows, significantly reduce the time-consuming administrative tasks often required for medication PAs and return time to prescribers, pharmacists, and care managers while quickly getting patients started on the best treatment path.

Finally, Amy Tennis at Medwatch affirms, "Technology is also reshaping the PA process. AI-powered, digital-first solutions have the potential to streamline approvals, reducing administrative burdens while ensuring compliance with clinical guidelines."

She cautions that this technology is still in the early stages, emphasizing, "But it shows promise in reducing turnaround times and shifting clinical resources away from clerical tasks, allowing companies to focus on more member-centric activities. Integrating automation into PA processes enhances efficiency while maintaining the necessary oversight for cost-effective care."

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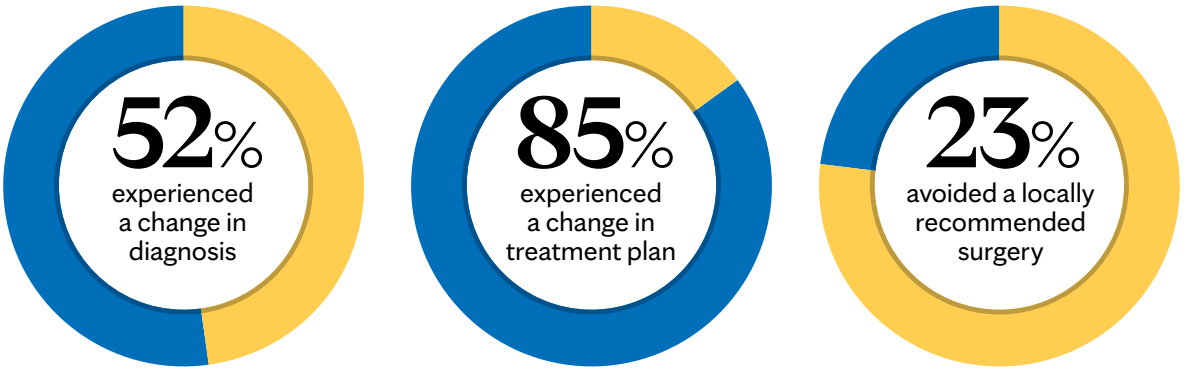

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Based on medical record review of 516 patients, from multiple employers, referred into the Mayo Clinic Complex Care Program in 2023.

SCATHING REPORTS OF AI ABUSE AND FAILURE.

One blistering report from the U.S. Senate Permanent Subcommittee on Investigations shows that the country's three largest Medicare Advantage (MA) insurers obstruct seniors' ability to receive post-acute care by using technology to reject PA claims.

Over a three-year period, three insurers -- UnitedHealthcare, CVS and Humana, which collectively cover nearly 60% of all MA enrollees -- denied claims for post-acute care at "far higher" rates than for other types of care. In one timeframe, Humana denials in post-acute care were 16 times higher than the companies' overall denial rates.

Furthermore, a recently released AMA survey of 1,000 practicing physicians—400 working in primary care, the remainder in other physician specialties -- shows:

- 61% of physicians said they fear that payers' use of unregulated AI is increasing PA denials, a practice that will override good medical judgment and exacerbate patient harm.
- 49% of physicians ranked oversight of payers' use of AI in medical necessity determinations among the top three priorities for regulatory action.

An AI-related lawsuit appears to be moving forward, as a federal judge in Minnesota has dismissed five out of seven counts in a class action lawsuit against UnitedHealth Group, allowing the case to proceed. Healthcare Finance News reports that the lawsuit alleges that the defendants improperly denied claims for post-acute care in MA plans by relying on an AI program, nH Predict, rather than medical professionals.

The program purportedly had a 90% error rate, with nine out of ten appealed denials later reversed. Plaintiffs who were denied coverage argue that these AI-driven denials led to worsening health conditions and, in some cases, death. The court is allowing claims for breach of contract and breach of the implied covenant of good faith and fair dealing to move forward. The lawsuit claims that NaviHealth's AI program overruled physician judgments and had a 90% error rate, with nine out of ten appealed denials later reversed.

COMMERCIAL PAYERS SCALE BACK PAS

- L.A. Care Health Plan removed 24% of PA requirements for most specialty visits; 50% of lab and radiology codes, durable medical equipment, and catheters.
- BCBS of RI eliminates 65% of PA requirements for PCPs by early 2025.
- Point32Health no longer requires PA for home care for first 30 days after hospital discharge.
- BCBS of Mass. will remove 14,000 PA requirements for home care services in response to the capacity crisis in the state's hospitals.
- BCBS of Michigan will cut 20% of its PA requirements.
- Optum Rx trims reauthorization requirements for about 80 drugs beginning May 1
- UnitedHealthcare plans to cut nearly 10% of PAs this year.

- Cigna Healthcare removed PA requirements for 600+ medical procedures, cutting required PAs by 25%.
- Anthem BCBS rescinded recent decision to stop paying for anesthesia care in select circumstances, following widespread scorn from anesthesiologists and patients.

WHAT'S NEXT FOR SELF-INSURED EMPLOYERS AND PA?

PA has historically been a controversial process in healthcare. While providers view it as a barrier to quality patient care, health plans recognize the process as an essential tool for cost containment and care quality. Now, technological advancements and regulatory shifts are transforming PA into an instrument that benefits professionals can leverage to improve employee health outcomes and satisfaction.

Plan sponsors and benefits administrators will need to innovate, accelerate decision-making, and improve data sharing throughout the PA process, especially as they seek to comply with state regulations and the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F).

Tennis states that PA has long been a critical component of medical management, but as the healthcare landscape evolves, so too must the processes that support it. "While challenges such as administrative burdens and delays have fueled criticism, ongoing advancements in automation and case management integration are transforming PA into a more efficient and responsive system," says Tennis. "Rather than serving as a barrier, PA -- when implemented thoughtfully -- ensures that care remains evidence-based, medically necessary, and cost-effective.

By continuing to refine these processes through technology and policy improvements, the industry can strike a balance between cost containment and timely, high-quality patient care.2025 will provide opportunities to streamline care access, harness responsible AI, reduce member and provider frustrations, and enhance the overall employee benefits experience.

If ever there was a grim reminder of PA challenges, the fatal shooting of Brian Thompson, CEO of UnitedHealthcare, certainly stirs one's memory. Some reports suggest the suspect may have been motivated by frustration with the health insurance industry, care denials, and rejection of insurance claims. PA is certainly in the crosshairs. ■

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