From Debate to Dialogue: Building Consensus on Prior Authorization (PA) Reform

Kimberly Westrich

Chief Strategy Officer

National Pharmaceutical Council®

What is prior authorization?

Prior authorization (PA):

A process that requires a doctor or patient to get permission from the health plan before receiving coverage

Intended objectives:

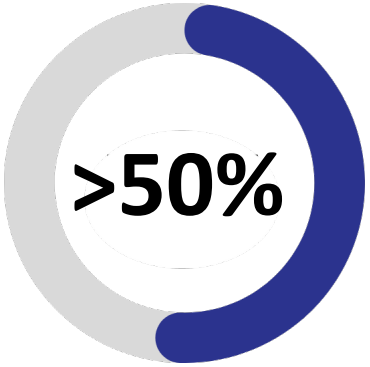
- Prevent inappropriate care
- Protect patient safety
- Reduce costs

PA is one of many **utilization management (UM) tools** payers use to manage prescription drug utilization. Others include:

- **Step therapy**
- **Quantity limits**
- **Prescriber restrictions**
- **Formulary exclusions**
- **Tiered cost sharing**

Use of UM is common across payer types

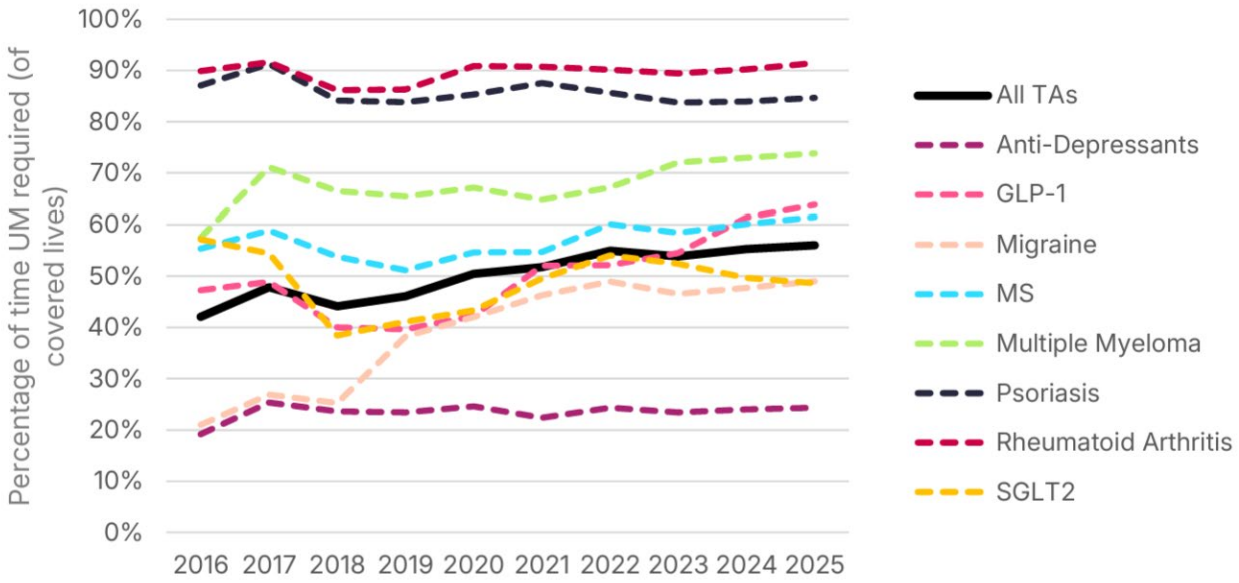
Medicare plans



In 2025, both Medicare prescription drug plans and Medicare Advantage drug plans used some form of utilization management for **more than half** of the drugs listed on a plan's formulary.

Commercial plans

UM status (percentage of time UM was required, of covered lives) 2016-2025, single-source brand drugs



https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_SEC-2.pdf
https://advisory.avalerehealth.com/wp-content/uploads/2026/02/White-Paper_Coverage-and-UM-trends-in-the-commercial-market-2016-2025.pdf

PA is among the most widely used UM tools

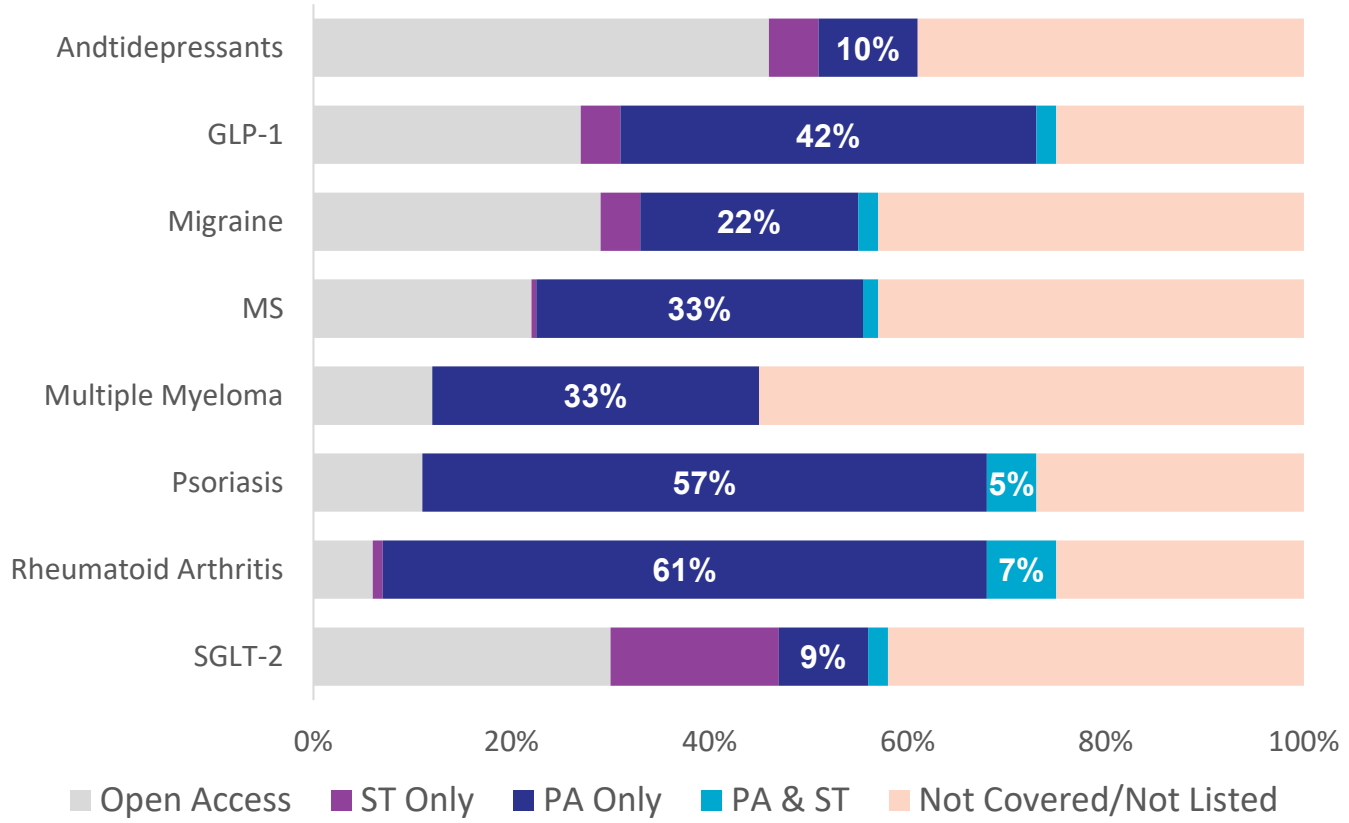
Medicare plans

32%

of all covered drugs in Medicare Part D plans were subject to prior authorization in 2024 vs only **8%** in 2007

Commercial plans

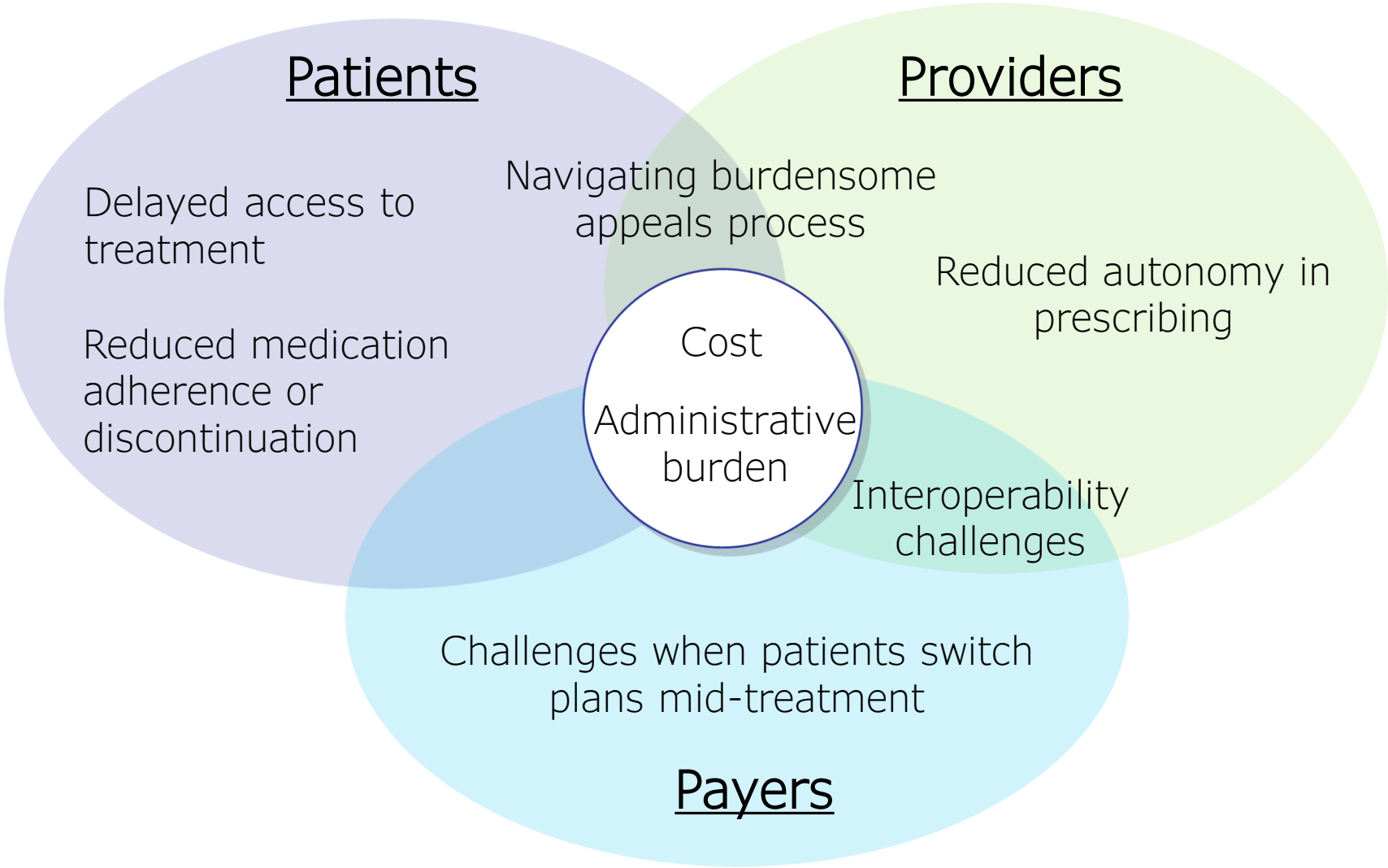
Coverage/UM status for single-source brand drugs, by TA, 2025



https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf
https://icer.org/wp-content/uploads/2020/11/Cornerstones-of-Fair-Drug-Coverage-_-September-28-2020.pdf
https://advisory.avalerehealth.com/wp-content/uploads/2026/02/White-Paper_Coverage-and-UM-trends-in-the-commercial-market-2016-2025.pdf

Rising use of PA is causing problems across stakeholder groups

Overlapping frustrations present an opportunity to build consensus on potential reforms



Stakeholders are proposing policy reforms

Federal reforms

2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule

*Proposes expanding PA reforms to prescription drugs

WISeR (Wasteful and Inappropriate Service Reduction) Model

CMS.gov Centers for Medicare & Medicaid Services

Provider and patient organizations

EVIDENCE. CARE. IMPACT. ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY

American Society of Clinical Oncology (ASCO) Position Statement:

The Use of Artificial Intelligence in Prior Authorization

Approved by the ASCO Board of Directors May 29, 2025

AMA AMERICAN MEDICAL ASSOCIATION

Prior Authorization and Utilization Management Reform Principles

State legislative reforms

Since 2024, states have introduced 659 bills related to utilization management tools, of which 145 have been enacted.[1]

Payer organizations

BlueCross BlueShield Association

AHIP

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Health Plans Take Action to Simplify Prior Authorization

1. AMCP. Utilization Management Policy in 2026. LINK Handout. January 29, 2026.

Today's discussion

How can prior authorization for prescription drugs be reformed to support value in the healthcare system without undermining appropriate clinical care, harming patients, or increasing clinician burden?

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Trends in Specialty Drug Coverage

May 20, 2026

James Chambers PhD

Background

- Health plans make complex coverage decisions to ensure appropriate access
- Decisions balance evidence, patient need, and real-world factors
- How do plans accommodate new and innovative therapies?

525
specialty therapies

175,000+
coverage policies

SPEC DATABASE
Specialty Drug Evidence & Coverage

100+
manufacturers

190+ million
covered lives

500,000+
citations


United
Healthcare


Humana


Blue Cross
Blue Shield
Blue Care Network
of Michigan


Independence


Anthem
Blue Cross


HIGHMARK
HEALTH

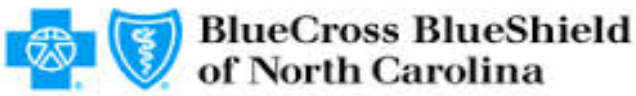

Cigna


aetna


KAISER
PERMANENTE


HCSC
Health Care Service Corporation


CENTENE
Corporation


BlueCross BlueShield
of North Carolina


EmblemHealth


Horizon
Horizon Blue Cross Blue Shield of New Jersey


MASSACHUSETTS


CareFirst
BlueCross BlueShield

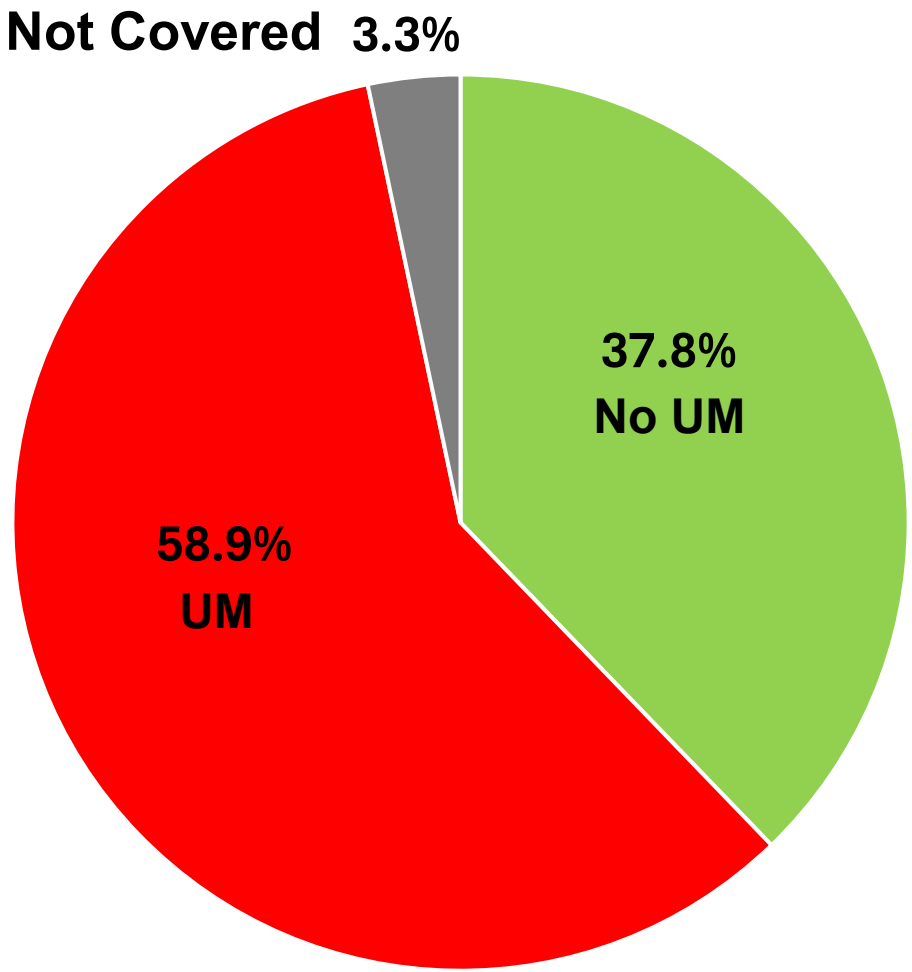

Florida
Blue


of Tennessee

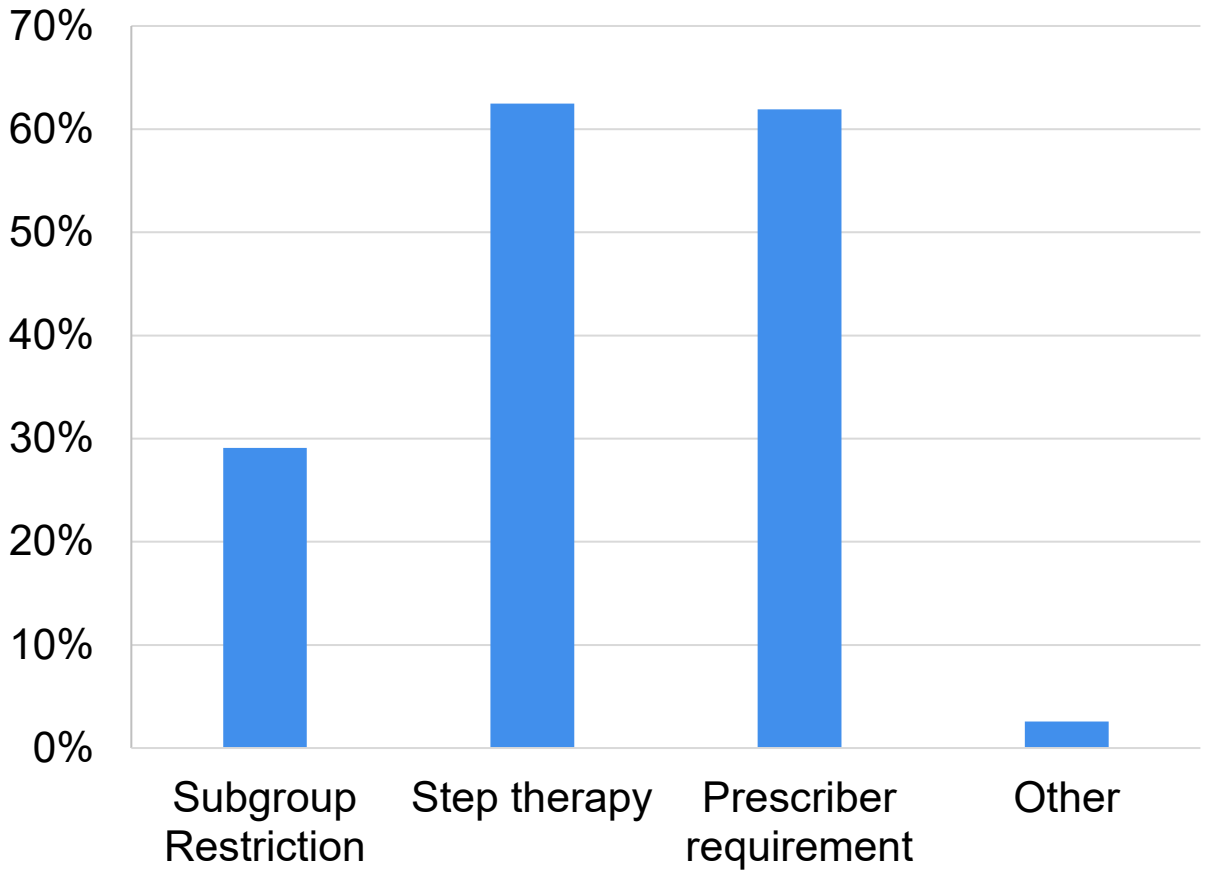
How often do plans impose UM?

SPEC DATABASE
Specialty Drug Evidence & Coverage

16,364 coverage policies

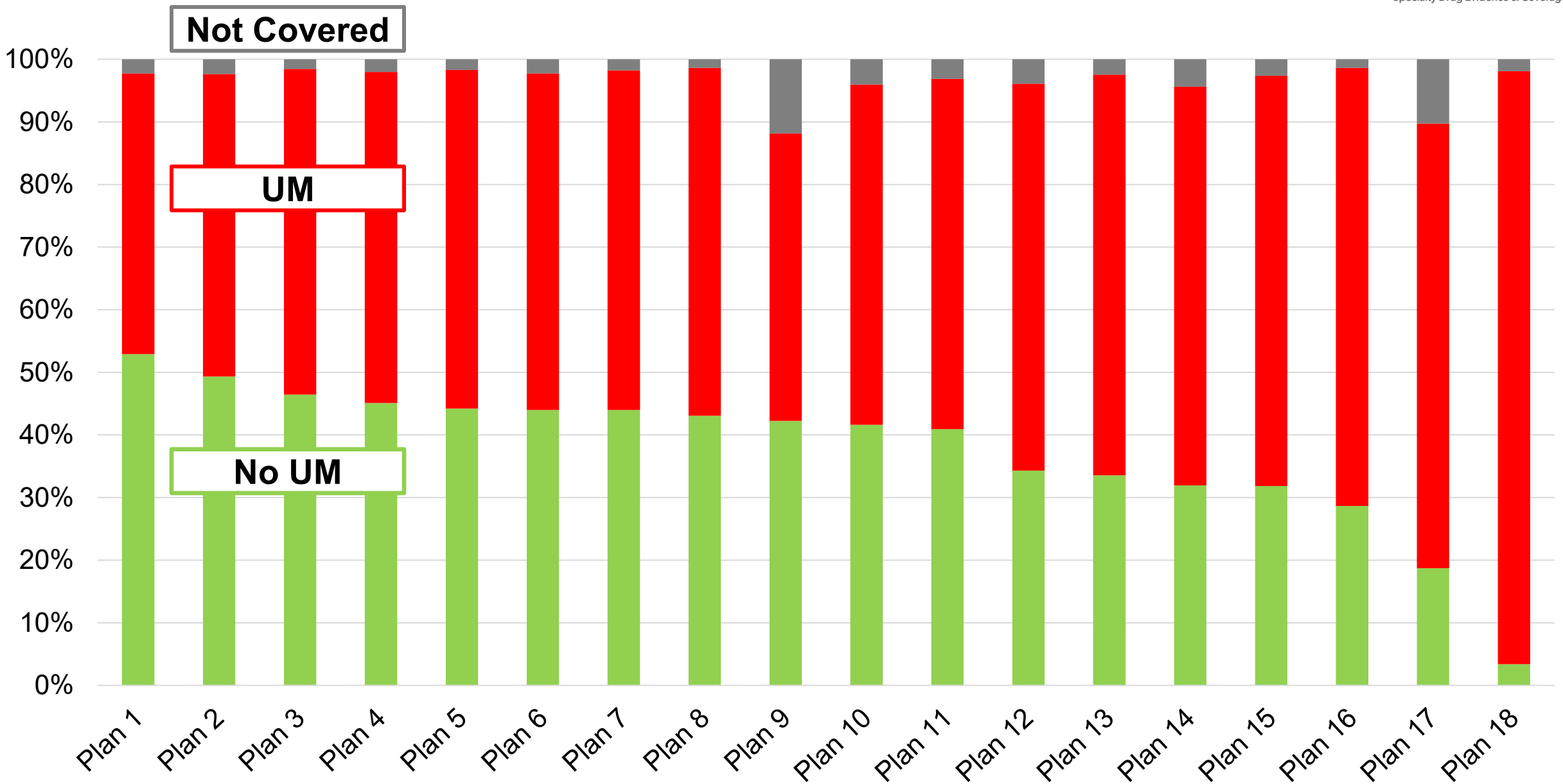


9,636 coverage policies with UM



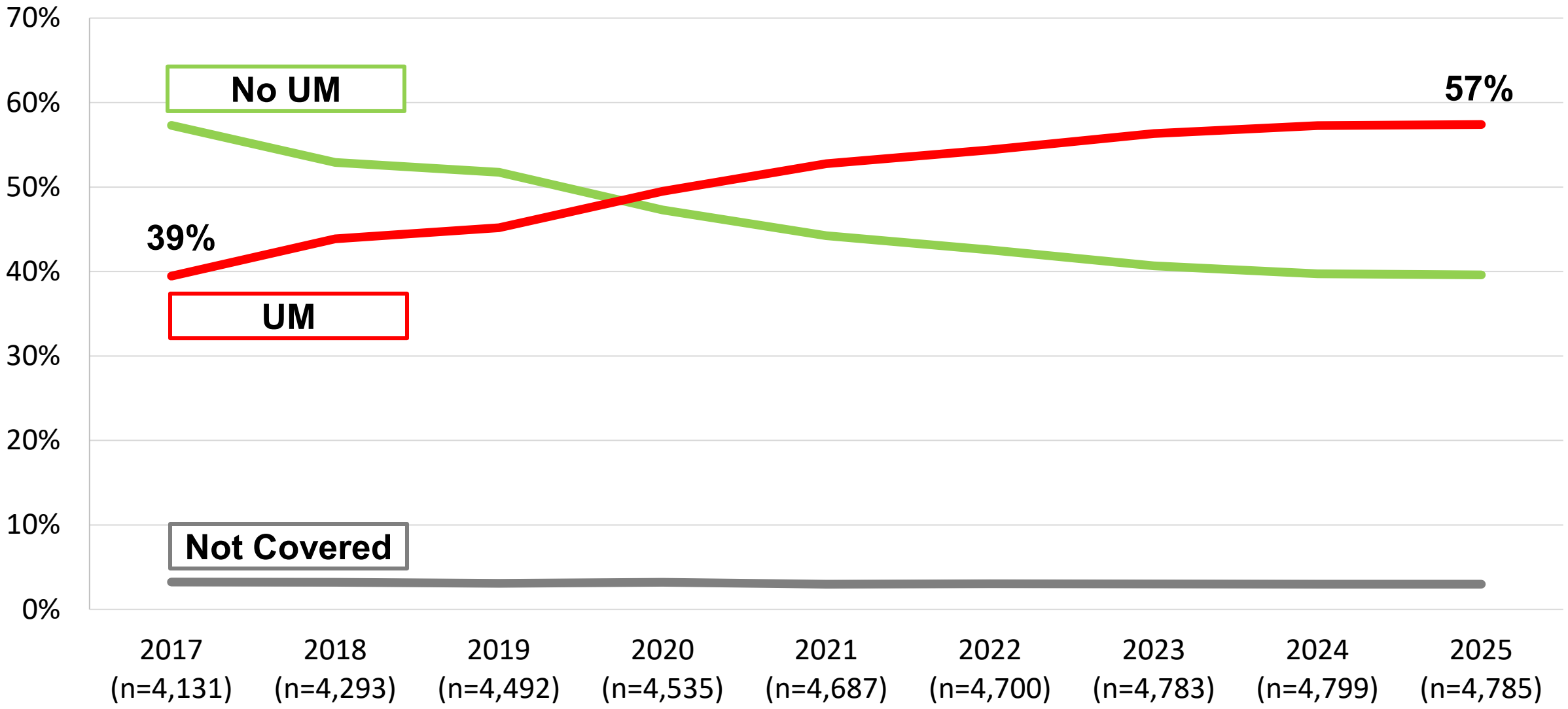
Source: SPEC Database

Variation across health plans



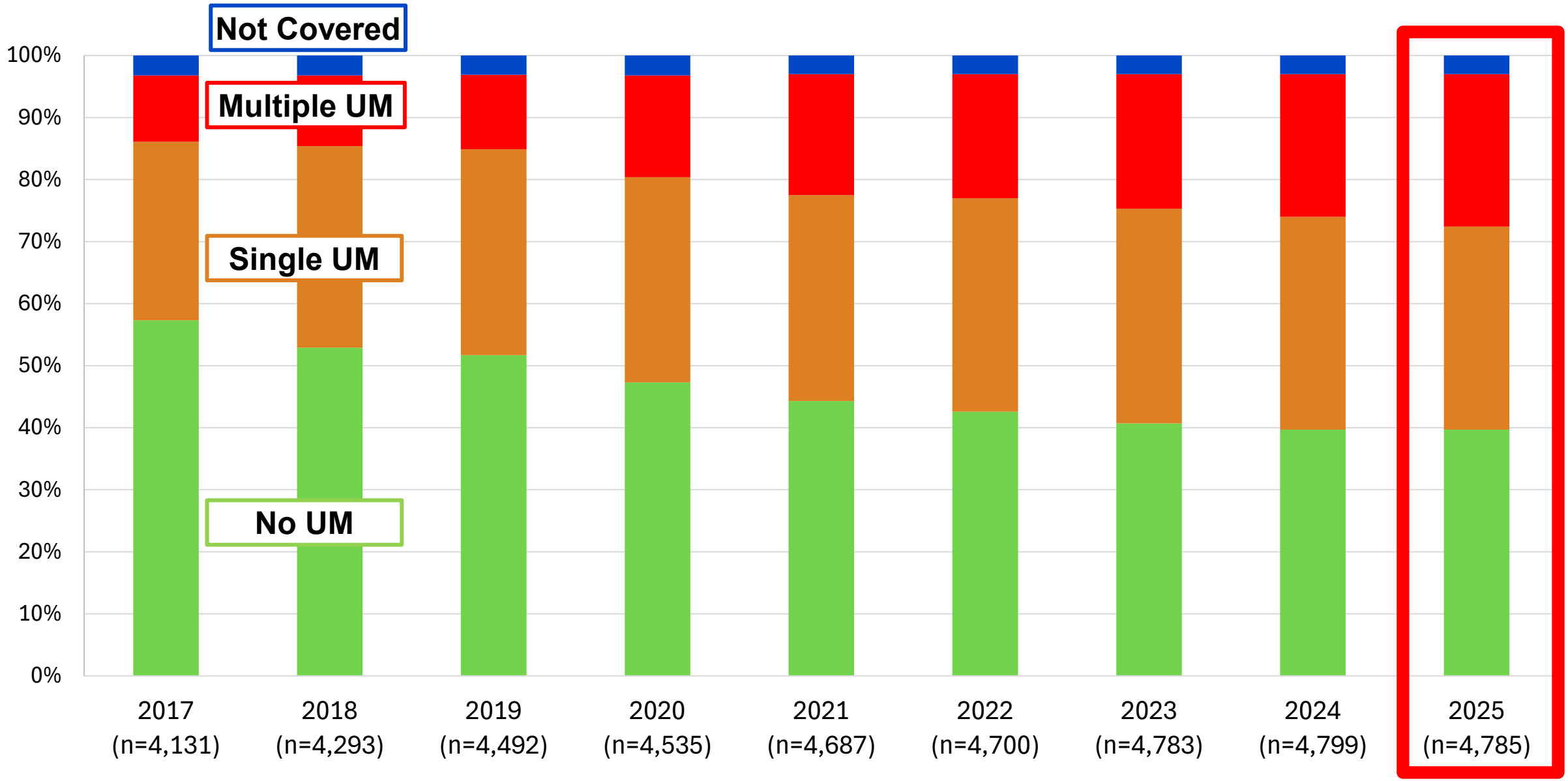
Source: SPEC Database

Use of UM has become more common over time



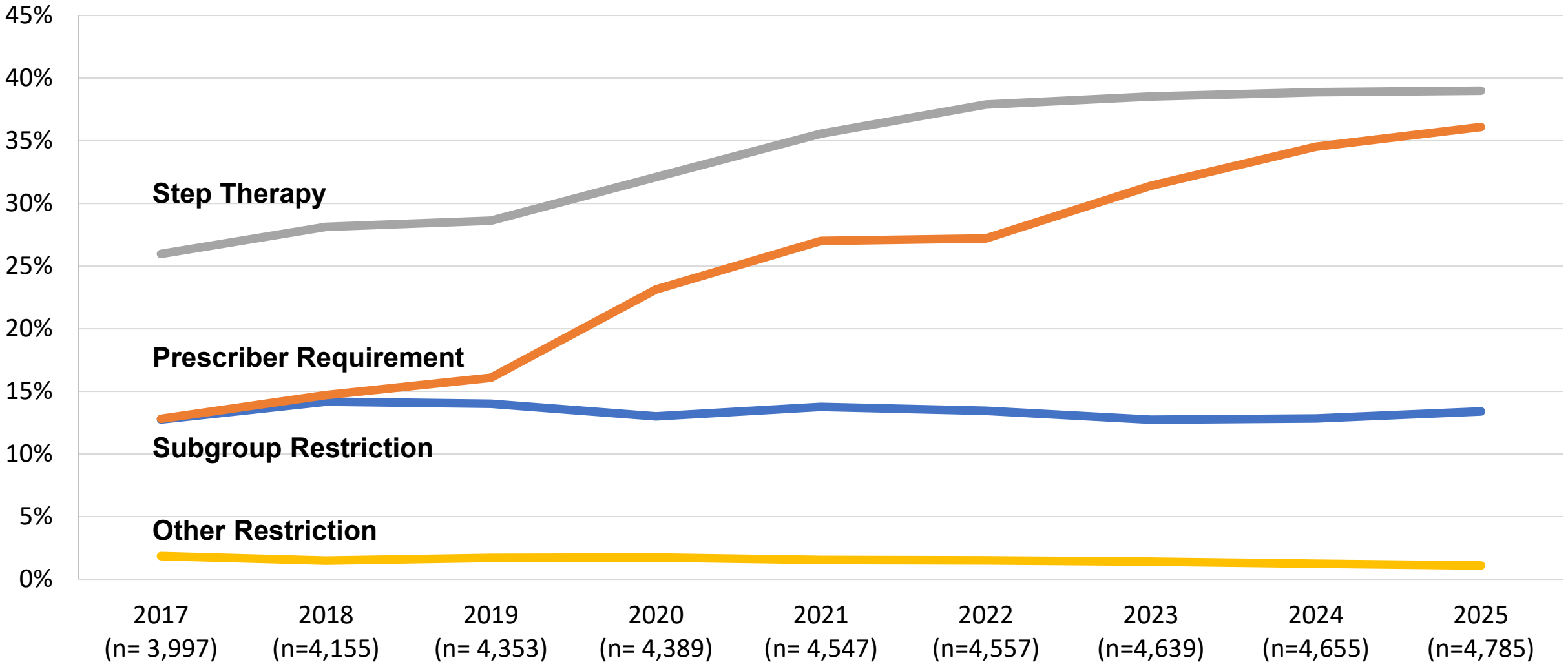
Source: SPEC Database

Plans more often use multiple forms of UM



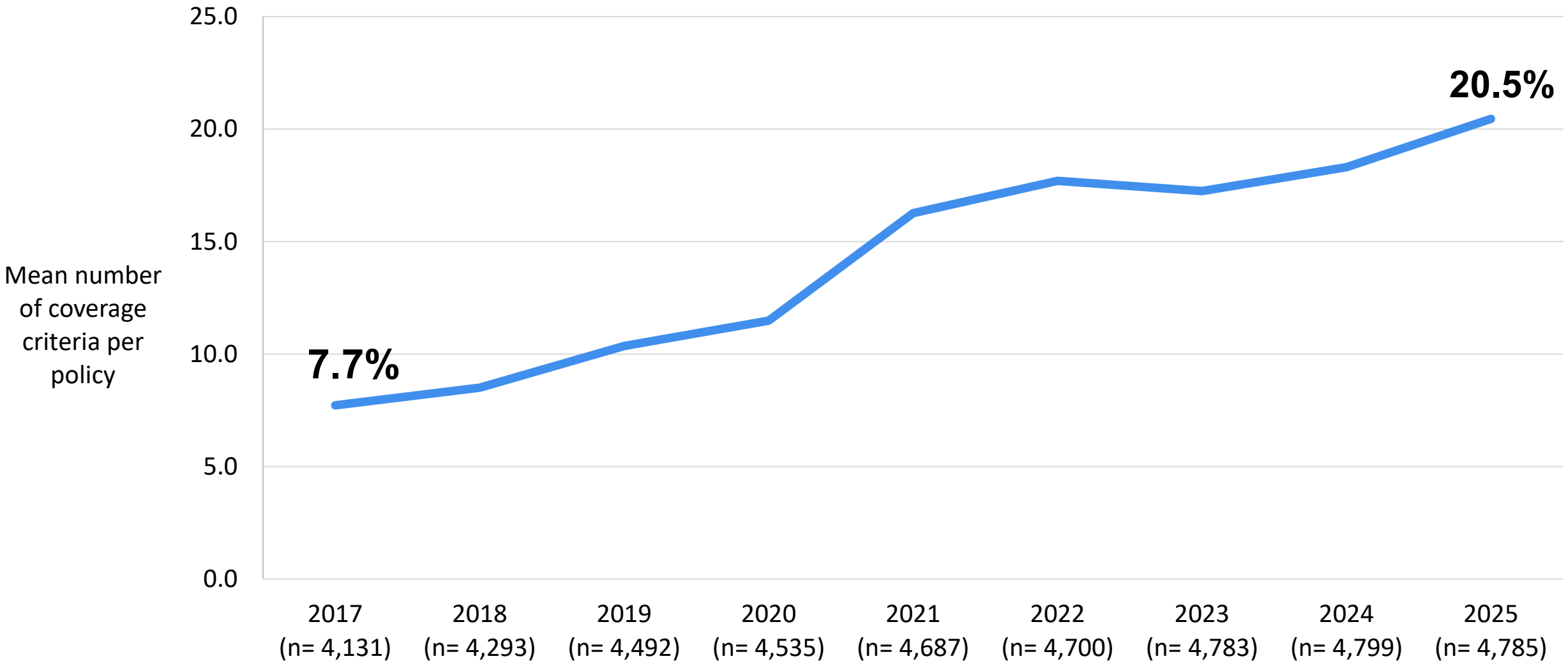
Source: SPEC Database

Growth in UM varies by type



Source: SPEC Database

Longer, More Complex Policies



Source: SPEC Database

Takeaways

SPEC DATABASE
Specialty Drug Evidence & Coverage

1. Majority of policies include some form of UM
2. Coverage varies across plans
3. Plans have imposed more UM over time
4. Coverage polices have become more complex

Arthritis Foundation Prior Authorization Patient Research Findings

Anna Hyde
Vice President of Advocacy and Access

Arthritis Foundation®

Prior Auth Experiences: In Their Own Words

"I have RA and PsA. Every time my body decides that a certain medicine will no longer work, there is a wait for prior authorization and then I usually have to take one day to connect my rheumatologist, the pharmacy, and my insurer to straighten it out."

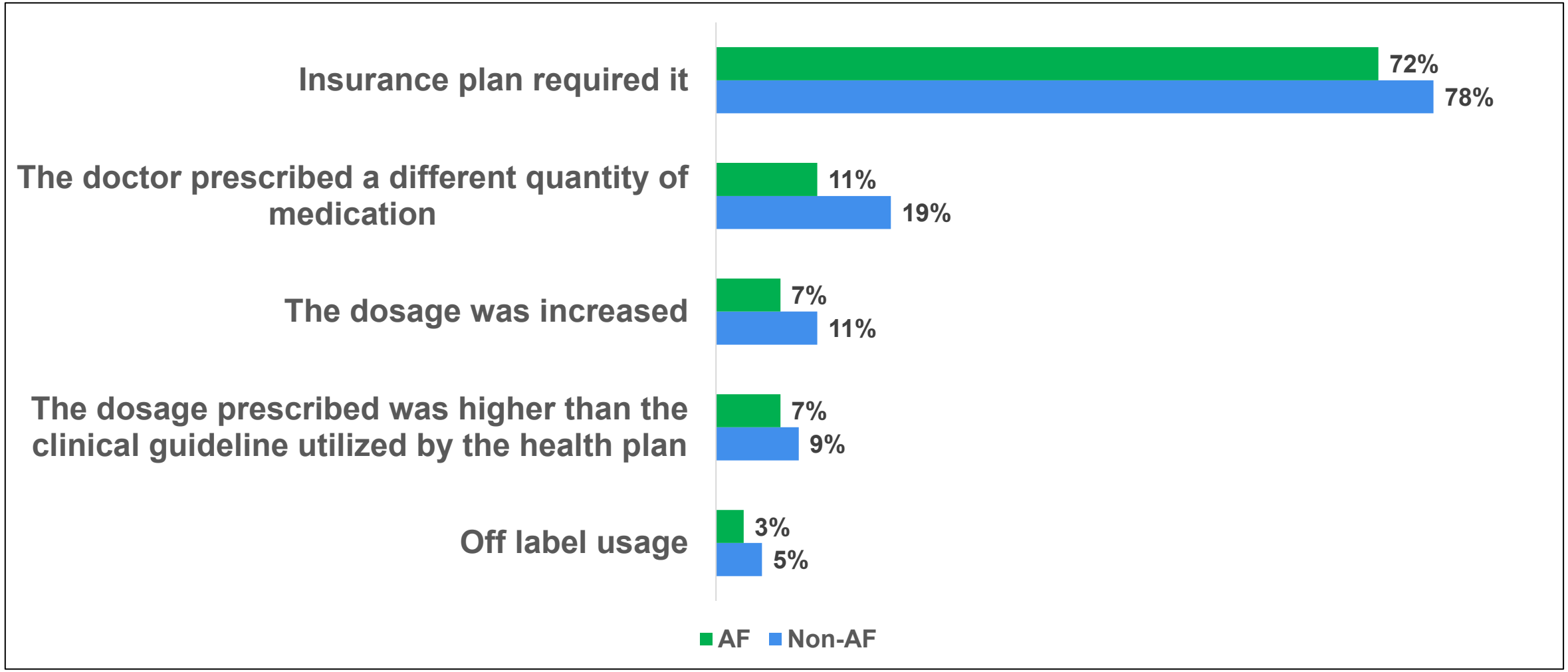
"Prior auth is my hurricane. I stockpile when I can so I don't have medication disruptions when I inevitably have to go through the next lengthy, cumbersome prior auth process."

"My physician decided the biologic medication I was on was not working. It took over six weeks before a new biologic was approved. The pain level required I return to prednisone, which causes other issues, such as weight gain, thinning of bones, interrupted sleep and higher blood glucose levels. I ended up needing a painful procedure to reduce the buildup of fluid in my knee. I can't help but think if I had gotten the new medication approved sooner, I would have been able to avoid this painful procedure."

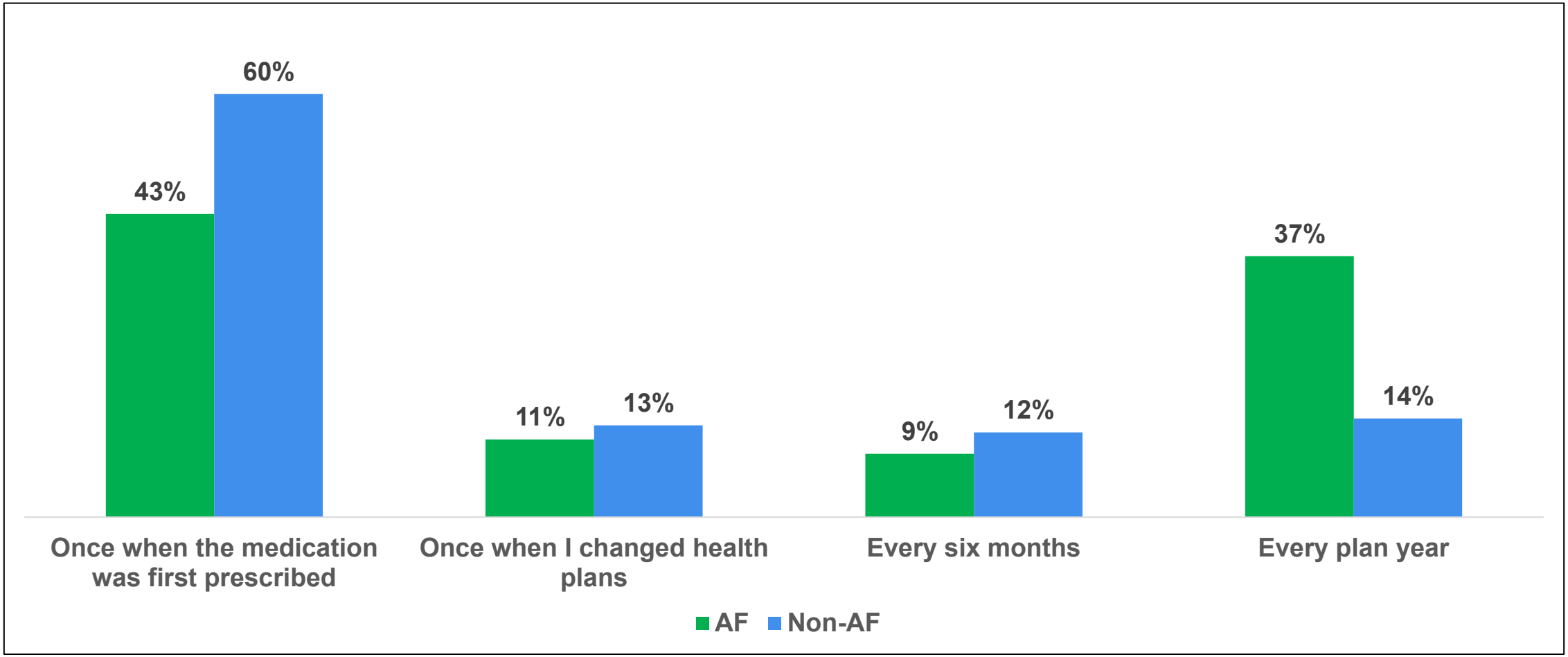
2023 Prior Auth Survey Highlights

- 43% went through PA the first time a medication was prescribed; 37% have to go through it every plan year.
- Mean wait time for approval was 3 days; 31% indicated 7+ day wait time; prior auth was granted 88% of the time.
- For denials, 43% appealed and it was not successful; 28% appealed and it was successful; 28% didn’t appeal.
- 55% used different medication or didn’t use medication when appeal was not successful.

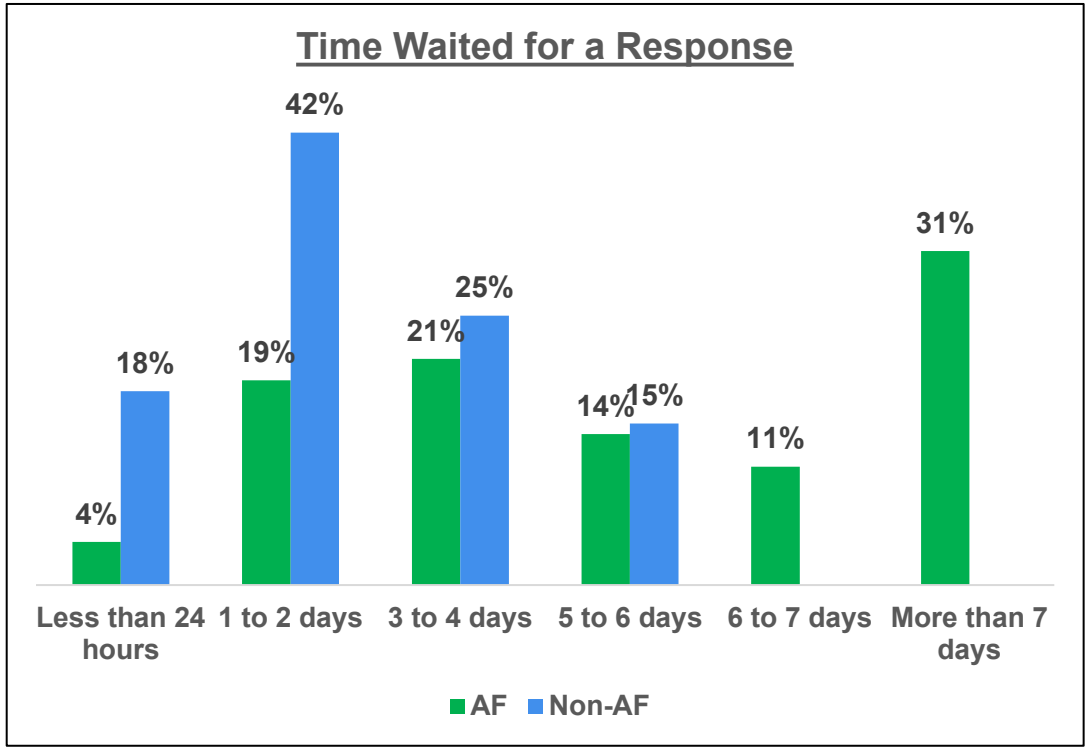
Reasons for Prior Authorizations

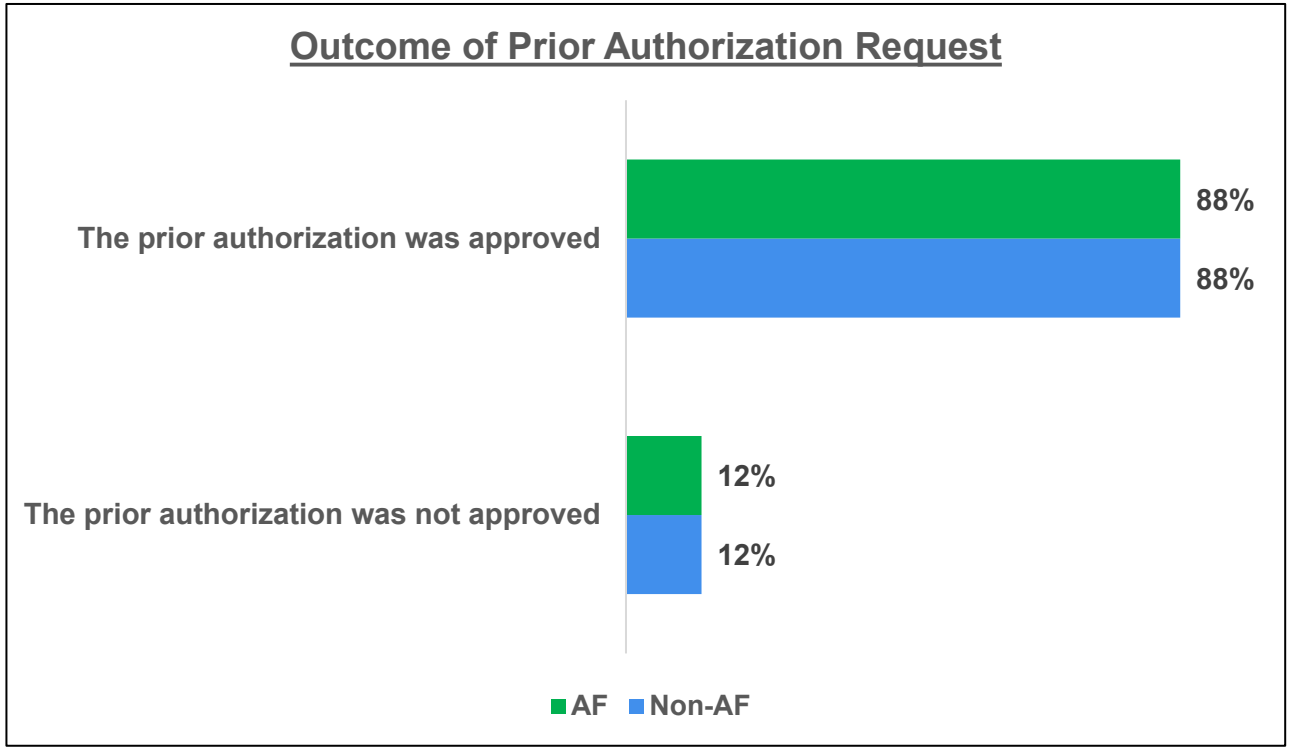


Number of Times PA was Required in the Past 5 Years

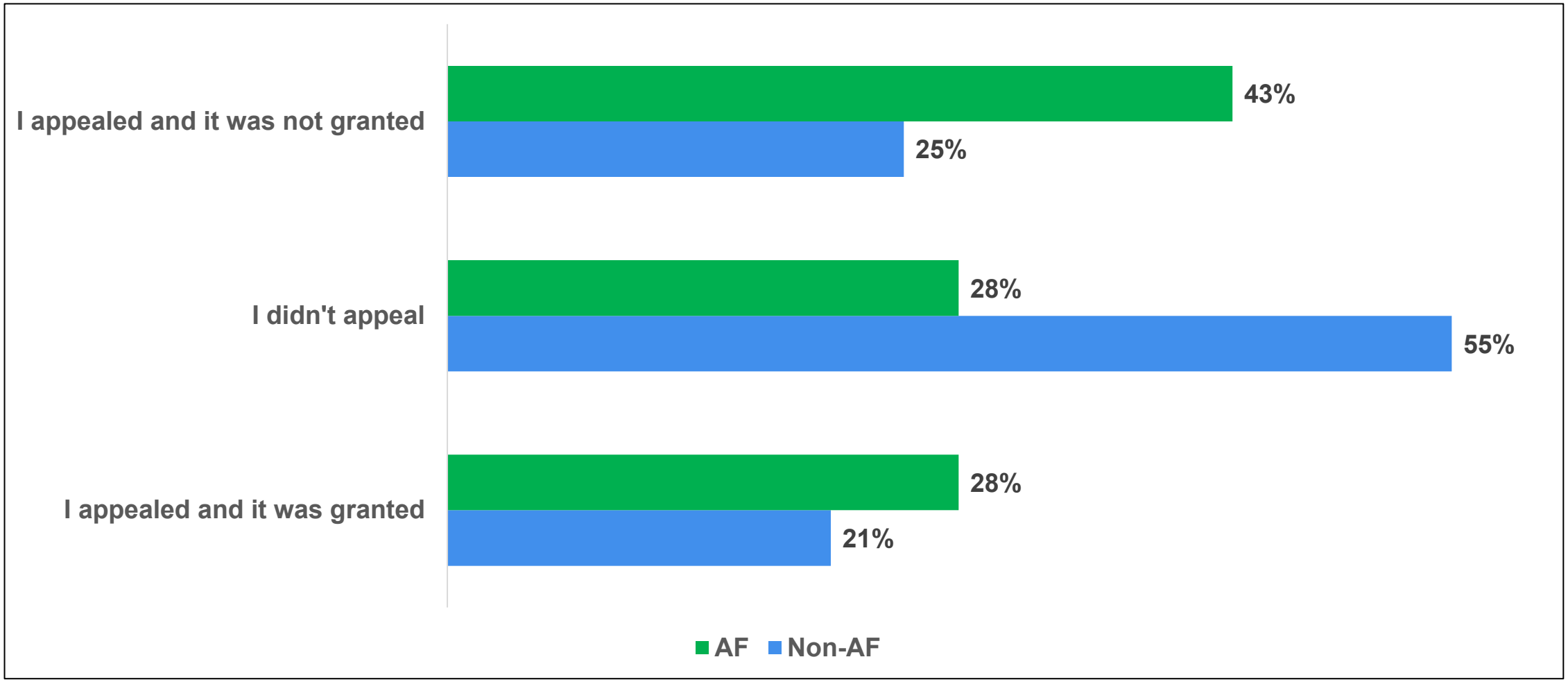


Wait Times for Responses and Outcomes

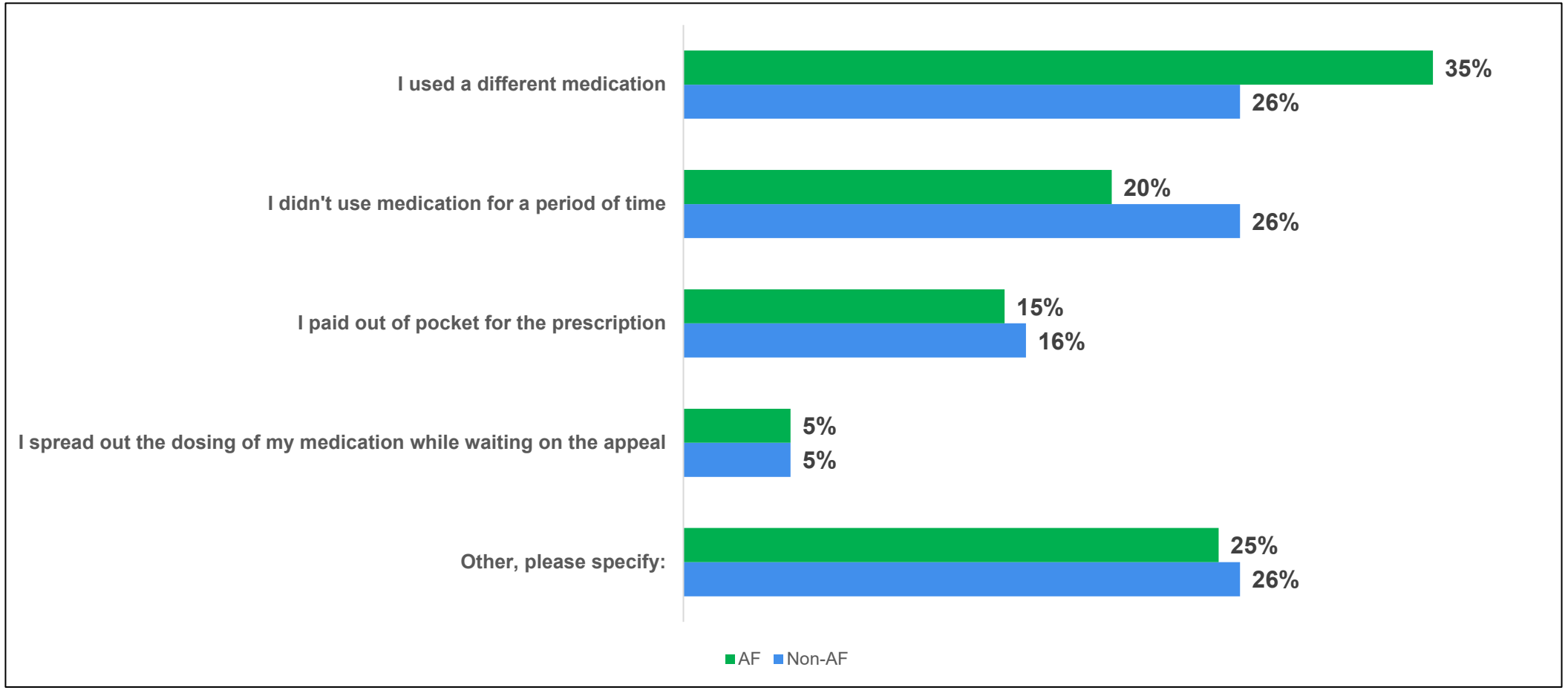




Outcomes when PA Requests were Denied

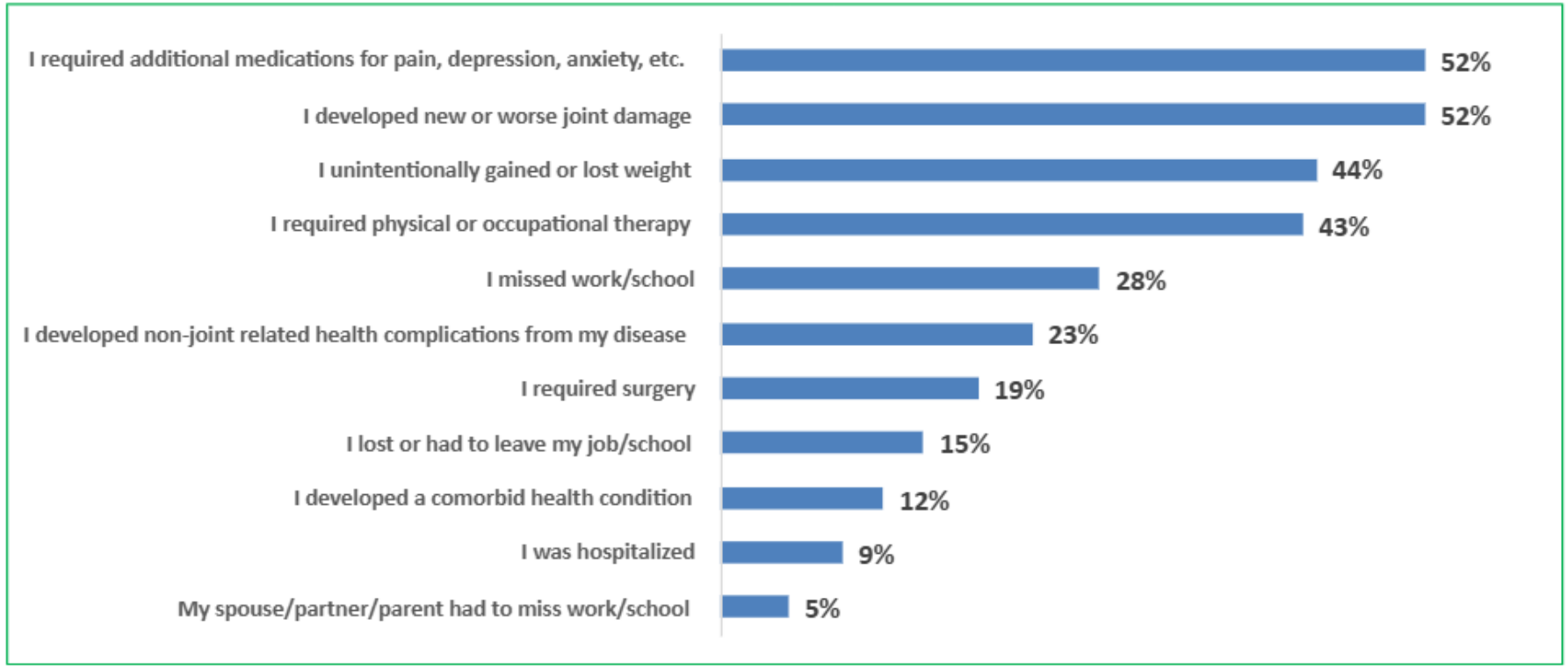


Result When an Appeal was Unsuccessful



Impacts When Delays Lead to Adherence Issues

When arthritis is not well-controlled with medication, the whole body is impacted: additional medications are needed, new or worse joint damage ma develop, weight may fluctuate, and additional PT/OT may be required.



Main Frustrations and Wish List for Patients
2023 Focus Group Results

- Patients generally prefer digital communication and more than anything just want communication to be accessible, transparent, and efficient.
- Sense of being walled off from insurance decisions – either by navigating themselves or getting partial/full support by provider's team.
- Phone is particularly time-consuming and worst offender is snail mail (patients shared stories about receiving letters after an issue had already been entirely resolved).
- Frustration about opacity of processes; desire for more concrete processes, universal across plan type and geographic location.
- There is a strong patient desire to be self-sufficient and able to drive the process or at least be aware of status and where in the process they are.
- Provider's role is key! Having the provider give detailed notes from clinical visits helps a lot, and partnership with the provider increases understanding and reduces anxiety.

Recommendations for Improving Prior Auth

- Ideally patients/patient advocacy groups can co-design a more user-friendly system for navigating prior auth.
- There should be clear education to patients from payers and providers on how to navigate the process (eg patients report easier time if they know their diagnosis and treatment codes).
- Patients and providers should have access to real-time benefit tools.
- Ensure strong implementation and oversight of CMS prior auth rules (0057 and proposed 0062).
- There should be clear guardrails and protections on response times, length of prior auths, reasons for denials, and proactive, clear instructions on appeals (model legislation).
- More research is needed to measure health impacts of practices on patients:
  - Impact of delays on patients and cost-effectiveness for insurers
  - Long-term and indirect effects of UM, including mental/stress response and administrative time costs

PAYER PERSPECTIVE:

IMPROVING PRIOR AUTHORIZATION UTILIZING AGENTIC AI

John Watkins, PharmD, MPH, BCPS
Affiliate Professor, Pharmacy
May 20, 2026

THE CHOICE INSTITUTE
School of Pharmacy

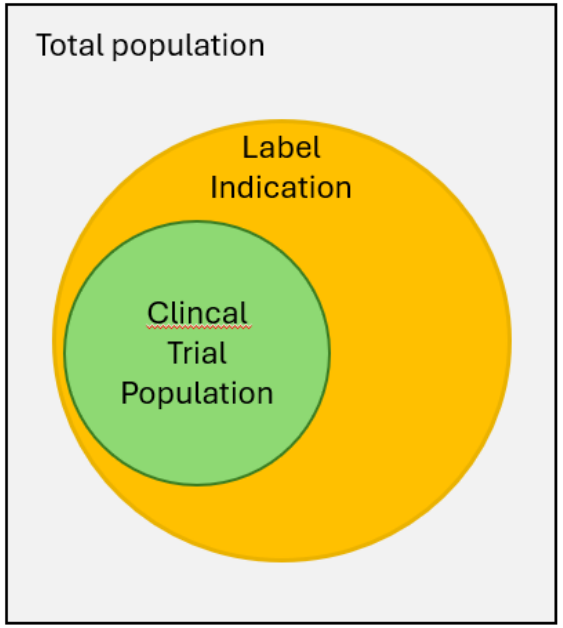
PRIOR AUTHORIZATION: SCIENCE-BASED COST MANAGEMENT

- **Why do we need it? PA gives payers leverage to**
  - Manage unnecessary utilization and promote cost-effective care
  - Negotiate drug price discounts and rebates
- **What's wrong with how we currently do it?**
  - Adversarial provider/payer relationships hinder collaboration
  - Friction and miscommunication create burden and delayed treatment
- **Medical vs Pharmacy Benefit process**
  - Medical: prospective and retrospective review (NOT POC)
  - Pharmacy: UM occurs at POC (pharmacy dispensing)
  - Specialty drugs may be covered on **either** benefit

Types of Prior Authorization Edits

- **Prescriber Requirement – usually this is “common sense”**
- **Step Therapy –where lower cost alternatives exist**
  - Clinically appropriate “first steps”
  - Approve exceptions based on case circumstances
  - Verify from payer pharmacy claims history if possible
- **“Subgroup Restrictions (patient-specific requirements)**
  - Diagnosis, demographics, age, disease severity, etc.)
  - May be verifiable from medical record information
  - Usually based on information from the pivotal trials
  - May be more or less restrictive than label indication

Level of restriction



Possibilities:

- Coverage criteria identical to label
- Coverage criteria identical to clinical trial criteria
- Coverage criteria somewhere in between
- Coverage criteria broader than label

Concerns:

- Could the drug be less safe or effective outside the trial population?
- Is there reason to extend the results beyond the trial population? (i.e., trial subjects restricted for logistic reasons to avoid invalidating results)
- Are all diagnostics required for coverage available in routine clinical practice (outside of academia and RCTs)?

AHIP PLANS TAKE ACTION TO SIMPLIFY PRIOR AUTHORIZATION

Over 50 payers signed 6 commitments with HHS and CMS:

- Standardized electronic PA using FHIR APIs (HL7 standard)
- Reduced scope of claims subject to PA
- Continuity of care when patients change plans (90-day transition)
- Enhanced communication and transparency on determinations
- Real-time responses (≥80%, when required data submitted)
- Review of requests to be denied by appropriate healthcare professional

To be fully implemented by January 2027

https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization

PAYERS ARE TRYING TO DO THEIR PART
THOUGHTFUL APPLICATION OF AGENTIC AI CAN HELP

NEWS

Major payers say they cut prior authorizations by 11%

Major Blues plans, Cigna, Humana and United are among the payers reporting reduced prior authorizations amid an industry-wide push to streamline the process.

By **Jacqueline LaPointe,** Executive Editor

Published: **08 Apr 2026**

Leading healthcare payers said they have pared back prior authorizations after taking a pledge last year to simplify the notoriously cumbersome process.

https://www.techtarget.com/healthcarepayers/news/366641208/Major-payers-say-they-cut-prior-authorizations-by-11?bt_ee=ES%2FDSIEmQTp7BW0OL5tJYpvphMCOWx7L%2B7ss8FqsWOUnSjFZakRQV1352mBQWDVj&bt_ts=1775992217539

BRIDGING THE FORMULARY INFORMATION GAP: USE OF AGENTIC AI TO EXPEDITE REVIEW: PATIENT CASE EXAMPLE:

- **AB is a 35-year-old female with a history of severe asthma** (GINA Step 8). Last year she was referred to an allergist who is currently managing her asthma symptoms with high dose inhaled ICS-LABA. She is biologic therapy naïve. AB is monitored with a home digital device that updates her chart weekly. She is due for a routine office visit next week.
- For AB's upcoming appointment, the provider's EHR AI evaluates her current parameters using software that is programmed with a GINA decision support algorithm. Based on the electronic evaluation, the AI flags AB as a candidate for biologic therapy. With her history and biomarkers, the AI recommends treatment with an anti-IL5 agent.
- The EHR AI checks her insurance coverage and queries the payer's AI, which replies that the payer's first line IL5 agent is benralizumab and supplies the applicable medical necessity criteria. The provider's AI submits a PA request, which is approved by payer's AI.
- When AB arrives for her appointment, the allergist reviews her current situation and accepts the AI's recommendation. After a thoughtful discussion, AB agrees to a trial of benralizumab. The EHR informs them that benralizumab has been pre-approved for a 6-month trial. The allergist signs the prescription, and the EHR transmits it to the payer's network specialty pharmacy, which reaches out to AB to arrange further training support and supply the medication as ordered.
- This substantially reduces paperwork for everyone involved. The provider's approval is required before AB can receive the medication, and the payer affirms that it is medically necessary. Without further human intervention, AB is started on the payer's first-line drug, with savings from the payer's rebate contract, a portion of which is passed on to AB at the point of sale.

PAYER AND PROVIDER AI AGENTS CAN WORK TOGETHER

- **Payer's and Provider's interconnected agentic AI agents identify:**
  - Newly prescribed therapy requiring authorization
  - Which insurance the patient has
  - Which drug is preferred by the payer
  - Payer's coverage criteria
  - Payer's network specialty pharmacy
- **The AI agents organize:**
  - Authorization of the recommended drug
  - Specialty pharmacy to dispense and teach the patient
- **A human is present exactly where a human is needed**

BARRIERS TO ADOPTION OF AI TECHNOLOGY

- **Trust between payers and providers**
  - Use time saved by AI for exception cases
  - Automate more sophisticated “gold carding”
- **Concerns about Agentic AI**
  - Fear of automated denials
  - Optics and Legal risk
  - Cybersecurity and need for data governance
- **Patient-focused concerns**
  - Patient data privacy
  - Physician-patient relationships
  - Dehumanization

“Healthcare has transitioned the abstract AI hype of years past into a reality in which agentic AI is used daily in clinical and administrative settings.”

-Jill Hughes, Xtelligent Healthtech Analytics

"In 2026, we're entering what I call an agentic moment for healthcare."

-Aashima Gupta, Global Director, Healthcare Strategy and Solutions’ Google Cloud

Discussion and Questions

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