

Do We Really Need Prior Authorization?



2025 Princeton Conference
Lew Sandy MD MBA
November 6, 2025

Behind the numbers 2026

No let up in sight. Medical cost trend set to grow at 8.5%. Is your playbook ready?

<https://ncmedsoc.org/government-affairs/prior-authorization/>

<https://www.pwc.com/us/en/industries/health-industries/library/behind-the-numbers.html>



What Is Prior Authorization?

Prior Authorization: What It Is, When It's Used, and Your Options

While receiving medical care or picking up a prescription, you may have heard about something called prior authorization. Prior authorization requires your doctor or provider to obtain approval from your health plan **before** providing health care services or prescribing prescription drugs.

Without prior authorization, your health plan may not pay for your treatment or medication. (Emergency care doesn't need prior authorization.)

Why do health plans require prior authorization? Prior authorization is a check that your plan covers the proposed care. It's also a way the health plan can decide if the care is medically necessary, safe, and cost effective.

(Medicare Part A and Part B generally do not require prior authorization. However, Medicare Advantage and Medicare prescription drug plans (Part D) may require prior authorization.)

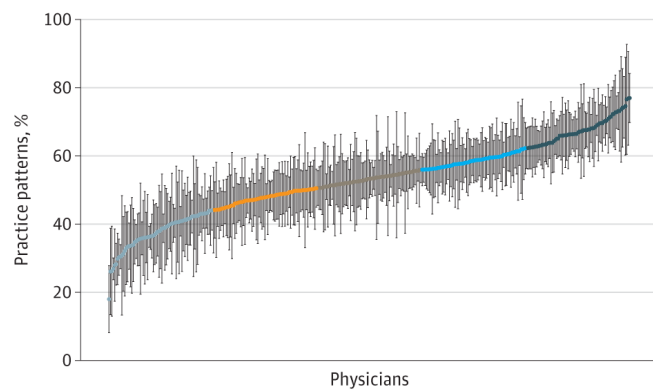
Overview of Prior Authorization:

- A tool in the Medical Management “toolbox”
- A pre-service review of a proposed service for:
 - Coverage determination (is it a covered service under the benefit plan?)
 - Appropriateness (evidence-based medicine, cost-effectiveness, other)
- A low-yield inspection process:
 - 5-8% denial rates; if appealed, 80% overturn rate (MA data)
 - Most denials are information-related
- Aggravating and administratively burdensome
- Evolving state and federal regulations

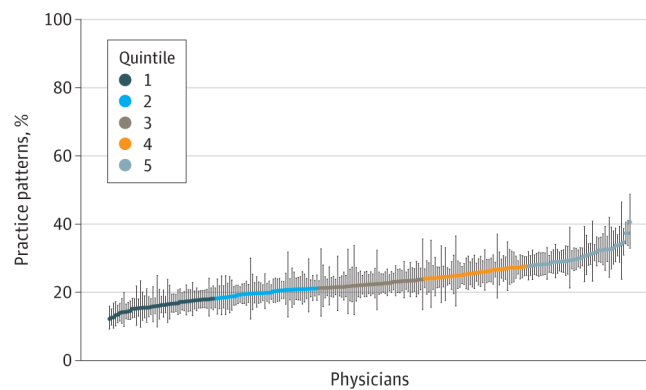
If Prior Authorization is so bad, why does it persist?

- Because it works to reduce inappropriate utilization
- Because of persistent, unexplained, and unwarranted practice variations
- Employers can choose to reduce or eliminate PA (a few do; most don't)
- PPACA could have eliminated or further regulated PA, but did not-why?
- Remains an important tool to address affordability and inappropriate care
- But could be: better, smarter, simpler, and far less frustrating

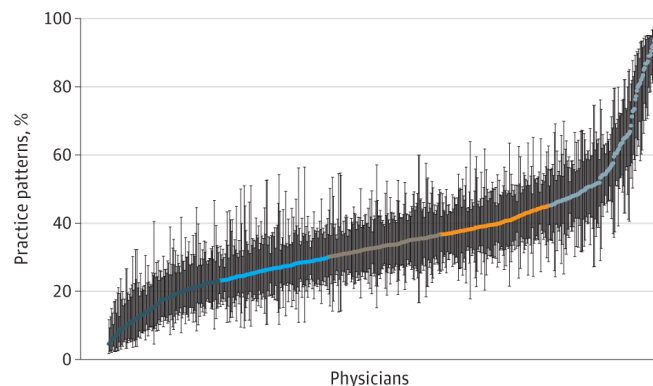
A Statin therapy in patients with chronic CAD



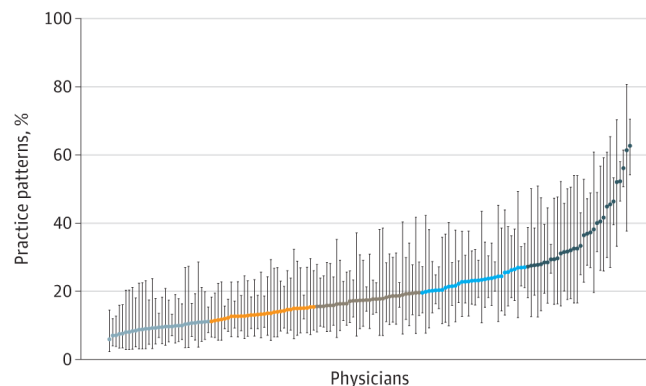
B Endoscopy in patients with GERD and no alarm symptoms



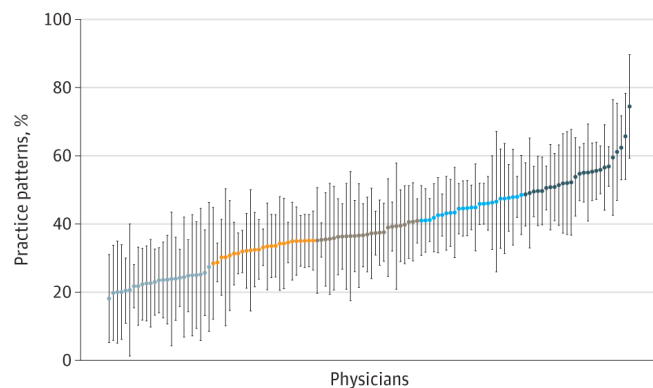
C Cesarean delivery in patients with low-risk pregnancies



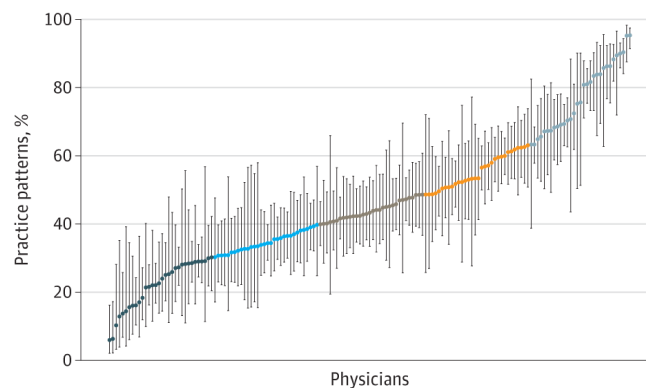
D Any PT before elective hip or knee replacement



E Bronchodilator use in patients with COPD



F Spinal fusion for patients with low back pain



Original Investigation Physician Practice Pattern Variations in Common Clinical Scenarios Within 5 US Metropolitan Areas

[Zirui Song, MD,
PhD^{1,2}](#); [Sneha Kannan, MD²](#); [Robert
J. Gambrel, MS, MA³](#)
[et al](#)

JAMA Health Forum

Published Online: January 28, 2022

2022;3;(1):e214698. doi:10.1001/jamahealthforum.2021.4698



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Final Prior Authorization Rules Look to Streamline the Process, but Issues Remain

Authors: [Kaye Pestaina](#), [Justin Lo](#), [Rayna Wallace](#), and [Michelle Long](#)

Published: May 2, 2024

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As concerns continue to be [raised](#) about [consumer barriers](#) to care resulting from prior authorization requirements, the federal government issued a [final regulation](#) aimed at streamlining and automating the prior authorization process and improving transparency for certain payers. Over the past two years, research and investigations into the use of prior authorization in [Medicare Advantage](#) and [Medicaid managed care](#) plans have brought renewed attention to the prior authorization process. For private commercial coverage, a

ALSO OF INTEREST

Prior Authorization in Health Insurance: A Needed Tool to Contain Costs or an Excessive Barrier to Needed Care?

Consumer Problems with Prior Authorization: Evidence from KFF Survey

KFF Health Tracking Poll: Public Finds Prior Authorization Process Difficult to Manage

<https://www.kff.org/private-insurance/final-prior-authorization-rules-look-to-streamline-the-process-but-issues-remain/>



CMS WISER Model



Morgan Lewis

LAWFLASH

CMS IS GETTING WISER ABOUT MEDICARE WASTE— BUT AT WHAT COST TO PROVIDERS?

July 03, 2025

The Centers for Medicare & Medicaid Services (CMS) recently announced the launch of the Wasteful and Inappropriate Services Reduction (WISeR) Model, a six-year model under the CMS Innovation Center aimed at reducing avoidable, non-evidence-based utilization in Original Medicare. While CMS promotes WISeR as a progressive step toward cost containment and greater efficiency in care delivery and optimization, the model raises a number of complex issues relating to provider burden, technological oversight, contractor incentives, and the potential for



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<https://www.cms.gov/files/document/wiser-fact-sheet.pdf>

Wasteful and Inappropriate Service Reduction Model

Voluntary Model: 2026 - 2031

The Wasteful and Inappropriate Service Reduction Model (WISeR) will harness enhanced technologies like Artificial Intelligence (AI) and Machine Learning (ML) to streamline the review process for certain services that are vulnerable to fraud, waste and abuse, helping people with Medicare receive safe and appropriate care and protecting federal taxpayers.



Model Goals

- Focus health care spending on services that will improve patient well-being
- Increase transparency of existing Medicare coverage policy
- Apply commercial payer processes that may be faster, easier, and more accurate
- De-incentivize and reduce use of medically unnecessary care

<https://www.morganlewis.com/pubs/2025/07/cms-is-getting-wiser-about-medicare-waste-but-at-what-cost-to-providers>

PA Reforms in the Private Sector



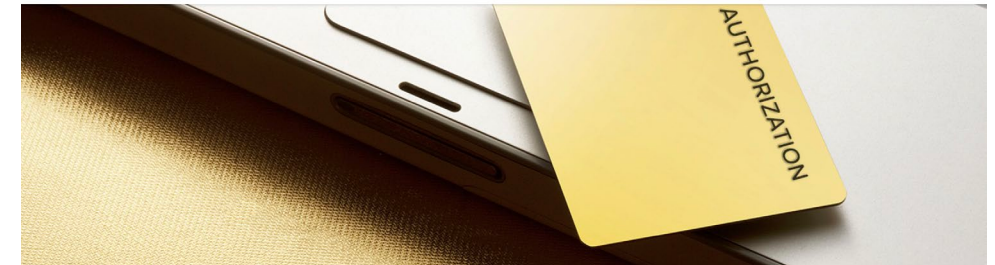
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In the AHIP statement, insurers including multiple Blue Cross and Blue Shield companies, Humana, Kaiser Permanente, and UnitedHealthcare said they would:

- Standardize electronic prior authorization.
- Reduce the scope of claims subject to prior authorization by Jan. 1, 2026.
- Honor existing authorizations while patients are switching to another insurance plan.
- Enhance communication and transparency about prior authorization determinations by Jan. 1, 2026.
- Ensure that at least 80% of electronic prior authorization approvals (with all needed clinical documentation) will be answered in real time by 2027.
- Ensure that medical professionals review all denials for clinical care and services.



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June 26, 2024 | [Blog Article](#) | [Legislation](#) | 4 minute read time

Gold Carding in Healthcare: *Balancing Efficiency and Quality in Prior Authorization Reform*



by NantHealth Inc.

<https://www.shrm.org/topics-tools/news/benefits-compensation/insurers-pledge-to-reform-prior-authorization-employer-impact>

<https://nanthealth.com/resources/articles/gold-carding-in-healthcare-balancing-efficiency-and-quality-in-prior-authorization-reform/>



Looking Ahead: Ways Forward

- Transparency
- Technology and AI
- Process Improvement
- Clinical Improvement
- Better Evidence



appendix

Improving Prior Authorization Processes

Beginning January 1, 2026



PRIOR AUTHORIZATION DECISION TIMEFRAMES

Certain impacted payers are required to send standard prior authorization decisions within 7 calendar days and expedited prior authorization decisions within 72 hours. This policy change for standard decisions does **not** include QHPs on the FFEs.



PROVIDING A SPECIFIC REASON FOR DENIAL

Payers must provide specific information about prior authorization denials, regardless of how the prior authorization request is submitted.



PRIOR AUTHORIZATION METRICS

Impacted payers are required to report certain metrics about their prior authorization processes on their public website on an annual basis. This includes the percent of prior authorization requests approved, denied, and approved after appeal, and average time between submission and decision.

Prior Authorization API

Beginning January 1, 2027



API REQUIREMENT

Impacted payers must implement and maintain a Prior Authorization API.



IDENTIFYING WHETHER AN ITEM OR SERVICE REQUIRES PRIOR AUTHORIZATION

The API must be populated with the list of items and services (excluding drugs) that require prior authorization from the payer.



PAYER-SPECIFIC DOCUMENTATION REQUIREMENTS

The API must identify the payer's documentation requirements for all items and services (excluding drugs) that require a prior authorization request.



EXCHANGING PRIOR AUTHORIZATION REQUESTS AND RESPONSES

The API must support the creation and exchange of prior authorization requests from providers and responses from payers.

10