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August 13, 2025

Mississippi Senator Michel  
Sponsor of NCOIL Prior Authorization Reform Act

Sent via email: [Walter@WalterMichel.com](mailto:Walter@WalterMichel.com)

Dear Senator Michel,

On behalf of AHIP, thank you for the opportunity to comment on the NCOIL Prior Authorization Reform Act (“Model”).

Health plans share NCOIL’s commitment to ensuring patients have access to high-quality, affordable health care and recently announced their voluntary commitments to improve prior authorization, which we believe will address many of the provisions included in the Model.

**Health Plans Take Action to Simplify Prior Authorization.** The recent announcement by health plans of a series of commitments to streamline, simplify and reduce prior authorization – is a critical safeguard to ensure their members’ care is safe, effective, evidence-based, and affordable.

Building on health plans’ existing efforts, these new actions are focused on connecting patients more quickly to the care they need while minimizing administrative burdens on providers.

These commitments are being implemented across insurance markets, including for those with Commercial coverage, Medicare Advantage and Medicaid managed care consistent with state and federal regulations, and will benefit more than 260 million Americans.

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

We know that the health care system remains fragmented and burdened by outdated manual processes, resulting in frustration for patients and providers alike. Health plans are making voluntary commitments to deliver a more seamless patient experience and enable providers to focus on patient care, while also helping to modernize the system.

Participating health plans commit to:

- **Standardizing Electronic Prior Authorization.** Participating health plans will work toward implementing common, transparent submissions for electronic prior authorization. This commitment includes the development of standardized data and submission elements

(using FHIR® APIs) that will support seamless, streamlined processes and faster turn-around times. The goal is for the new framework to be operational and available to plans and providers by January 1, 2027.

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

Progress will be tracked and reported. A full list of participating health plans and additional information are available at: [www.ahip.org/supportingpatients](http://www.ahip.org/supportingpatients).

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**AHIP NCOIL Prior Authorization Model Recommendations.** It is through the lenses of this industry initiative that we offer a series of recommendations to the pending NCOIL Prior Authorization (“Model”). Most of these red line recommendations are centered on four (4) key areas:

1. **This is a Prior Authorization Model.** Many of the red lines are aimed at ensuring that the Model is focused on prior authorization.

- 2. Electronic Prior Authorization.** Providers and plans agree that efforts to improve and strengthen electronic submissions is an area of significant opportunity to reduce administrative burden for providers, while ensuring patient quality and affordability of care. This is a shared responsibility. However, during November 2024 and April 2025 presentations to NCOIL, providers and plans indicated that manual submissions continue to be the major mode of provider submissions. In fact, almost half of provider submissions are done manually.

Providers and plans should modernize outdated systems. To that end, AHIP recommended redline changes ensure that plans and providers are both working together to move away from outdated manual prior authorization submissions. Examples of recommended redlines include:

- When plans are required to establish electronic PA systems, turn-around times should apply to providers only when they utilize those electronic systems for PA submissions.
- Providers should be required to utilize the electronic systems when they are providing information to incomplete and / or inaccurate PA submissions and also use turnaround times for those submissions.

- 3. Alignment with Federal law.** During the NCOIL 2025 Summer meeting, both providers and plans referenced the need to align with the federal “Advancing Interoperability and Improving Prior Authorization Processes” Rule (“Rule”) and other federal relevant laws to ensure consistency and avoid confusion for patients and providers. AHIP’s recommended red lines support this alignment. Examples of recommended redlines include:

- The Advancing Interoperability and Improving Prior Authorization Process rule (“Rule”) explicitly exempts prescription drugs from its prior authorization requirements. The NCOIL Model should as well. This Rule recognized “the processes and standards for prior authorization of drugs differ from the other ‘items and services’ included in our final policies.” To that end, AHIP’s recommended red line edits align the language accordingly.
- AHIP recommended red lines align NCOIL Model definitions, turnaround times, and system changes with federal requirements for consistency and to avoid confusion for patients and providers.

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- 4. Belt and Suspenders.** AHIP recommended red line edits are intended to clarify and fix language to ensure language is clear and consistent.

Thank you for your consideration of these comments. We stand ready to continue to work with you and our provider partners on this critical issue. Our enrollees deserve high quality, outcome based, affordable care and our recommendations are aligned with that important objective. If you have any questions on these or other areas of our red lines, please do not hesitate to reach out.

Sincerely,

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