Utilization Management and Prior Authorization:
Potential State-Level Reforms to Ensure Access to Standard of Care Treatments

Center for Health Law and Policy Innovation

Utilization management—a range of techniques used by health insurance plans to ensure that the plan only pays for clinically appropriate and cost-effective services—has been the subject of growing criticism. Providers and patients have pointed to the significant barriers to care utilization management creates for patients and the increasing burdens these requirements place on providers.[1] Many of these critiques are also driven by the concern that utilization management strategies are being implemented as cost control measures and are untethered from clinical standards.

This issue brief highlights the most promising state-level solutions to curtail inappropriate use of utilization management techniques by state-regulated private insurers, including fully insured employer plans and Qualified Health Plans. These proposed reforms focus on strategies to enable state regulators to ensure that utilization management reflects up-to-date standards of care and does not operate as a mechanism to reduce healthcare costs at the expense of patient access to medically necessary care. The considerations outlined below may also be relevant for other public and private insurance markets.

Terminology

Medical necessity = a determination that a service is clinically required treatment for the prevention or treatment of a medical condition

Utilization management = a series of plan policies that limit coverage for what the plan deems unnecessary services (i.e., not medically necessary)

Prior authorization = a form of utilization management that requires a provider to get plan approval for a particular service before the plan will pay for the service

Step therapy = a form of utilization management that requires the patient to try and fail on an alternative (usually older, cheaper) service before the plan will pay for a specific (usually newer, more expensive) service

[1] Grace Sparks et al, KFF Health Tracking Poll: Public Finds Prior Authorization Process Difficulty to Manage (July 25, 2025) https://www.kff.org/patient-consumer-protections/kff-health-tracking-poll-public-finds-prior-authorization-process-difficult-to-manage/ (three in ten insured adults surveyed reported that their insurer "delayed their ability to get or denied coverage for a health care service, treatment, or medication that they or their doctor requested"); Kevin B. O'Reilly, 1 in 3 doctors has seen prior auth lead to serious adverse event (March 29, 2023), https://www.ama-assn.org/practice-management/prior-authorization/1-3-doctors-has-seen-prior-auth-lead-serious-adverse-event;
American Medical Association, Prior Authorization Resources, https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization.

I. Utilization Management and Medical Necessity

Medical necessity is the overarching requirement that a plan provide coverage for services that are clinically necessary for treatment and prevention of a medical condition.[2] Medical necessity for state-regulated plans is sometimes defined in state law, but more often is defined by plans themselves, typically in member contracts, benefits summaries, or payment policies for specific services.

Plans may use utilization management, including prior authorization and step therapy, to limit service coverage. But plans must ensure that any utilization management technique they employ allows patients to access medically necessary treatment.

When plans employ prior authorization and step therapy, they justify these requirements through a set of clinical criteria typically found in plan payment guidance documents. These clinical criteria set out the requirements that patients must meet, through evidence submitted by their provider, in order for a specific service to be covered. The clinical criteria incorporated into utilization management may be drafted by the insurer or by for-profit companies that develop utilization review criteria[3] and may be different than the clinical standards of care set by medical societies and organizations. When the clinical criteria used in utilization management do not align with the clinical standards of care recognized by provider organizations, patients are denied access to medically necessary care.

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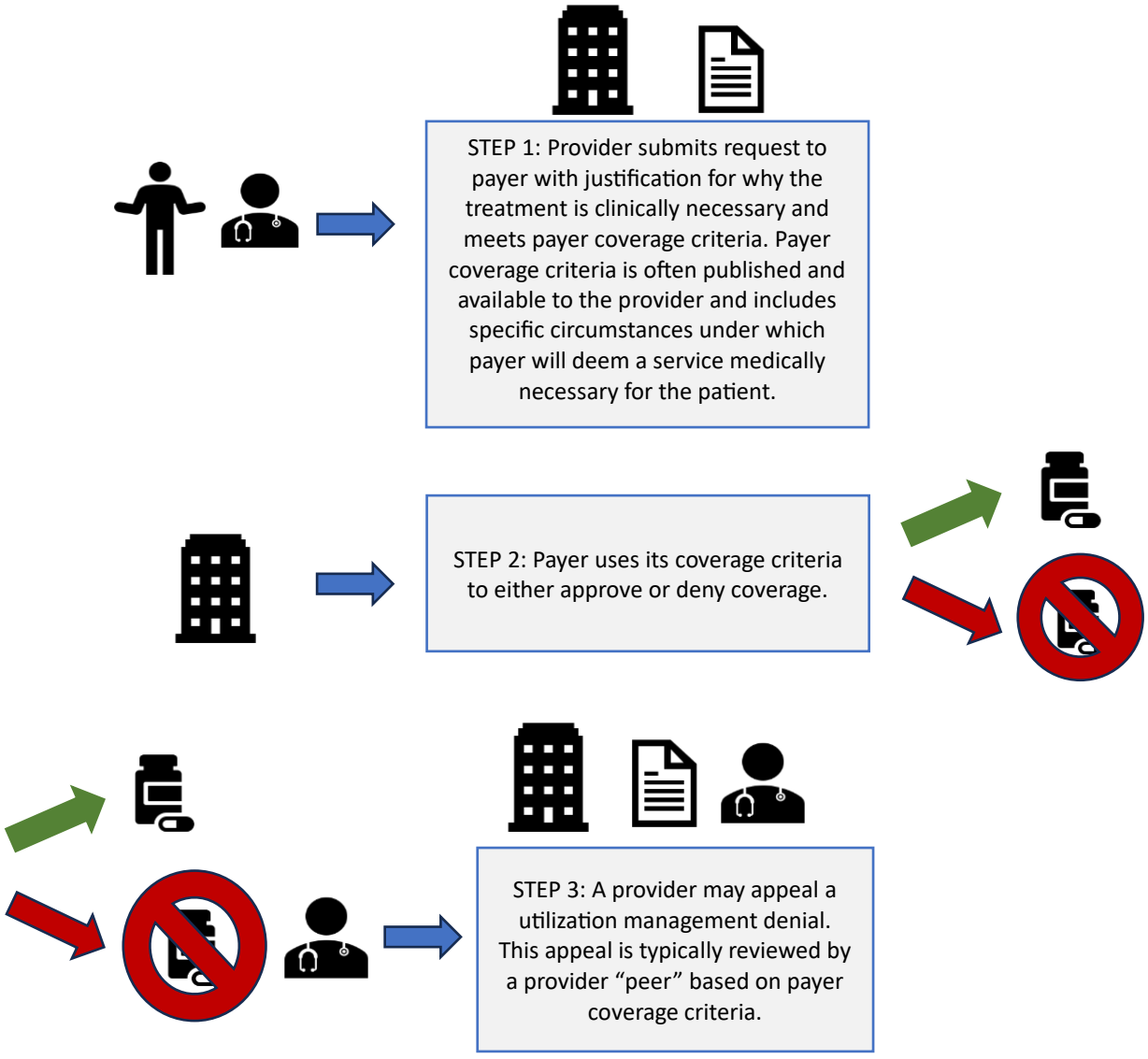
[2] National Association of Insurance Commissioners (NAIC), Understanding Health Care Bills: What Is Medical Necessity, https://content.naic.org/sites/default/files/consumer-health-insurance-what-is-medical-necessity.pdf.

[3] See, e.g., InterQual, Case Study, https://business.optum.com/content/dam/o4-dam/resources/pdfs/case-studies/interqual-payer-customer-success.pdf (describing how a large national health plan transitioned to InterQual, a clinical criteria vendor, as part of a utilization management "modernization initiative").

Figure 1: Utilization Management and Medical Necessity



II. When Inappropriate Utilization Management Jeopardizes Clinically Appropriate Care

A common challenge identified by patients and providers is that utilization management criteria are not aligned with appropriate clinical standards of care. If these criteria are not based on clinical standards, it can result in potentially arbitrary coverage decisions that prevent access to medically necessary care.[4,5] Provider surveys reflect this concern, with 31% of providers reporting that prior authorization criteria are "rarely or never evidence-based."[6] Reasons for the disconnect between utilization management criteria and clinical standards of care include:

One Study Finds Arbitrary use of Prior Authorization for HIV Pre-exposure prophylaxis (PrEP)[5]

Researchers at the University of Virginia found that Qualified Health Plans' use of prior authorization for medications used to prevent HIV infections varied considerably by region, raising questions as to whether each plan's prior authorization requirements were based on a clear clinical standard or were arbitrary.

- **Clinical standards of care are not primarily written for payers, necessitating translation** Clinical standards of care for particular conditions or diseases are typically developed by independent medical bodies made up of subject matter experts in that particular field. Often medical specialty societies will promulgate clinical care guidelines for relevant conditions. These standards articulate best practices for clinical care and are not necessarily written with coverage questions in mind. While these standards of care are relevant for coverage decisions by payers, they are not necessarily written in a way that easily translates into coverage guidelines.[7]

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[4] See, e.g., Mark TL, Parish WJ, Zarkin GA, Weber EM. The association of Medicare Part D prior authorization for buprenorphine-naloxone with adherence to opioid use disorder treatment guidelines in the United States. Addiction. 2022 Jan;117(1):141-150. doi: 10.1111/add.15585 (finding that prior authorization for buprenorphine-naloxone did not result in higher likelihood of receiving high-quality treatment for opioid use disorder than patients not subject to prior authorization).

[5] McManus KA, Fuller B, Killelea A, Strumpf A, Powers SD, Rogawski McQuade ET. Geographic Variation in Qualified Health Plan Coverage and Prior Authorization Requirements for HIV Preexposure Prophylaxis. JAMA Netw Open. 2023;6(11):e2342781. doi:10.1001/jamanetworkopen.2023.42781 (researchers assessed geographic variation in QHP use of prior authorization applied to medications used for pre-exposure prophylaxis (PrEP) for the prevention of HIV. QHP prior authorization for PrEP varied considerably by geography, pointing toward possible arbitrary use of prior authorization).

[6] American Medical Association, Advocacy in Action: Prior Authorization (May 2025), https://www.ama-assn.org/practice-management/prior-authorization/advocacy-action-fixing-prior-authorization

[7] See, e.g., MCG, The Value of Independent Clinical Guidelines (January 23, 2024), https://www.mcg.com/blog/independent-clinical-guidelines/ (describing how MCG reviews, consolidates, and translates medical society guidelines and other clinical evidence into clinical guidelines for payers, hospitals, and others).

- **Payment coverage criteria do not always properly reference or reflect clinical standards of care**
  Because clinical standards of care are not written primarily for payers, payers generally develop their own payment coverage criteria or use industry guidelines that may or may not be fully aligned with clinical standards of care. Companies that draft payment criteria often conduct evidence reviews as part of developing coverage policies, including reviewing available clinical standards of care. However, some medical societies and patient advocates have argued that they are unable to discern whether commonly used utilization management guidelines are appropriately incorporating clinical standards of care due to the proprietary nature of those guidelines.[8]

- **Payment coverage criteria are designed to control cost, whereas clinical standards of care focus on individual patient care**
  Clinical standards of care "are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."[9] Although some physician specialty societies do consider cost as a factor that may influence their recommendations in certain contexts (such as when comparing two equally effective interventions),[10] in general, clinical standards of care are designed to guide individual patient care rather than to minimize costs. Conversely, utilization management is primarily a cost management approach to healthcare financing that enables insurers to control healthcare spending by driving patients toward lower cost services (including services for which the insurer has negotiated a lower price) and using prior authorization to limit access to certain more expensive services, although insurers claim it is also necessary to ensure that care is clinically appropriate, reduce waste, and promote healthcare quality and cost effectiveness.[11] This misalignment in purpose—with clinical standards of care being centered on supporting decision making in specific clinical contexts, while utilization management is foremost about cost effectiveness—may incentivize insurers to delay or decline to adopt the latest clinical standards of care. An example of this has occurred in the context of access to direct acting antivirals (DAAs) for treatment of hepatitis C: treatment with DAAs is considered the standard of care, yet prior authorization requirements remain in place for many public and private insurance plans, delaying access to treatment and straining health system resources.[12]

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[8] The Kennedy Forum and Legal Action Center, Generally Accepted Standards of Care: Aligning Coverage Criteria and Utilization Review Criteria with Clinical Practice (September 2025), https://www.thekennedyforum.org/app/uploads/2025/06/Gold-Standard-GASC_May_2025.pdf

[9] National Institutes of Health, National Center for Complementary and Integrative Health, Clinical Practice Guidelines, https://www.nccih.nih.gov/health/providers/clinicalpractice.

[10] Jennifer A. T. Schwartz, Steven D. Pearson, Cost Consideration in the Clinical Guidance Documents of Physician Specialty Societies in the United States, JAMA Internal Medicine (June 24, 2013), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1685895.

[11] Leila Sullivan, Zeynep Celik, Amy Killelea, Prior Authorization Reform Heats Up (Nov. 24, 2025), https://www.healthaffairs.org/content/forefront/prior-authorization-reform-heats-up; Angelo P. Giardino, Roopma Wadhwa, Utilization Management, StatPearls, (July 10, 2023) https://www.ncbi.nlm.nih.gov/books/NBK560806/.

[12] Marjan Javanbakht, Roxanne Archer, Jeffrey Klausner, Will prior health insurance authorization for medications continue to hinder hepatitis C treatment delivery in the United States? Perspectives from hepatitis C treatment

- **Plan policies leave discretion to reviewers without appropriate expertise to interpret whether a patient meets criteria**
  Even when a plan coverage policy is appropriately tethered to a medical necessity standard based on clinical standards of care, that coverage policy may be applied incorrectly by reviewers without appropriate expertise. Utilization management requests are frequently routed to third-party vendors or artificial intelligence (AI) tools whose purpose is to help insurance plans process these requests efficiently.[13] Prior authorization and step therapy denials can be appealed by providers, and often those appeals must be reviewed by medical peers. However, there is not a consistent standard to identify an appropriate "peer."[14] Providers report that prior authorization and other utilization management appeals are sometimes reviewed by clinicians in completely different specialties, without the requisite expertise to evaluate whether covering a certain service is medically necessary.

- **Plans often do not provide information to providers, patients or the public about the criteria they are using to make utilization management decisions**
  Though federal and state laws are starting to require more transparency, it has historically been very difficult for providers and patients to get information from the plan about the criteria the plan is using to make coverage decisions.[15] This not only makes it difficult to submit a utilization management approval request that is likely to succeed, it also leaves providers in the dark about the specific denial reasons, making it hard to submit an effective appeal.[16] Lack of transparency around clinical criteria also makes it difficult to discern whether plans are accurately citing and translating clinical standards of care.[17]

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providers in a large urban healthcare system, PLOS One, (Nov. 4, 2020) https://pmc.ncbi.nlm.nih.gov/articles/PMC7641373/.

[13] T. Christian Miller, ProPublica; Patrick Rucker, The Capitol Forum; and David Armstrong, ProPublica "Not Medically Necessary": Inside the Company Helping America's Biggest Health Insurers Deny Coverage for Care, https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations

[14] Tanya Albert Henry, AMA, Fixing Prior Auth: Give Doctors a True Peer to Talk with—Stat (April 24, 2025), https://www.ama-assn.org/practice-management/prior-authorization/fixing-prior-auth-give-doctors-true-peer-talk-stat

[15] Kaye Pestaina, Justin Lo, Rayna Wallace and Michelle Long, Final Prior Authorization Rules Look to Streamline the Process, but Issues Remain (May 2, 2024), https://www.kff.org/private-insurance/final-prior-authorization-rules-look-to-streamline-the-process-but-issues-remain/

[16] See, e.g., Kristof Stremikis, California Health Care Foundation, Reforming Prior Authorization in California (February 4, 2025), https://www.chcf.org/resource/reforming-prior-authorization-california/

[17] The Kennedy Forum and Legal Action Center, Generally Accepted Standards of Care: Aligning Coverage Criteria and Utilization Review Criteria with Clinical Practice (September 2025), https://www.thekennedyforum.org/app/uploads/2025/06/Gold-Standard-GASC_May_2025.pdf.

III. State Policy Approaches to Ensure Utilization Management Criteria Reflect Clinical Standards of Care

Recognizing the access challenges that arise from misalignment between utilization management criteria and clinical standards of care, states have enacted varying legislation aimed at requiring fully insured plans to ensure coverage of medically necessary care. Much of these state efforts have focused on reforming utilization management processes, such as setting concrete timelines for approving or denying a request.[18] Fewer states have focused on substantive reforms,[19] which are important to set appropriate boundaries on the use of utilization management and to make sure patients can access standard of care treatments.

Some state-level reforms that are particularly promising for ensuring access to standard of care treatments for patients subject to utilization management include:

- **Define medical necessity**
  Medical necessity does not have a federal definition, and it is often not defined in state law either. This lack of a uniform definition means that plans may approach medical necessity determinations—particularly determinations that underlie utilization management decisions—in different ways using varying criteria. To address this variability, increase transparency, and reduce the potential for arbitrary denial of necessary care, some states have passed laws better defining medical necessity.[20] For instance, Arkansas uses the American Medical Association's (AMA's) definition of medical necessity (see text box).[21] Other states have embedded a broader standard into utilization management reforms, requiring plans to base coverage decisions on "peer-reviewed clinical review criteria."[22]

AMA Definition of Medical Necessity

Health care services or products that a prudent physician would provider to a patient for the purposes of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

a. In accordance with generally accepted standards of medical practice;
b. Clinically appropriate in terms of type, frequency, extent, site and duration; and
c. Not primarily for the economic benefit of health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

- **Require utilization management to reflect published clinical guidelines**
  Several states have enacted utilization management reforms that require payer

[18] Leila Sullivan, Zeynep Ceilk, Amy Killelea, Prior Authorization Reform Heats Up, Health Affairs Forefront (November 24, 2025), https://www.healthaffairs.org/content/forefront/prior-authorization-reform-heats-up.
[19] *Id.*
[20] See, e.g., Ark. Code §23-99-1103.
[21] *Id.* Compare AMA Policy Finder, Definitions of "Screening" and "Medical Necessity" H-320.953, https://policysearch.ama-assn.org/policyfinder/detail/H-320.953?uri=%2FAMADoc%2FHOD.xml-0-2625.xml.
[22] See, e.g., Mich. Admin Code r. 500.2212e(1)(a) (2022).

coverage criteria and coverage decisions to reflect clinical guidelines. Some states have referenced guidelines for a specific condition—for example, Illinois has required medical necessity determinations for care for substance use disorders to be made in accordance with criteria from the American Society of Addiction Medicine.[23]

- **Prohibit use of prior authorization and step therapy for particular conditions or services**
  Some states have chosen to explicitly prohibit regulated plans from using either prior authorization or step therapy for particular services where evidence suggests the harm of utilization management outweighs any benefit. Prohibitions have been applied to certain conditions and interventions such as HIV medications and medications for opioid use disorder (MOUD).[24]

- **Require providers with relevant expertise to review utilization management denials**
  Another protection some states have put in place is a requirement that utilization management review denials be reviewed by a peer provider with relevant expertise in the intervention or disease state.[25] Provider groups have pushed this reform after reporting that denials are upheld by reviewers who often practice in completely different specialties and do not have the expertise needed to thoroughly review the coverage decision. This type of legislation also addresses concerns that insurers are using AI tools to make utilization management denial decisions without meaningful human review.[26] These reforms are more likely to be effective where they place the burden of compliance on the insurer, not the provider or the patient—if the insurer cannot secure a peer reviewer within a reasonable amount of time, or provide a realistic time window and

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[23] 215 ILCS 5/370c(b)(3) (2023). California has also enacted sweeping legislation aimed at expanding access to mental health care, which includes the requirement that "medical necessity determinations… must be made using the most recent versions of clinical practice guidelines developed by nonprofit professional associations for the relevant clinical specialty." Insurance Commissioner Ricardo Lara, Notice to All Health Insurance Companies (Dec. 10, 2020), https://www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/Notice-to-Health-Insurers-re-Requirements-of-Senate-Bill-855.pdf.

[24] Rachel Swindle and Kristen Ukeomah, Georgetown University McCourt School of Public Policy Center on Health Insurance Reforms (CHIR), Tackling Another Public Health Emergency: Recent State and Federal Policies to Increase Opioid Use Disorder Treatment Access (August 7, 2023), https://chir.georgetown.edu/tackling-another-public-health-emergency-recent-state-and-federal-policies-to-increase-opioid-use-disorder-treatment-access/#:~:text=Some%20states%20have%20adopted%20policies,made%20available%20without%20prior%20authorization. Colorado bans use of prior authorization or step therapy for HIV medications. CO Rev Stat § 10-16-152. In addition to banning use of prior authorization for MAT, Illinois has banned step therapy altogether for state regulated private insurance, Medicaid, and state group health plans through the IL Health Care Protection Act.

[25] See, e.g., Delaware Pre-Authorization Act of 2025, https://legiscan.com/DE/text/SB12/id/3258755

[26] NORC at the University of Chicago on behalf of the Consumer Representatives to the NAIC, Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management (November 2024), https://consumeradvocacyforhealth.org/resource/report-on-artificial-intelligence-and-health-insurance/

callback number to enable the patient's provider to connect with the peer reviewer, then the appeal should be deemed approved.[27]

- **Build off federal prior authorization transparency requirements to require more information on plan coverage criteria**
  Transparency requirements could allow patients, providers, and advocates to better understand the coverage criteria plans are using, including whether those criteria are aligned with clinical guidelines. Transparency requirements could also help providers to get initial utilization management requests approved as well as tailor appeals of denials. The Centers for Medicare and Medicaid Services (CMS) released a comprehensive regulation in 2024, which requires plans to provide coverage criteria information and prior authorization denial reasons to patients and providers.[28] States could build off these requirements, including extending them to prescription drugs, which the federal law currently omits.

The above reforms are most likely to be effective if implemented in combination with each other and with a firm commitment to state level enforcement. For example, transparency requirements that enable providers to access insurer criteria for payment would help identify plans that may be out of compliance with state legal definitions of medical necessity. Likewise, robust enforcement mechanisms and a commitment from state insurance regulators to leveraging their authority to promote compliance will help ensure that these new reforms are not just window dressing. Enforcement mechanisms could include meaningful interpretive guidance spelling out insurers' responsibilities under new state laws, authority of state regulators to audit or impose civil fines for noncompliance, and resources to help patients know and protect their rights. With state policymakers growing increasingly concerned about prior authorization abuses, and adopting new state laws to improve prior authorization processes and quality of decision making,[29] these reforms should be packaged in ways that promote both their letter and their spirit—improving access to medically necessary care.

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[27] See, e.g., Alexa B. Kimball, The dangerous illusion of 'peer-to-peer' review for prior authorization, STAT+ (Nov. 5, 2025) https://www.statnews.com/2025/11/05/peer-to-peer-review-prior-authorization-insurance-companies/ (highlighting unreasonable insurer practices that make it difficult for providers to connect with peer reviewers).
[28] CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), https://www.cms.gov/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f.
[29] Leila Sullivan, Zeynep Ceilk, Amy Killelea, Prior Authorization Reform Heats Up, Health Affairs Forefront (November 24, 2025), https://www.healthaffairs.org/content/forefront/prior-authorization-reform-heats-up..

IV. Conclusion

The calls for overhauling utilization management are coming from multiple sectors – patients, providers, and health systems. These stakeholders are increasingly pointing to broken systems that are denying medically necessary services instead of ensuring access to appropriate care. Even insurance trade groups are beginning to acknowledge that prior authorization is a problem and have committed to reducing the prior authorization burden on patients and providers.[30] While there are many ways to reform prior authorization and other forms of utilization management, an important next step is to ensure that utilization management criteria transparently and closely track clinical standards of care, and that qualified experts are charged with applying payment criteria guidelines.

[30] AHIP, Health Plans Take Action to Simplify Prior Authorization (June 2025), https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization