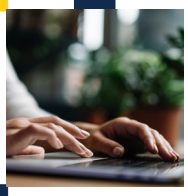
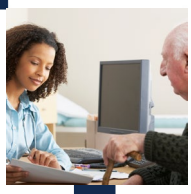
# Chapter 848 and Chapter 847, *Health Insurance – Utilization Review – Revisions* (2024)





## *Findings and Recommendations on the Implementation of § 19–108.5 Health – General Article*

DRAFT

September 18, 2025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# Table of Contents

## MARYLAND LAW

During the 2024 legislative session, the General Assembly passed Chapter 848 (Senate Bill 791) and Chapter 847 (House Bill 932), *Health Insurance - Utilization Review – Revisions* (law).[1] Among other things, the law requires payors to establish and maintain an online process for prior authorizations that meets specified parameters by July 1, 2026 (Figure 1). The law also includes study and reporting requirements for the Maryland Health Care Commission (MHCC) and the Maryland Insurance Administration (MIA). In 2024, MHCC and MIA, in consultation with providers and payors, studied the development of standards for modifying prior authorization requirements for prescription drugs, medical care, and other services; the study also considered adjustments to prior authorization requirements that have been implemented or considered by other states. Findings pertaining to select policy and technical aspects of the prior authorization process and three recommendations were included in the final report (November 21, 2024) submitted to the General Assembly.[2]

The law requires MHCC in consultation with the MIA to monitor progress towards implementing requirements for the online process. This includes reviewing federal or State developments and issues or recommendations from other states that are implementing a real-time benefit requirement, including establishing a link at the point of prescribing for any available coupons. By December 1, 2025, MHCC must inform the General Assembly of any findings and recommendations relating to the implementation of the online process. This report is intended to satisfy the 2025 reporting requirement.

**Figure 1: Online Process – Payor Requirements**

***Maryland Code, Health-General § 19-108.5***

- Link directly to all e-prescribing and electronic health record (EHR) systems that use the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard[3] and the NCPDP Real Time Benefit Standard;[4]
- Accept electronic prior authorization requests from a health care provider;
- Approve prior authorization requests for which no additional information is required by the payor to process the electronic prior authorization request, for which no clinical review is required, and that meet the payor's criteria for approval; and
- Link directly to real-time patient out-of-pocket costs, including copayment, deductible, and coinsurance costs, and more affordable medication alternatives at the point of prescribing.

[1] Md. Laws ch. 848 (S.B. 791) (2024); Md. Laws ch. 847 (H.B. 932) (2024), available at mgaleg.maryland.gov/mgawebsite/Legislation/Details/SB0791?ys=2024RS

[2] Maryland Health Care Commission, *Health Insurance – Utilization Review – Revisions: An Environmental Scan of the Prior Authorization Process* (Nov. 21, 2024), https://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/hit_prior_auth_proc_rpt.pdf

[3] The NCPDP SCRIPT Standard is widely used as the core standard for e-prescribing to support electronic data transfer for new prescriptions, prescription modifications, refill requests, prescription fill status notifications, prescription cancellations, and medication history; the standard supports the process of determining if prior authorization is needed, requesting and communicating prior authorization approval, and appealing adverse decisions. More information is available at: www.ncpdp.org/Resources/ePrescribing-Industry-Information

[4] The NCPDP Real Time Benefit Standard enables prescribers, pharmacies, and PBMs to exchange information about a patient's drug benefit coverage and out-of-pocket costs in real-time prior to prescribing and dispensing. More information available at: www.ncpdp.org/Resources/NCPDP-Work-Group-Approves-BETA-Version-of-the-(1)

The law prohibits payors from charging a fee for using the online process or accessing provider data via the online process without the provider's consent. Payors were required to make available on request of a health care provider and on its website the contact information for each third-party vendor or other entity the payor will use to meet the requirement on or before July 1, 2025. By July 1, 2026, payors and pharmacy benefits managers (PBMs) must be able to provide accurate and real-time patient specific benefit information and make the information available at the point of prescribing. Health care providers must ensure their e-prescribing or EHR system used to maintain health records has the ability to access the online process.[5] The MHCC is required to establish by regulation a process through which a health care provider may request and receive a waiver of compliance from the requirement.

## IMPLEMENTATION OF THE ONLINE PROCESS

Payors self-attested they will be compliant with all technical requirements for the online process by July 1, 2026. Nearly all payors have implemented the requirements; Cigna is working with its third-party vendors to complete implementation (Table 1). PBMs have the capability to provide real-time patient-specific benefit information, as required by the law.[7]

**Table 1: Payor Implementation Status – Online Process**
Maryland Code, Health-General § 19-108.5
*as of July 2025*

| **Payor**<br>Third-party vendor(s)[6] for the online process | **Technical Requirements** | | | | |
|---|---|---|---|---|---|
| | Link to EHR and e-prescribing systems | Accept prior authorization requests | Approve prior authorization requests | Provide real-time patient out-of-pockets costs | Provide more affordable medication alternatives |
| **Aetna**<br>CVS Caremark, Availity | **Completed** | **Completed** | **Completed** | **Completed** | **Completed** |
| **CareFirst**<br>CVS Caremark | **Completed** | **Completed** | **Completed** | **Completed** | **Completed** |
| **Cigna**<br>Surescripts, CoverMyMeds | In Progress | **Completed** | **Completed** | In Progress | In Progress |
| **Kaiser Permanente**<br>MedImpact | **Completed** | **Completed** | **Completed** | **Completed** | **Completed** |
| **UnitedHealthcare**<br>Surescripts, CoverMyMeds | **Completed** | **Completed** | **Completed** | **Completed** | **Completed** |

**Notes:** "Completed" means the payor attested that the technical requirement has been implemented; "In Progress" means the payor attested that implementation of the technical requirement is underway.
- Third-party vendor names and contact information are posted on payors' websites; payor names hyperlinked above.

PBMs use third-party vendors noted in parenthesis:
**CVS Caremark** (Surescripts, CoverMyMeds, Arrive Health)
**Express Scripts** (Surescripts, CoverMyMeds, EviCore by Evernorth, ExpressPAth)
**MedImpact** (Surescripts, CoverMyMeds, CenterX)
**OptumRX** (Surescripts, CoverMyMeds)

[5] E-prescribing is a standard feature in most EHR systems.
[6] Third-party vendors offer health information technology solutions that support medication access and facilitate prior authorizations. Availity is a comprehensive portal that enables providers to submit claims and check and submit prior authorizations, among other things.
[7] The MHCC distributed a brief questionnaire to payors and PBMs in May 2025 inquiring about preparedness to comply with the online process by July 1, 2026. Discussions with select payors, PBMs, and technology vendors took place through July 2025. Testing and validation of the online process is planned to occur from Q4 2025 through Q2 2026.

## CURRENT LANDSCAPE

### *Electronic Prior Authorization*

Nearly every pharmacy,[8] payor, PBM, and EHR vendor supports electronic prior authorization.[9] Electronic prior authorization technology allows users to initiate and manage prior authorizations within existing workflows. The prior authorization process begins when a provider prescribes a service or medication that requires approval by a payor or PBM to be covered; review of a prior authorization request ensures certain criteria are met (e.g., medical necessity, cost-effectiveness, and formulary compliance).[10] Nationally, about half of prior authorization requests for prescription drugs are submitted using partially manual methods with the most common being online portals, which often rely on fax and call centers to complete the process; less than 20 percent are fully manual (e.g. phone, fax, and mail).[11] *Refer to the Supplemental Information section for more information on submission methods and challenges with the prior authorization process.*

### *Real-Time Benefit Checks and Drug Coupons*

Third-party vendors support the prior authorization process for medications by offering real-time benefit check tools at the point of prescribing.[12] These tools allow providers to obtain patient-specific information about prescription benefits, out-of-pocket costs, and prior authorization requirements before prescriptions are sent to a pharmacy.[13] After a prescriber selects a medication, the real-time benefit check triggers a request for information from the applicable payor or PBM, which helps prescribers make decisions based on insurance coverage, formulary status, and potential cost savings for patients.[9] As real-time benefit check tools become more common (used by roughly more than half of prescribers nationally),[14, 15] functionality is emerging that links to available coupons and other discounts that may lower patients out-of-pocket cost for prescriptions. This functionality is supported by network partners offering technology solutions that enable providers and pharmacists to search and compare prescription prices (e.g., GoodRx).[16] Expanding access to prescription coupons and other discounts requires policy considerations regarding potential trade-offs and unintended consequences

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[8] Certain pharmacies may not be able to support electronic prior authorization due to existing systems that lack the needed functionality or lack of resources needed to implement and maintain the technology.

[9] CoverMyMeds. 2020 medication access report. Accessed August 26, 2025. https://insights.covermymeds.com/medication-access-report/2020/electronic-prior-authorization

[10] Squires T. Prior Authorization: Take it out of the hands of non-fiduciary PBMs. TransparentRx. August 24, 2023. Accessed August 26, 2025. https://transparentrx.com/prior-authorization-pa-take-it-out-of-the-hands-of-non-fiduciary-pbms

[11] Council for Affordable Quality Healthcare. Issues brief: Use of NCPDP SCRIPT for prescription drug prior authorizations is increasing. 2024. Accessed August, 26, 2025. https://www.caqh.org/hubfs/Issue%20Briefs/CAQH_Insights_NCPDP_SCRIPT_Issue_Brief.pdf

[12] Adoption of the NCPDP Real-Time Prescription Benefit Standard supports real-time-benefit checks to ensure consistency, accuracy, and accessibility specifically for prescription benefits at the point of prescribing. This complements the Health Care Eligibility Benefit Inquiry and Response (270/271) standards that are used more broadly for eligibility and benefits verification.

[13] E-prescribing is a standard feature in most EHRs systems.

[14] Klebanoff MJ, Li P, Chatterjee P, Doshi JA. Real-time prescription benefit tool adoption among US hospitals. *JAMA Health Forum*. 2024;5(10):e243181. doi:10.1001/jamahealthforum.2024.3181.

[15] Surescripts. More than half of U.S. prescribers use Surescripts real-time prescription benefit to address medication affordability & adherence. June 14, 2022. Accessed August 26, 2025. https://surescripts.com/press-releases/more-half-us-prescribers-use-surescripts-real-time-prescription-benefit-address-medication-affordability-adherence

[16] Instead of searching on individual company site, the information is presented with other information made available through the real-time benefit check tool and may include an option to text information on coupons and other discounts to patients. More information is available at: https://arrivehealth.com/save-providers-time-by-streamlining-access-to-patient-affordability-programs/#:~:text=A%20better%20approach%20than%20searching,more%20time%20from%20the%20provider.

related to access, costs, patient consent, and market dynamics.[17, 18, 19] *Refer to the Supplemental Information section for more information on real-time benefit check tools and prescription discounts.*

### *Artificial Intelligence*

The evolving use of artificial intelligence (AI) solutions offers the potential to increase quality and automation by reducing time and cost associated with the prior authorization process.[20] In general, AI-enabled technology is increasingly used by payors and PBMs to automate administrative tasks, improve accuracy, and inform decision-making.[21, 22, 23] Concerns exist that payors and PBMs use of AI could potentially override clinical judgment and deny coverage for care that is medically necessary.[24] National reform efforts are exploring principles and oversight mechanisms for the use of AI in the prior authorization process.[25] Several states, including Maryland,[26] have enacted laws that limits the use of AI;[27] this includes restrictions on the denial, delay, or modification of care based solely on AI. *Refer to the Policy Developments section for more information on state-level approaches to implement safeguards on the use of AI.*

## POLICY DEVELOPMENTS

Improving the prior authorization process requires increased reliance on data exchange standards to enable interoperability.[28] In January 2020, a national trade association, America's Health Insurance Plans (AHIP), launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative to better understand how electronic prior authorization can improve the prior authorization process. AHIP, in collaboration with two technology vendors (Availity and Surescripts) and six payors covering 50 million insureds (Blue Shield of California, Cambia Health Solutions, Cigna, Florida Blue, Humana, and WellCare), used application programming interfaces (APIs)[29] to standardize data submissions for prior authorizations. Findings from the Fast PATH initiative provided valuable insights into the benefits

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[17] Hoops S. Drug coupons: an ongoing debate between states, payers, and manufacturers. Biosimilar Development. November 19, 2019. Accessed August 26, 2025. https://www.biosimilardevelopment.com/doc/drug-coupons-an-ongoing-debate-between-states-payers-and-manufacturers-0001

[18] Joyce, G, Van Nuys K, Ribero R. Prescription drug coupons: a one-size-fits-all policy approach doesn't fit the evidence. *Health Affairs* blog. February 16, 2018. doi: 10.1377/hblog20180215.988517.

[19] National Council for Prescription Drug Programs, Upstream reporting of copay assistance issues brief. June 2018. Accessed August 26, 2025. https://www.ncpdp.org/NCPDP/media/pdf/20180604_Upstream_Reporting_of_Copay_Assistance_Issues_Brief.pdf?ext=.pdf

[20] Shryock, T. Can AI and tech help streamline prior auths? *Medical Economics*. July 12, 2025. Accessed August 26, 2025 www.medicaleconomics.com/view/can-ai-and-tech-help-streamline-prior-auths-the-impact-of-ai

[21] DeFrain K, Andrews D, Sobel S, King E, Beydler N. Health insurance artificial intelligence/machine learning survey results: NAIC staff report. National Association of Insurance Commissioners. May 20, 2025. Accessed September 3, 2025. https://content.naic.org/sites/default/files/inline-files/NAIC%20AI%20Health%20Survey%20Report%20.pdf

[22] Ekbote R, Lu E, Garg P, Villareal N. Unlocking the potential of AI in prior authorization. Oliver Wyman. Accessed August 26, 2025 https://www.oliverwyman.com/our-expertise/perspectives/health/2024/september/unlocking-the-potential-of-ai-in-prior-authorization.html

[23] Innovaccer, Top 5 AI vendors for prior authorization 2025. May 29, 2025. Accessed August 26, 2025. https://innovaccer.com/resources/blogs/top-5-ai-vendors-for-prior-authorization-2025

[24] American Medical Association. Physicians concerned AI increases prior authorization denials. February 24, 2025. Accessed August 26, 2025. https://www.ama-assn.org/press-center/ama-press-releases/physicians-concerned-ai-increases-prior-authorization-denials

[25] Shachar C, Killelea A, Gerke S. AI and health insurance prior authorization: Regulators need to step up oversight. *Health Affairs Forefront*. July 8, 2024. doi: 10.1377/forefront.20240703.824037.

[26] Chapter 747/House Bill 820, *Health Insurance – Utilization Review – Use of Artificial Intelligence,* was enacted following the 2025 legislative session of the Maryland General Assembly and takes effect October 1, 2025. More information is available at: mgaleg.maryland.gov/mgawebsite/Legislation/Details/HB0820.

[27] Directly or through contracted entities.

[28] Weber E. The path forward for prior authorization reform. *CAQH* blog. July 2, 2025. Accessed August 26, 2025. https://www.caqh.org/blog/the-path-forward-for-prior-authorization-reform

[29] APIs are a set of rules that determine how one software application is able to access data or functionality in another software application.

of standards-based electronic prior authorization, from faster times to receive a decision and deliver patient care, to improvements in determining if prior authorization is required and opportunities to decrease administrative burden associated with manual methods like phone calls and faxes.[30] The AHIP initiative demonstrated that greater adoption of standards-based technology for electronic prior authorization is critical to maximize clinical decision making efficiencies.[31]

In response to growing concerns that prior authorization delays patient access to care, AHIP in collaboration with the federal government, announced an initiative in June 2025 that aims to improve access to care and reduce administrative burdens for patients and providers.[32] More than 50 payors[33] have voluntarily pledged a commitment to standardize electronic prior authorization, reduce the scope of claims subject to prior authorization, ensure continuity of care when patients change plans, enhance communication and transparency on determinations, expand real-time responses, and ensure medical review of non-approved requests.[34] This includes responding to more prior authorization requests in real time and upholding existing prior authorizations when patients switch plans while undergoing a course of treatment (i.e., 90-day transition period).

### *Federal*

On April 12, 2023, the Centers for Medicare & Medicaid Services (CMS) finalized a rule[35] to strengthen protections for consumers enrolled in or seeking coverage from Medicare Advantage plans by way of improvements to prior authorization and coverage guidelines starting in 2024. In general, the final rule requires plans to follow traditional Medicare laws for coverage decisions, limits use of prior authorization, ensures continuity of care, and establishes a Utilization Management Committee with the aim of promoting transparency and consistency for providers and their patients.[36] In response to concerns regarding the use of prior authorization in Medicare Advantage plans, CMS included provisions to improve the prior authorization process, such as requiring requests to be reviewed by clinicians with relevant expertise and be valid for an entire course of approved treatment and during transitions to a new plan for at least 90 days. Furthermore, the rule required plans to make internal coverage criteria publicly available for the first time, with requirements that they are based on current evidence in widely used treatment guidelines or clinical literature.[37]

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[30] AHIP. Fast PATH initiative: Helping patients receive safe, effective, and appropriate care. Accessed August 26, 2025. https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care

[31] Pathways to support broader adoption require increasing the availability of the technology to providers and increasing use of the technology where it is already available by identifying and addressing challenges, such as provider readiness, training, and workflow integration.

[32] AHIP. Health plans take action to simplify prior authorization. June 23, 2025. Accessed August 27, 2025. https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization

[33] AHIP. Health plans are making voluntary commitments to support patients and providers. June 23, 2025. Accessed August 27, 2025. https://www.ahip.org/health-plans-are-making-voluntary-commitments-to-support-patients-and-providers

[34] AHIP. Improving prior authorization for patients & providers. June 2025. Accessed August 27, 2025. https://ahiporg-production.s3.amazonaws.com/documents/202506_AHIP_Report_Prior_Authorization.pdf

[35] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. *Fed Regist*. 2023;88:22120-22356. Published April 12, 2023. Available at: https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

[36] Tucker C. CMS final rule: Changes to the Medicare Advantage Program. *Ensemble Health Partners* blog. May 3, 2023. Accessed August 26, 2025. https://www.ensemblehp.com/blog/cms-final-rule-changes-to-the-medicare-advantage-program/

[37] Centers for Medicare & Medicaid Services. Fact Sheet: 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F). April 5, 2023. Accessed August 26, 2025. https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f

On January 17, 2024, CMS released the *Interoperability and Prior Authorization Final Rule*.[38] The rule aims to improve access to care and reduce administrative burden for medical items and services that require prior authorization. Federally regulated payors[39] must comply with both non-technical and technical requirements. Payors must implement non-technical provisions by January 1, 2026, including rendering prior authorization decisions within specified timeframes, reporting certain metrics, and providing reasons for a prior authorization denial (see Appendix A). Technical provisions must be implemented by January 1, 2027 and require payors to connect to EHR systems via four APIs (see Appendix B). This federal mandate creates a standardized technical and operational framework that can be adopted more broadly by commercial payors and providers, reducing fragmentation and improving the prior authorization process. Data that must be made available through the APIs include:

- Prior authorization status;
- Date of approval or denial of the request;
- Date or circumstance when the prior authorization ends;
- Approved medical items or services;
- Reason for denial; and
- Administrative and clinical information submitted by a provider.[40]

Payors are currently in the process of implementing the APIs. For the most part, implementation is viewed as complex. Based on findings from the Workgroup for Electronic Data Interchange (WEDI),[41] a large percentage of payors and providers[42] have not fully complied with API-related mandates.[43] Nationally, about 43 percent of payors have not yet started the work, and roughly 31 percent have partially completed implementation (about a quarter of the work).[44] Payors in Maryland are developing plans and beginning to implement select APIs.[45] In 2027, providers will begin reporting on their use of the prior authorization API as part of the CMS Merit-Based Incentive Payment System (MIPS). More than half of providers (52 percent) in the nation report they have not started working with their EHR vendors to ensure their systems are compatible with the APIs to identify prior authorization requirements, submit requests, and receive responses electronically.[46]

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[38] Centers for Medicare & Medicaid Services. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F). Updated August 20, 2025. Accessed August 26, 2025. https://www.cms.gov/priorities/burden-reduction/overview/interoperability/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

[39] Includes Medicare Advantage Organizations, Medicaid and the Children's Health Insurance Program, Medicaid managed care plans, and state Qualified Health Plans.

[40] Pestaina K, Lo J, Long M. Final prior authorization rules look to streamline the process, but issues remain. Kaiser Family Foundation. May 2, 2024. Accessed August 26, 2025. https://www.kff.org/private-insurance/final-prior-authorization-rules-look-to-streamline-the-process-but-issues-remain/

[41] From January to February 2025, WEDI conducted a national (baseline) survey to assess readiness to implement the APIs.

[42] Providers are not required to implement, maintain, or use the APIS, but they must ensure their EHR is ONC-certified and supports the API workflows.

[43] Nelson H. Providers, payers struggle with CMS interoperability rule. *TechTarget.* April 10, 2025. Accessed August 26, 2025. https://www.techtarget.com/searchhealthit/news/366622475/Providers-payers-struggle-with-CMS-interoperability-rule

[44] Implementation challenges reported by payors include determining a cohesive enterprise strategy for interoperability, digitizing prior authorization policies, and funding. Implementation costs are estimated to be $1 to $5 million.

[45] Payors reported on their implementation of the APIs in the 2024 EDI Progress Report, as required by COMAR 10.25.09.

[46] Pennic F. WEDI survey: Industry readiness for CMS Interoperability and Prior Authorization Rule. *Health It Consultant*. April 5, 2025. Accessed August 26, 2025. https://hitconsultant.net/2025/04/11/wedi-survey-industry-readiness-for-cms-interoperability-and-prior-authorization-rule/

In April 2025, CMS finalized a Medicare Advantage rule that 1) restricted plans' ability to reopen and modify previously approved inpatient hospital decisions, and 2) closed additional loopholes to specify that organizational determinations included MA plan decisions made concurrently to the enrollee's receipt of services.[47] Additional proposed policies, such as promoting public accessibility of utilization management coverage criteria by removing barriers, and further defining internal coverage criteria, were not finalized, but could be finalized in the future.

In June 2025, the CMS Center for Medicare and Medicaid Innovation (CMMI) announced the Wasteful and Inappropriate Service Reduction (WISeR) Model. The WISeR Model will run from January 1, 2026 to December 31, 2031 with the goal of leveraging technologies like AI to streamline the prior authorization process for certain items and services. Participants will consist of vendors with expertise managing the prior authorization process for payors and will make their AI technology available in designated states to assist medical reviewers[48] in determining whether certain items and services:[49] 1) pose concerns related to patient safety if delivered inappropriately; 2) have existing publicly available coverage criteria; and 3) may involve prior reports of fraud, waste and abuse.[50, 51] Providers in select states (Arizona, New Jersey, Ohio, Oklahoma, Texas, or Washington) will either submit a prior authorization request directly to participating vendors or their claim will be subject to pre-payment medical review (also conducted by participating vendors) before payment is issued.[52, 53] In September 2025, the House Appropriations Committee introduced an amendment to a 2026 spending bill that would block funding for the WISeR Model, citing concerns over provider burden and delaying or denying patient access to care.[54]

### *State-Level*

Most states have identified prior authorization reform as essential and are implementing various policies to reduce administrative burden, improve access to care, and promote transparency.[55] *Refer to Appendix C for links to state laws and their effective dates.*

### ***APIs***

Approaches to reform prior authorization include aligning with federal policies to support broader implementation of APIs. Adopting APIs promotes data interoperability and helps reduce administrative

[47] Centers for Medicare and Medicaid Services. Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-F). Published April 15, 2025. Available from: https://www.federalregister.gov/documents/2025/04/15/2025-06008/medicare-and-medicaid-programs-contract-year-2026-policy-and-technical-changes-to-the-medicare

[48] Participants must have clinicians with expertise to conduct medical reviews to validate determinations. Recommendations for non-payment will be determined by applying standardized, transparent, and evidence-based procedures.

[49] Examples of items and services chosen by CMS include skin and tissue substitutes, electrical nerve stimulators, and knee arthroscopy for knee osteoarthritis.

[50] WISeR excludes inpatient-only services, emergency services, and services that pose a substantial risk to patients if delayed.

[51] Centers for Medicare & Medicaid Services. Model overview fact sheet: Wasteful and Inappropriate Service Reduction (WISeR) Model. Accessed August 26, 2025. https://www.cms.gov/files/document/wiser-fact-sheet.pdf

[52] The model excludes inpatient-only, emergency, and high-risk services where delays could harm patients.

[53] Under the model, technology vendors can earn a share of the savings generated.

[54] Cass A. House panel blocks funding for traditional Medicare prior authorization pilot. Becker's Hospital Review. September 10, 2025. Accessed September 12, 2025. https://www.beckershospitalreview.com/finance/house-panel-blocks-funding-for-traditional-medicare-prior-authorization-pilot/

[55] Large Urology Group Practice Association. LUGPA policy brief: Prior authorization reform - state and federal efforts. October 2024. Accessed August 26, 2025. https://www.lugpa.org/prior-authorization-reform---state-and-federal-efforts

burden and improve access to care. AHIP recommends that state-level policies be consistent with federal rules and encourage provider adoption of payors' electronic prior authorization systems.[56]

- Five states (CA, MN, OK, TN, WA) have enacted laws that include provisions for providers and/or payors to use systems that adhere to national standards and generally align with the federal January 2027 implementation timeline.[57]

***AI***

Interest and use of AI is growing faster than supporting policies and regulatory frameworks to ensure responsible use of AI systems. Use of AI in prior authorization denials can erode transparency and trust.[58] Several states, including Maryland,[59] have enacted laws that explicitly regulate how AI can be used in prior authorization.

- Five states (AZ, CA, CO, IL, MD[60]) prohibit the sole use of AI to deny, delay, or modify a health care service.
- Maryland[61] and California require AI-driven recommendations to be based from an individual patient's specific medical chart (e.g., test results, diagnoses, medications, treatment history) rather than group datasets (i.e., population level trends, generalized data from people with similar conditions); both states also require payors to avoid discrimination against patients, be open to inspection by state regulatory agencies, and undergo regular performance reviews to ensure accuracy and reliability in their use of AI tools in utilization review.[62]
- Maryland requires payors to report whether algorithms or other software tools were used in adverse decisions.[63]
- Illinois requires payors to attain accreditation for any automated system used in adverse determinations, specifying URAC (Utilization Review Accreditation Commission)[64] or NCQA (National Committee for Quality Assurance) as approved accrediting bodies;[65] proof of accreditation must be filed with the Illinois Department of Insurance.

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[56] AHIP. Impact of federal prior authorization requirements on states. February 20, 2024. Accessed August 26, 2025. https://www.ahip.org/resources/impact-of-federal-prior-authorization-requirements-on-states

[57] National Governors Association. State strategies to advance health data interoperability. March 2021. Accessed August 26, 2025. https://www.nga.org/wp-content/uploads/2021/03/State-Strategies-to-Advance-Health-Data-Interoperability.pdf

[58] Proprietary algorithms (i.e., instructions that enable AI systems to process information and make decisions) are being developed and implemented to automate various aspects of health care. More information is available at: https://www.asco.org/news-initiatives/policy-news-analysis/safeguarding-ai-use-in-prior-authorization

[59] 2025 Md. Laws ch. 747 (enacted by H.B. 820, *Health Insurance – Utilization Review – Use of Artificial Intelligence*), available at https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/hb0820

[60] Md. Code Ann., Ins. § 15–10B–05.1(c)(5)–(9)

[61] Md. Code Ann., Ins. § 15–10B–05.1(c)(1)(i)–(iii), (c)(2)

[62] Md. Code Ann., Ins. § 15–10B–05.1(d)

[63] Payors provide the MIA with quarterly reporting of adverse decisions (Md. Code Ann., Ins § 15-10A-06).

[64] URAC's Health Utilization Management Accreditation assures the clinical and operational soundness of your health utilization management process by evaluating it against a stringent set of nationally recognized standards. More information is available at: https://www.urac.org/accreditation-cert/health-utilization-management-accreditation/

[65] NCQA's Utilization Management Accreditation helps guarantee that organizations making decisions are following objective, evidence-based best practices. More information is available at: https://www.ncqa.org/programs/health-plans/utilization-management/

***Gold Carding***

Several states (AR, CO, GA, IL, LA, MI, NM, TX, WY, WV) have passed legislation in the last four years requiring payors to exempt certain providers from prior authorization requirements based on their track record of approval and adherence to medical necessity standards, which is referred to as "gold carding." Most state-mandated gold carding programs are limited to medical services. More often than not, such programs are exploratory, and data is only beginning to emerge on the effectiveness of gold carding programs.[66, 67]

- Illinois requires the Medicaid program to exempt providers with a history of prior authorization requests for medical services and procedures that were approved at least ≥90 percent of the time (minimum of 50 requests over the prior year) in outpatient or inpatient settings; the law does not apply to commercial payors and automatically sunsets in 2030.
- Five states (AR, NM, TX, WV, WY) set eligibility requirements for payor gold carding programs, which generally require a 90 percent approval rate for a service within a six-month or 12-month period.
- Four states (CO, GA, LA, MI) allow payors to have sole discretion over program criteria and provider eligibility, including what services or medications are included in the program.
- Arkansas is one of the only states that requires payors to implement gold carding for both medical services and pharmaceuticals.
- Texas amended its gold carding law in 2025 to extend the evaluation period for provider eligibility (from six months to one year), removing physicians who hold a license to practice administrative medicine as an individual who may direct a utilization review, carving out exceptions for providers with less than five claims during an evaluation period, and requiring payors to submit annual reports to the Texas Department of Insurance regarding prior authorization exemptions and rescissions.

***Real-Time Benefit Information***

Eight states, including Maryland (CO, CA, OH, MD, ME, TN, TX, VA), require payors to furnish real-time patient benefit information on out-of-pocket costs and more affordable medication alternatives at the point of prescribing.

- Three states (VA, MD, ME) require payors to integrate directly with all e-prescribing or EHR systems using NCPDP Real Time Benefit standard.

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[66] Huff C. State-mandated "gold card" programs to ease prior authorization burdens offer little relief, experts say. *Medscape*. July 7, 2025. Accessed August 26, 2025. https://www.medscape.com/viewarticle/state-mandated-gold-card-programs-ease-prior-authorization-2025a1000hw9?form=fpf

[67] The Texas Department of Insurance (TDI) reported that three percent of providers statewide qualified for "gold card" status in 2022, prompting the state to amend the law in 2025. More information is available at: https://content.naic.org/sites/default/files/national_meeting/hiwg-bowden-presentation.pdf

- Some states include provisions that require payors to: allow for an integrated technology or service to provide the required information (CA, TX); furnish real-time benefit information in the same format as requested by the provider (CO, OH, TN); or ensure information is updated at the time of request or within a short time-frame before the request (CA, CO, TN, TX).
- Five states (CA, CO, OH, TN, TX) prohibit payors from instituting consent requirements or processes, policies, and procedures that would likely increase the complexity or burden of accessing, exchanging, or using real-time benefit information at the point of prescribing.

***Drug Coupons***

Several states have adopted policy approaches to regulate the use of prescription coupons as part of broader efforts to improve prescription drug affordability. Due to anti-kickback laws,[68] manufacturer drug coupons are prohibited in federally funded programs (Medicare and Medicaid).

- Massachusetts and California have enacted statutory bans on the use of manufacturer coupons for brand drugs when generics are available.[69]
- At least 20 states, including Maryland,[70] have laws restricting payors from implementing copay accumulator programs, which prevent drug manufacturer assistance from counting towards a patient's deductible or out-of-pocket maximums.[71] The Maryland law was enacted in 2025 and will be effective January 1, 2026 through July 1, 2029.

## RECOMMENDATIONS

1. ***Encourage payors and PBMs to build provider awareness of electronic prior authorization and real-time benefit check tools. Initiatives should target providers and care teams involved in the prior authorization process, and at a minimum, offer technical guidance on accessing and using online real-time benefit check tools within existing workflows, while addressing the benefits and acknowledging potential limitations (MHCC in collaboration with the MIA).***

   Rationale

   Expanding use of electronic prior authorization and real-time benefit check tools is essential to realizing the full value of the State-mandated online process. Awareness building efforts led by payors and PBMs will help providers and care teams embed prior authorization into workflows by

[68] The federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)) prohibits the knowing and willful solicitation, offer, or payment of remuneration to induce or reward patient referrals or the generation of business involving any item or service payable by Federal health care programs.
[69] Gray J. Manufacturer coupons and patient assistance programs: Actuaries should account for the impact of coupons and PAPs on the health care system. May 2020. Accessed August 25, 2025. https://www.theactuarymagazine.org/manufacturer-coupons-and-patient-assistance-programs/
[70] 2025 Md. Laws ch. 692 (enacted by S.B. 773, *Health Benefit Plans—Calculation of Cost-Sharing Contribution—Requirements*), available at https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0773
[71] Long, M, Salaga, M, Pestaina K. Copay adjustment programs: What are they and what do they mean for consumers? Kaiser Family Foundation. October 24, 2024. https://www.kff.org/health-costs/copay-adjustment-programs-what-are-they-and-what-do-they-mean-for-consumers/#ac2ac3a5-95af-47b7-bee7-1f9291e6ac27

utilizing existing technology systems and capabilities. This supports timely decision-making at the point of care and enables earlier identification of prior authorization requirements.

2. ***Update the legislature by December 1, 2026 and December 1, 2027 on post-implementation of the State-mandated online process (MHCC).***

   Rationale

   The MHCC plans to monitor progress in building awareness. Providing a post-implementation update to the legislature will offer a snapshot on payors and PBMs awareness building strategies and utilization of the State-mandated online process among providers and care teams. The progress update should address adoption of real-time benefit check tools, assess accuracy and completeness of the information exchanged, and identify any operational challenges. The information will be used to assess progress and identify future policy considerations for enhancing efficiency, transparency, and equitable access to care.

3. ***Explore regulatory and oversight approaches to require that payers make coverage criteria publicly accessible with a summary of all current evidence justifying each criterion based on widely used treatment guidelines or clinical literature. Consider regulatory authorities for PBMs in conducting drug utilization review (MHCC in collaboration with the MIA).***

   Rationale

   Requiring payors to include high-quality supporting evidence strengthens transparency and aligns with federal standards for Medicare Advantage. Extending similar transparency requirements to PBMs in their drug utilization review processes ensures consistency across payors and PBMs. Transparency ensures medical necessity determinations are grounded in widely accepted treatment guidelines or high-quality clinical literature. It also empowers patients to make more informed decisions when choosing plans, improves predictability in care planning, supports more informed clinical workflows, and fosters accountability in how coverage policies are developed and applied.

## NEXT STEPS

As required by the law, MHCC will establish by regulation a process to grant a time-limited waiver to health care providers whose e-prescribing or EHR system cannot access the online process. Amendments to the existing regulatory framework (COMAR 10.25.17, *Preauthorization of Health Care Services*) will be proposed this fall; final regulations are anticipated to be completed by Spring 2026. *Refer to the Supplemental Information section for more background information on a 2012 law and COMAR 10.25.17*.

## SUPPLEMENTAL INFORMATION

### *Background – State Law*

In 2012, Maryland became one of the first states to enact legislation (Chapters 534/535, SB 540/HB 470, *Maryland Health Care Commission – Preauthorization of Health Care Services – Benchmarks*)[72] requiring payors and PBMs to establish online portals for prior authorization. The MHCC worked with stakeholders to develop supporting regulations, COMAR 10.25.17, *Benchmarks for Preauthorization of Health Care Services*, which require payors and PBMs to implement the following four benchmarks:

1. Provide online access to a listing of all medical and pharmaceuticals that require preauthorization and the key criteria for making a preauthorization determination;
2. Establish an online system to receive electronic preauthorization requests and assign a unique identification number to each request for tracking purposes;
3. Process electronic preauthorizations for pharmaceuticals in real-time or within one business day of receiving all pertinent information, and process non-urgent medical requests within two business days of receiving all pertinent information; and
4. Establish an electronic override process for a step therapy or fail-first protocol for electronic preauthorizations for pharmaceuticals.

The benchmarks aim to create administrative efficiencies in the prior authorization process. The MHCC reported to the General Assembly on payors' and PBMs' progress and attainment of the benchmarks through December 2016.[73]

### *The Prior Authorization Process – Challenges and Other Insights*

Prior authorization aims to ensure the delivery of safe and evidence-based care.[74] Certain medical and pharmaceutical services that require prior authorization are viewed by providers and consumers as a barrier to care. The process to request prior authorization and receive approval can be time-intensive, requiring phone calls and faxes by providers and other staff.[75] Despite federal and state efforts to reform prior authorization, the process remains time-consuming and costly for providers.[76] Manual methods like phone and fax can cause information exchanged between providers and payors to be misunderstood or misplaced and often lacks real-time visibility into changing payor and PBM rules, which can lead to longer wait times and higher out-of-pocket costs.[77] While online portals are commonly used, they are often non-standardized, requiring providers to learn multiple systems.

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[72] S.B. 540, 2012 Leg., 430th Sess. (Md. 2012) (enacted as 2012 Md. Laws ch. 534), available at https://mgaleg.maryland.gov/2012rs/chapters_noln/Ch_534_sb0540E.pdf

[73] The final report is available at: mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/documents/2016_Preauth_Report_100716.pdf.

[74] Resnick A, Joynt Maddox KE. Reframe the role of prior authorization to reduce low-value care. *Health Affairs Forefront*. July 11, 2022. doi: 10.1377/forefront.20220708.5413

[75] Kyle MA, Song Z. The consequences and future of prior-authorization reform. *N Engl J Med*. 2023;389(4):291-293. doi:10.1056/NEJMp2304447

[76] The American Medical Association estimates that physicians spend an average of nearly two days per week handling prior authorizations while 35 percent have staff who work exclusively on prior authorizations.

[77] Experian Health. Manual to automated prior authorization software. August 3, 2023. Accessed August 25, 2025. https://www.experian.com/blogs/healthcare/manual-to-automated-prior-authorization-software/

Additionally, these portals frequently rely on manual methods of support, placing a significant administrative burden on staff to complete the process.

### *Real-Time Benefit Check Tools*

Lack of transparency around patient out-of-pocket costs at the point of prescribing is a major barrier to clinicians offering treatment options based on affordability.[78] Unaffordable prescription costs are associated with detrimental effects, including poor patient health outcomes and high costs.[79] Although e-prescribing workflows typically provide clinicians with information regarding formulary tier, EHR-integrated real-time benefit check tools can provide more detail around a patient's out of pocket cost of medication and coverage restrictions (including need for prior authorization).[78] Access to real-time benefit check tools is increasing; in 2024, 889,907 prescribers (39 percent) nationally used the Surescripts network for real-time benefit checks, an increase of 16 percent since 2023.[80, 81] Over 100 EHR vendors, including Epic, Oracle/Cerner, and Allscripts, integrate with Surescripts to enable access to this service.[82] CoverMyMeds and other vendors (e.g., GoodRx, Arrive Health, CenterX) also offer real-time benefit check tools.[83] In 2021, CMS required Medicare Part D plan sponsors to implement real-time benefit check tools that are capable of integrating with providers' e-prescribing and EHR systems.

Real-time benefit check tools receive patient benefit information through agreements and direct technical connections with individual PBMs; EHRs may integrate with more than one vendor to increase the likelihood of retrieving benefit data regardless of a patient's insurance plan.[84] As a result, different real-time benefit check tools may display conflicting information due to variations in data sources and update frequencies (e.g., a drug might appear covered in one tool but require prior authorization in another), which can reduce patient and provider trust in the information.[85, 86] Some real-time benefit check tools do not capture savings for patients receiving medication refills (e.g., refill requests often go directly to the pharmacy or are handled without the prescriber re-evaluating the prescription); if lower-cost alternatives become available or the patient's insurance plan changes, opportunities for savings may be missed.[87]

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[78] Wong R, Mehta T, Very B, et al. Where do real-time prescription benefit tools fit in the landscape of high US prescription medication costs? A narrative review. *J Gen Intern Med*. 2023;38(4):1038-1045. doi:10.1007/s11606-022-07945-z

[79] Krishnamurthy B, Parikh M. Drug prices and shortages jeopardize patient access to quality hospital care. *American Hospital Association* blog. May 22, 2024. Accessed August 25, 2026. https://www.aha.org/news/blog/2024-05-22-drug-prices-and-shortages-jeopardize-patient-access-quality-hospital-care

[80] Surescripts. Annual Impact Report, 2024. Accessed August 25, 2025. https://surescripts.widen.net/s/hdf8b99xvw/annual-impact-report-2024

[81] Between January and May 2022, Surescripts electronically processed 34 percent more real-time benefit checks and 33 percent more prior authorizations. More information is available at: https://surescripts.com/press-releases/more-half-us-prescribers-use-surescripts-real-time-prescription-benefit-address-medication-affordability-adherence

[82] Colorado Department of Health Care Policy & Financing. Real-time prescription benefit tool FAQs. Accessed August 25, 2025. https://hcpf.colorado.gov/real-time-prescription-benefit-tool-faqs

[83] Gliadkovskaya A. Providers can now see patients' insurance coverage in GoodRx's cost comparison tool. August 30, 2023. Accessed August 25, 2025. https://www.fiercehealthcare.com/health-tech/goodrx-launches-real-time-benefit-check-feature-providers

[84] Salzbrenner SG, McAdam-Marx C, Lydiatt M, Helding B, Scheier LM, Hill PW. Perceptions of prior authorization by use of electronic prior authorization software: A survey of providers in the United States. *J Manag Care Spec Pharm*. 2022 Oct;28(10):1121-1128. doi: 10.18553/jmcp.2022.28.10.1121

[85] Luo J, Wong R, Mehta T, et al. Implementing real-time prescription benefit tools: Early experiences from 5 academic medical centers. *Healthcare (Amst)*. 2023;11(2):100689. doi: 10.1016/j.hjdsi.2023.100689

[86] Berg S. When health plans delay and deny, they must say why. American Medical Association. June 11, 2024. Accessed August 25, 2025. https://www.ama-assn.org/practice-management/prior-authorization/when-health-plans-delay-and-deny-they-must-say-why

[87] MedCityNews. Health plans, this is why real-time benefit tools have let you down. May 16, 2022. Accessed August 25, 2025. https://medcitynews.com/2022/05/health-plans-this-is-why-real-time-benefit-tools-have-let-you-down/

### *Coupons and Discount Programs*

Manufacturer drug coupons[88] are offered by pharmaceutical companies to help reduce or eliminate the cost of brand-name drugs for consumers. Coupons typically do not have maximum income thresholds and are available for a variety of medical conditions.[89] The terms of use and conditions for coupons vary (e.g., single use, a specific period after the initial fill, a certain number of fills).[89] Anti-kickback laws[90] make it illegal for pharmaceutical companies to offer discounts for medications that will be paid for by the federal government.[91] Provider and payor views on coupons are mixed. Some providers assert that coupons increase affordability and medication adherence; payors have noted that coupons drive use of higher cost drugs when lower cost alternatives may be available, which increases spending.[92] The percentage of brand-name prescription drug spending involving a coupon increased in the U.S. from 26 percent in 2007 to 90 percent in 2017, while the number of drugs offering coupons grew from around 200 in 2008 to over 800 by 2018.[93]

Drug discount cards offer another option for consumers to reduce their out-of-pocket costs for various medications (including generics and brand-name drugs) at participating chains and independent pharmacies. Various entities sponsor drug discount card programs, with PBMs being most common; retail stores, associations, nonprofit organizations, and states also sponsor drug discount card programs.[94] Discounts vary by program, drug, quantity, geography, and mode of purchase (e.g., retail or mail-order);[95] out-of-pocket cost for the same medication can differ across vendors and locations.[96, 97] Views about the influence of these programs are multi-faceted and include concerns about the financial implications on independent pharmacies.[98]

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[88] Also referred to as "copay coupons" or "copay assistance programs."
[89] Kang S, Liu A, Anderson G, Alexander GC. Patterns of manufacturer coupon use for prescription drugs in the US, 2017–2019. *JAMA Netw Open*. 2023;6(5):e2313578. doi: 10.1001/jamanetworkopen.2023.13578
[90] U.S. Department of Health and Human Services, Office of the Inspector General. *Special advisory bulletin: Pharmaceutical manufacturer copayment coupons*. September 2014. Accessed August 25, 2025. https://oig.hhs.gov/documents/special-advisory-bulletins/878/SAB_Copayment_Coupons.pdf
[91] Choi D, Zuckerman AD, Gerzenshtein S, et al. A primer on copay accumulators, copay maximizers, and alternative funding programs. *Journal of Managed Care & Specialty Pharmacy. 2024; 30*(8), 883–896. doi: 10.18553/jmcp.2024.30.8.883
[92] Commonwealth of Massachusetts, Health Policy Commission. *Prescription Drug Coupon Study*. July 2020. Accessed August 26, 2025. https://www.mass.gov/doc/prescription-drug-coupon-study/download
[93] O'Donnell E. How coupons keep drugs costly. *Harvard Magazine*. Published December 6, 2022. Accessed August 26, 2025. https://www.harvardmagazine.com/2022/12/right-now-coupons-keep-drugs-costly
[94] Arkansas Center for Health Improvement. *Prescription discount cards: A change in the pharmacy industry*. February 2025. Accessed August 26, 2025. https://achi.net/wp-content/uploads/2025/02/250224A_Rx-Discount-Cards.pdf
[95] Wheeler JS, Heidel RE, Dong A, et al. Association between prescription drug discount cards and out-of-pocket costs for HFrEF regimens: cross-sectional pricing analysis across geographic regions and discount programs. *Circ Cardiovasc Qual Outcomes*. 2023;16(10):e010329. doi:10.1161/CIRCOUTCOMES.123.009987
[96] Fein AJ. How GoodRx is evolving its reimbursement approaches to help pharmacies and consumers. *Drug Channels*. April 2024. Accessed August 26, 2025. https://www.drugchannels.net/2024/04/how-goodrx-is-evolving-its.html
[97] Tate J. The rise of integrated discount card programs. Pharmaceutical Strategies Group. June 20, 2024. Accessed August 26, 2025. https://www.psgconsults.com/blog/the-rise-of-integrated-drug-discount-card-programs/
[98] Pharmacies must accept the PBM-negotiated discounted rate instead of their usual retail price and pay a post-sale fee to the PBM for each discounted transaction, part of which is passed along to the discount card provider, reducing the pharmacy's revenue significantly. More information is available at: www.drugchannels.net/2020/08/how-goodrx-profits-from-our-broken.html.

## APPENDIX A – INTEROPERABILITY AND PRIOR AUTHORIZATION FINAL RULE, NON-TECHNICAL PROVISIONS

| **Federal Interoperability and Prior Authorization Final Rule**<br>*Non-Technical Provisions* | | |
|---|---|---|
| **Category** | **Requirements/Details** | **Compliance Date** |
| **Decision Timelines** | Standard requests: ≤ 7 calendar days; Expedited: ≤ 72 hours | January 1, 2026 |
| **Patient Notification** | Inform patients (not just providers) of approval or denial, with clear denial reasons | 2026–2027 depending on plan type |
| **Public Reporting & Transparency** | Prior auth metrics (volume, decisions, timeframes) must be publicly posted annually | Reporting begins 2026 |
| **Educational Resources** | Plain-language materials for patients/providers on APIs, opt-in/opt-out instructions | By API launch (January 1, 2027) |
| **Appeals Transparency** | Reason for denial must be consistently communicated via any channel | January 1, 2026 |
| Source: www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f | | |

## APPENDIX B – INTEROPERABILITY AND PRIOR AUTHORIZATION FINAL RULE, TECHNICAL PROVISIONS

| **Federal Interoperability and Prior Authorization Final Rule**<br>*Technical Provisions* |
|---|
| **Patient Access API**: Expands the set of data payers must make available to members via the Patient Access API that was implemented for CMS-9115-F to now include information about prior authorization status and decisions |
| **Provider Access API**: Payers are required to share data about members, including information about prior authorization status and decisions, with in-network treating providers at the request of the provider if the member does not opt out |
| **Payer-to-Payer API**: Requires data sharing via a FHIR Payer-to-Payer API, including prior authorization information to facilitate care coordination, between one payer and other payers covering that member, if the member opts in, when an individual changes payers, or has concurrent coverage. |
| **Prior Authorization API**: Mandates adoption of electronic prior authorization processes using a Prior Authorization API and requires authorization decisions within narrow windows, and public reporting of metrics about authorizations. |
| Source: www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f |

## APPENDIX C – STATE LAWS

| State Prior Authorization Laws |
|---|
| **Align with Federal Prior Authorization APIs** |
| **California AB 2198 Health Information**<br>Enacted 2024 \| Effective 1/1/27 |
| **Colorado HB 24-1149 Prior Authorization Requirements Alternatives**<br>Enacted 2024 \| Effective 1/1/27 |
| **Minnesota statute 62M.07**<br>Enacted 2024 \| Effective 1/1/27 |
| **Oklahoma HB 3190 Ensuring Transparency in Prior Authorization Act**<br>Enacted 2024 \| Effective 7/1/27 |
| **Tennessee SB2012/HB2011**<br>Enacted 2024 \| Effective 7/1/27 |
| **Washington HB 1357 - 2023-24**<br>Enacted 2024 \| Effective 1/1/25 |
| **Prohibit Sole Use of AI in Prior Authorization Denials** |
| **Arizona (HB 2175) – prior authorization; claims**<br>Enacted 2025 \| Effective 7/1/26 |
| **California (SB 1120) Health Care Coverage: Utilization Review**<br>Enacted 2024 \| Effective 1/1/25 |
| **Colorado (SB 24-205) Consumer Protections for Artificial Intelligence Law**<br>Enacted 2024 \| Effective 1/1/26 |
| **Illinois (HB2472)**<br>Enacted 2024\| Effective 1/1/25 |
| **Maryland (HB 820) Health Insurance - Utilization Review - Use of Artificial Intelligence**<br>Enacted 2025 \| Effective 10/1/25 |
| **Require Payors to Implement Real-Time Benefit Tools** |
| **California Assembly Bill No. 2352 Real-Time Verification of Prescription Drug Coverage**<br>Enacted 2022 \| Effective 7/1/23 |
| **Colorado Rev. Stat. § 10-16-122.9**<br>Enacted 2022 \| Effective 8/7/23 |
| **Ohio Section 3902.72 Health plan issuer disclosure of drug data**<br>Enacted 2021 \| Effective 1/1/22 |
| **Maryland (SB 791/HB 932) Health Insurance - Utilization Review – Revisions**<br>Enacted 2024 \| Effective 7/1/26 |
| **Maine Chapter 56-A: HEALTH PLAN IMPROVEMENT ACT Subchapter 1: HEALTH PLAN REQUIREMENTS**<br>Enacted 2022 \| Effective 1/1/22 (integrate with at least one EHR system); 1/1/23 (integrate with all EHR and ePrescribing systems) |
| **Texas Chapter 272 (SB 622)**<br>Enacted 2023 \| Effective 9/1/23 |
| **Tennessee Chapter 569/ HB 1398 - AN ACT to amend Tennessee Code Annotated, Title 4; Title 56 and Title 71, relative to pharmacy benefits**<br>Enacted 2021 \| 1/1/22 |

| State Prior Authorization Laws |
| --- |
| **Virginia HB 360 Health insurance; carrier contracts, carrier provision of certain prescription drug information.**<br>Enacted 2022 \| Effective 7/1/25 |
| **Gold Carding** |
| **Arkansas Act 575 – An Act to Amend the Prior Authorization Transparency Act**<br>Enacted 2023 \| 1/1/24 (medical services); 1/1/25 (pharmaceuticals) |
| **Colorado HB24-1149 Prior Authorization Requirements Alternatives**<br>Enacted 2024 \| Effective 1/1/26 |
| **Georgia Act 299 (SB 5)**<br>Enacted 2025 \| Effective 7/1/25 |
| **Illinois SB 3268**<br>Enacted 2024 \| Effective 1/1/25 (Medicaid only) |
| **Louisiana SB 112 – Reducing Administrative Burdens in Health Insurance**<br>Enacted 2022 \| Effective 6/1/22 |
| **Michigan SB 247 Insurance: health insurers; preauthorizations conducted by utilization review entities related to health care services**<br>Enacted 2022 \| Effective 6/1/22 |
| **New Mexico Administrative Code, N.M. Code R. § 13.10.31.12, Evaluation of Prior Authorization Policy and Provider Performance**<br>Enacted 2022 \| Effective 6/1/23 |
| **Texas Gold Card Law (HB 349)**<br>Enacted 2021 \| Effective 2022<br>Amended in 2025 (effective 9/1/25) |
| **West Virginia House Bill 2535**<br>Enacted 2023 \| Effective 10/1/24 |
| **Wyoming HB0014 - Prior authorization regulations**<br>Enacted 2024 \| Effective 1/126 |

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