States want to make it harder for health insurers to deny care, but firms might evade enforcement

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For decades, Amina Tollin struggled with mysterious, debilitating pain that radiated throughout her body. A few years ago, when a doctor finally diagnosed her with polyneuropathy, a chronic nerve condition, she had begun to use a wheelchair.

The doctor prescribed a blood infusion therapy that allowed Tollin, 40, to live her life normally. That is, until about three months ago, when it came time for reapproval and Medicaid stopped paying for the therapy. It was the result of an increasingly common process among private and public insurers known as prior authorization.

The monthly infusions for Tollin's condition cost about $18,000 for each session. When Medicaid stopped covering the infusions, she simply stopped getting them.

"The doctor has shown why I need it and they just decided I don't," Tollin, who lives in Tucson, Arizona, told Stateline. "It's been awful. I'm in pain."

To curb health care costs and block unnecessary services, insurers have long required doctors to obtain their approval before they'll pay for certain drugs, treatments and procedures. But in recent years insurers have ratcheted up their use of prior authorization, causing delays and denials of care that are harming or even killing people, many doctors and patients say.

In the past couple of years, more than two dozen states have considered legislation designed to minimize prior authorization delays and denials, and nine states have enacted new laws, according to the American Medical Association, which has advocated for them.

A New Jersey law, for example, sets a 72-hour deadline for most claims. Texas created a "gold card" system that exempts physicians with a 90% approval rate from prior authorization requirements. Washington state sets deadlines and requires insurers to automate the process to speed approvals, while Michigan mandates that prior authorization requirements be based on peer-reviewed criteria.

"It really is just a matter of building momentum and continuing to see this in more and more states," said Dr. Jack Resneck, who stepped down as president of the American Medical Association last June. Many of the bills are based on the organization's model legislation.

"We hope insurance plans will recognize that they have taken this entirely too far and will recognize that they are harming patients and preventing people from getting evidence-based appropriate care," Resneck told Stateline.

Insurers argue that prior authorization ensures that doctors only prescribe therapies and treatments that are medically necessary, protecting patients and lowering health care costs for everybody. Prior authorization "is designed to ensure that clinical care aligns with evidence-based recommendations—not to deny or discourage patients from getting the care they need," Robert Traynham, a spokesperson for AHIP, a trade group formerly known as America's Health Insurance Plans, wrote in an email.

Meanwhile, some who support curbs on prior authorization caution that the new state laws might not make much of a difference, largely because they lack strong enforcement mechanisms.

Ron Howrigon, a former executive at insurance giant Cigna and current president of Fulcrum Strategies, a firm specializing in insurance contracts, said the laws are "better than nothing" and that "there are definitely some people [they're] going to help."

But, Howrigon said, insurance companies are adept at finding ways to get around laws designed to hold them accountable, especially if the only type of enforcement against them involves third-party reviews or relatively small fines.

"Nobody should kid themselves and think that patients aren't going to have to deal with incorrect denials," Howrigon told Stateline. "Because that's not right."

Furthermore, state laws generally apply to state-regulated private health insurance plans, which excludes the 65% of people who work for large firms and are covered by self-funded employer plans. And many of the state laws don't apply to people on Medicaid, the joint state-federal health care program for people with low incomes, according to the National Association of Insurance Commissioners.

Earlier this year, the federal Centers for Medicare & Medicaid Services finalized a rule designed to speed up prior authorization in government insurance programs, including Medicaid and Medicare, the federal health care insurance program for people aged 65 and over and the disabled. The new rule, most of which will go into effect in 2026, requires a decision on "urgent" requests within 72 hours. But it applies only to "medical items and services," not drugs.

'Fed up'

Dr. Amy Faith Ho, an emergency medicine physician in Dallas, said many patients whose treatments are delayed or denied through prior authorization often end up in her waiting room.

"At some point they just get fed up. But what's sad to me is they did everything right," Ho said. She added that some patients with chronic illnesses don't end up in the emergency room, but they do experience a loss in quality of life. "We see those patients sometimes present as suicide attempts," she said.

For patients with certain diseases and conditions, such as cancer, prior authorization delays and denials are a common occurrence: A 2023 study

found that 1 out of every 5 cancer patients did not receive the care recommended by their treatment team because of the prior authorization process. In a 2022 survey conducted by the American Medical Association, 94% of doctors said prior authorization had led to a delay in care, and a third reported that prior authorization had led to a "serious adverse event" for a patient in their care.

States have generally tried to attack the problem in four ways, said Kaye Pestaina, the director of the program on patient and consumer protection at KFF, a nonprofit research organization.

The first strategy is to shorten the amount of time an insurer is allowed to decide on a medication or service request.

The second is to reduce the administrative burden physicians experience, often by giving a pass to doctors who have a high rate of approvals—Texas' gold card system is one example.

The third approach is to bolster transparency and data requirements.

And the fourth focuses on the review process itself by mandating that decisions be based on peer-reviewed, clinical data.

Pestaina said it might take years to determine which strategy, or combination of strategies, would yield the best outcomes.

In Texas, for example, the 2022 gold card law so far has had mixed results. Doctors who have received the pass say there's a more streamlined process, but there aren't very many of them: Only 3% of physicians had achieved gold card status by the end of last year, according to the Texas Medical Association.

"That should really be upside down and in the other direction," said

Resneck, the former American Medical Association president. "We should see 97% of doctors getting gold cards instead of 97% not getting them."

Enforcement challenges

State insurance commissioners largely will be responsible for enforcing the state laws. Many of the new laws empower commissioners to investigate insurers, issue fines for noncompliance and even take insurers to court to remove their license to operate in the state.

But to uncover violations, commissioners will rely heavily on complaints from patients and doctors, according to the National Association of Insurance Commissioners. And Howrigon notes that doctors and patients won't know to complain unless they are aware of their rights under the new laws.

Howrigon also emphasized that state-issued fines and penalties might not be enough to cow insurance giants that make tens of billions of dollars in profits. And, he noted, in 11 states insurance commissioners are elected and often get campaign donations from the companies they regulate.

A better enforcement approach, he suggested, would be to hold the medical directors within insurance companies accountable for decisions that harm patients.

"If those doctors had the same accountability and responsibility as the doctors who are writing the prescriptions, meaning they could be sued for malpractice ... all of this would go away," Howrigon said.

Under a prior authorization bill advancing in Oklahoma, insurance company medical directors could be held liable for medical malpractice, opening them up to lawsuits.

"I have had doctors tell me this is what is some of the best legislation they've seen in the country. It's fair to the insurance company and it's fair to the to the patient," said Republican state Rep. Ross Ford, one of the cosponsors. "It gives the right balance of oversight, but it also goes far enough to hold the insurance company responsible if they choose to deny a procedure."

Three months of limbo

In Arizona, a bill has been introduced that would require insurers to honor prior authorizations for at least 90 days, even if the patient switches insurers. But according to the Arizona Department of Insurance, it would not apply to Medicaid.

That means it wouldn't apply to Amina Tollin.

Medicaid finally approved Tollin for her infusions in late March. But through the three months of limbo, she says her symptoms—including pain, exhaustion, numbness and tingling—were agonizing.

She fears that at some point in the future, Arizona Medicaid might once again refuse to cover the infusions, which are covered for the next twelve months.

"I feel like I won, but I didn't really win because it's going to be a whole new fight in a year," she said.