

Reducing Scope of Claims Subject to Prior Authorization

Prior authorization is an important safeguard used by both public and private payers to ensure patient care follows clinical guidelines. It helps reduce patients' exposure to low-value, unsafe or inappropriate care by making sure services and prescriptions align with the latest research and guidelines for effectiveness. This leads to better health outcomes for patients. As part of a series of multi-year voluntary commitments announced in partnership with HHS and CMS, leading health plans committed to making specific reductions to the scope of claims subject to prior authorization as appropriate for the local markets each plan serves. This is designed to ensure that prior authorization is used selectively and focused on services that present higher clinical risk or variation in practice, while removing requirements that add administrative burden without improving patient outcomes.

Health plans' efforts to reduce prior authorization across the markets covered by the commitments will result in approximately 11% fewer prior authorizations occurring in 2026—or 6.5 million fewer prior authorizations for patients, which includes a reduction of more than 15% in Medicare Advantage.¹

Health plans regularly conduct comprehensive, data-driven reviews of services with prior authorization across lines of business, services and care settings. These assessments—led by medical directors and clinicians—take into account historical claims data, approval rates, utilization trends and up-to-date evidence-based clinical guidelines to identify services that may no longer need a prior authorization review. As a result, health plans have eliminated thousands of procedure codes from prior authorization lists, significantly reducing the scope of claims subject to prior authorization across markets. In addition, provider performance-based approaches, like gold carding, further reduce prior authorization friction for providers who consistently deliver care aligned with evidence-based standards for certain services and expedite care for their patients.

Highlights of Industry Initiatives

Expanding “Gold Carding” Programs

Health plans are expanding gold carding and performance-based programs to reduce or eliminate prior authorization requirements for providers who consistently deliver high-quality, evidence-based care. These programs allow providers to reduce or bypass prior authorization for certain services and items when delivered by providers with a demonstrated track record of appropriate utilization.

For example, across markets, health plans are introducing or expanding gold carding programs for providers who deliver high-volume services such as imaging, cardiology, radiology, select outpatient procedures and medications. These efforts are eliminating thousands of prior authorizations annually, speeding patient access to care and reducing burdens on providers.

Expanded Use of Electronic Prior Authorization (ePA)

Using electronic prior authorization (ePA) and other enhanced technologies, health plans can now approve some prior authorization requests with greater speed and efficiency. By expanding the adoption of ePA, health plans reduce friction with providers and patients by delivering quicker decisions while also preserving clinical oversight.

Highlights of Health Plan Programs

Aetna/CVS

Aetna is reducing administrative burden for members and providers by bundling prior authorization requests for select medical procedures and their associated medications. For example, providers may submit a single prior authorization request for in vitro fertilization (IVF); if approved, the related procedures and medications are automatically authorized as part of the same request.

This bundled approach has been extended to musculoskeletal care for total hip and total knee arthroplasty, covering diagnostic x-rays, nonopioid pain and anti-nausea medications, inpatient admission when clinically appropriate, infection control services, and durable medical equipment. Bundled prior authorization is also available for lung, breast, and prostate cancer care.

American Specialty Health (ASH)

As part of its partnerships with multiple health plans to help deliver evidence-based musculoskeletal, physical therapy, and occupational therapy services, American Specialty Health (ASH) uses a tiered gold carding Clinical Performance System (CPS) for contracted providers where different levels of clinical oversight are associated with each provider tier.

The model consists of ongoing monitoring of provider performance and continuous provider education and engagement to ensure consistent high-quality care. The gold carding model has resulted in high patient satisfaction and a reduced need for prior authorization, reserving medical necessity reviews and clinical oversight for the most complex cases.

Blue Cross Blue Shield of Minnesota

In 2025, Blue Cross Blue Shield of Minnesota (Blue Cross MN) improved the prior authorization process by expanding its performance-based prior authorization program, which recognizes providers who consistently meet evidence-based standards for qualifying services. Blue Cross MN invested in new technologies to scale the program across additional orthopedic surgeries and advanced imaging services – reducing turnaround times on approvals.

This targeted “greenlighting” approach has been especially successful with specialty practices, such as oncology and orthopedics, where a large number of providers meet program requirements. Blue Cross MN provides regular, transparent feedback, reducing oversight as providers demonstrate sustained success, working toward minimal or no routine audits.

Predictable approvals reduce administrative back-and-forth, allowing providers to act quickly and helping members access appropriate care without delay.

Centene

Centene is removing prior authorization requirements for select codes across multiple lines of business as part of a structured, multi-phase clinical review process. Led by medical and clinical teams, these reviews assess utilization patterns, approval rates and evidence-based guidelines to ensure prior authorization remains targeted and appropriate across markets.

For example, in Q4 2025, Centene began implementing changes focused on imaging services. Together, these efforts are expected to eliminate approximately 300,000 prior authorizations annually across Medicare and Marketplace plans while preserving appropriate medical and clinical review for higher-risk services.

Cigna

Using a clinical-first approach, over the past year, Cigna reduced paperwork and the time providers and patients spend obtaining approvals for more routine services by removing 345 tests, procedures, and services² from the Cigna prior authorization process. This change has decreased the volume of medical prior authorizations by approximately 521,000 (about 15%).³

Elevance Health

Elevance Health has removed prior authorization requirements for several hundred services over the last few years. Where prior authorization applies, digital technologies have made it significantly faster and more efficient.

Care providers that adopt electronic prior authorization through Elevance Health’s provider portals and select electronic medical records (EMRs) also benefit from two-way communication with clinicians at Elevance Health-affiliated plans, as well as quicker clinical determinations. Care providers can access all authorization data in a single location and quickly check the status of any authorization, even if it was not initially submitted electronically.

EmblemHealth

Each year, EmblemHealth conducts a comprehensive review of all items and services requiring prior authorization. These reviews have resulted in the plan removing 1,149 codes from the PA list between 2021 and 2025.

EmblemHealth continues to work with providers to simplify administrative processes and eliminate codes identified during these annual reviews. For instance, echocardiograms were removed from the prior authorization list for 2026, allowing cardiologists with in-house equipment to perform the procedure during the member's visit without delay.

Geisinger

Geisinger has reduced the frequency and burden of repeated prior authorization requests by extending authorization timeframes for members with chronic, progressive, and non-reversible conditions. Requests are reviewed on an individualized, case-by-case basis. Examples of these extended authorization periods include, but are not limited to, a two-year authorization for incontinence supplies, three-year authorizations for enteral nutrition and ventilator services and one-year authorization periods for shift or private duty nursing care.

Highmark Blue Cross Blue Shield

High-performing health care providers are seeing an 85% reduction in administrative work as a result of a program from Highmark Blue Cross Blue Shield. When a clinician has a proven track record of consistently meeting high clinical standards for a specified service type, they can become what Highmark calls a trusted provider for that service. Instead of the traditional prior authorization process, the 25,000 clinicians currently with this designation simply submit a very short prenotification that includes the procedure and diagnosis codes. Each month, Highmark processes 40,000 expedited requests through this trusted provider pathway. Of the more than 25,000 clinicians qualifying for faster review for at least one service type, about half are approved for multiple services. In addition to the dramatic reduction in paperwork, clinicians spend less time on peer-to-peer reviews.

"The prenotification process is quick and easy, allowing us to schedule and perform necessary imaging procedures much more efficiently," said the chief medical officer of an ambulatory practice in Buffalo, New York.

Humana

Humana has a continuous process of evaluating its prior authorization list to ensure it meets the safety and quality needs of its members while at the same time identifying ways to reduce provider abrasion. Across 2024 and 2025, Humana removed prior authorization requirements for over 340 codes, accounting for approximately one third of prior authorizations for 2025 outpatient diagnostic services across colonoscopies, transthoracic echocardiograms and select CT scans and MRIs. Ongoing annual review of Humana's prior authorization list may result in further code elimination in 2026.

In 2026, Humana will introduce a new gold carding program that eliminates prior authorizations for certain items and services. The gold carding program will include providers with a proven track record of meeting medical criteria and delivering consistent, high-quality care.

Independence Blue Cross

Independence Blue Cross (IBX) has expanded its partnership with Penn Medicine to include additional high-performing health systems in a program designed to eliminate prior authorization requirements for certain outpatient imaging tests, including CT, PET, nuclear medicine scans, MRI, and echocardiograms. Providers with a history of ordering imaging tests consistent with evidence-based guidelines are eligible for this program, resulting in 45,000 fewer prior authorizations a year from just one health system alone. Other positive results include a faster time to decision, with 83 percent of outpatient radiology requests approved in one-tenth of the time the process would typically take, and a 9 percent decrease in low-value requests for tests that have little to no clinical benefit or where the risk of harm outweighs the potential benefit.

Kaiser Permanente

In Kaiser Permanente's integrated care and coverage model, approximately 93% of ambulatory care is delivered within the system, virtually eliminating the need for prior authorization. For services delivered by external contracted providers, prior authorization is sometimes required. Kaiser Permanente has standardized these requirements across all markets and removed more than 3,600 codes from prior authorization. These changes will reduce prior authorizations by nearly 20% in 2026 compared to 2024 levels, with additional reductions anticipated in 2027.

UnitedHealthcare

UnitedHealthcare continues to evaluate and take steps to speed up, reduce and eliminate prior authorizations. This includes reducing the total volume of prior authorizations by nearly 20% in 2023 for common procedures, treatments and services and reducing the volume of prior authorizations by an additional 10% in 2025.

UnitedHealthcare's gold carding program recognizes and rewards provider groups who consistently adhere to evidence-based care guidelines by reducing their total prior authorization requirements across 514 codes, including those for primary care, orthopedics, cardiology, oncology, and more. The gold carding program has reduced the volume of prior authorization requests by an average of 30% for eligible provider groups.

1 The percent of prior authorization reductions was calculated using signatory health plan self-reported data. Plans provided the count of distinct CPT and HCPCS codes for medical services that were eliminated from their plan's prior authorization list as of the commitment go-live date of January 1, 2026. As a result of these codes eliminated, plans calculated how many of their 2024 prior authorization requests would therefore be eliminated. Prior authorizations managed by delegated vendors were also included in the scope of the commitment. Plans reported these metrics across the Commercial Fully-Insured, Medicare Advantage and Affordable Care Act lines of business resulting in the overall reduction in scope of 11%.

2 Based on absolute number of prior authorization codes removed during the year ended December 31, 2025, related to Cigna Healthcare U.S. business. Cigna Healthcare publishes a Master Precertification List quarterly. <https://www.cigna.com/health-care-providers/coverage-and-claims/precertification>

3 Reflects estimated prior authorizations that would have been avoided in 2024 if the codes removed in 2025 had been removed for the calendar year 2024. Population consists of core medical prior authorizations and excludes pharmacy.