

A B A R C A

REDESIGNING PRIOR AUTHORIZATION

A White Paper from Abarca Health
Based on the outcomes of Abarca
Forward 2026

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EXECUTIVE SUMMARY

Prior authorization has become one of the most widely criticized mechanisms in healthcare. It is, as Abarca Health CEO Jason Borschow has noted, “the only piece of healthcare that every single stakeholder, including payers and insurance companies, agrees is broken and needs to be reformed.”

According to the 2025 AMA Prior Authorization Physician Survey, 95% of physicians report PA causes care delays, and 79% report it leads to treatment abandonment. Physician practices average 40 prior authorization requests per physician per week, consuming approximately 13 hours of physician and staff time—with 40% of practices employing staff dedicated exclusively to PA. More than 1 in 4 physicians (26%) report that PA has led to a serious adverse event for a patient in their care.¹ Recent research from NYU Langone Health found that patients whose prescriptions required prior authorization took three times longer to fill an ARNI prescription and six times longer to fill an SGLT2 inhibitor prescription. Patients whose SGLT2 inhibitor prescriptions required prior authorization were also twice as likely never to fill them.²

The burden extends to health plans and PBMs as well. While no single public figure captures the full cost of administering prior authorization across the healthcare system, available data illustrates the scale of the opportunity. The 2024 CAQH Index estimated that the medical industry could save approximately \$515 million annually by transitioning remaining manual and partially electronic prior authorization transactions to fully electronic workflows. Full electronic adoption could also save providers an average of 14 minutes per authorization. Prior authorization is not just a physician problem. It is a system-wide administrative burden that no stakeholder has fully measured or optimized.³

In February 2026, Abarca Health convened its fifth Abarca Forward event, an annual “anticonference,” a collaborative thought leadership forum that brings together executives from health plans, providers, pharmacies, manufacturers, technology companies, employers, and policy stakeholders to discuss pressing industry topics. This year’s focus was prior authorization. In the afternoon, attendees came together for an intensive co-creation session. The charge was to move beyond broad agreement that prior authorization needs reform and begin building alignment around how to redesign it.

This white paper captures the outcomes of that convening. It presents a six-principle framework organized across three domains—Experience, Infrastructure, and Performance—and concludes with five cross-stakeholder commitments identified by participants to help move the framework into action. Together, the principles describe the desired future state for prior authorization, while the commitments outline how stakeholders can begin advancing it.



95%

of physicians
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40

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WHY THIS ISSUE MATTERS NOW

The urgency around prior authorization reform has reached a tipping point. What was once an operational concern discussed within industry circles has become a matter of public scrutiny and congressional attention. In January 2026, executives from five of the nation's largest health insurers appeared before two House committees, where lawmakers from both parties questioned them about healthcare affordability, prior authorization requirements, and coverage denials. The scrutiny is reinforced by the latest available Medicare Advantage data: in 2024, insurers made 52.8 million prior authorization determinations and fully or partially denied 4.1 million requests, representing 7.7% of all Medicare Advantage prior authorization determinations that year.⁴

The regulatory landscape is also moving. CMS-0057-F, the Interoperability and Prior Authorization Final Rule, established new expectations for electronic prior authorization, transparency, and health data exchange.⁵ More recently, CMS-0062-P proposed additional interoperability standards for prior authorization for drugs, reinforcing the direction of travel: PA reform is no longer a distant policy conversation; it is becoming an operational requirement.⁶ For the industry, the opportunity is to lead with alignment before compliance alone defines the path.

Health plans have acknowledged the problem. In June 2025, more than 60 health insurers pledged to streamline, simplify, and reduce prior authorization through six new commitments. But the industry has heard similar pledges before. The AMA has noted that comparable commitments made in 2018 to reduce volume, improve transparency, and automate the process did not lead to meaningful change.⁷ Public trust in the healthcare system's administrative processes is eroding. Patients increasingly perceive prior authorization not as a safeguard but as a barrier. Borschow put it plainly: "People think of prior authorization as life and death, not just an inconvenience."⁸

THE CURRENT STATE: WHERE FRICTION LIVES

To understand why prior authorization resists reform, it helps to map where friction exists across the system today.



For patients, prior authorization creates uncertainty at the most vulnerable moments. Decisions arrive days or weeks after a prescription is written, if they arrive at all. The process is opaque: patients often cannot see where a request stands, what documentation is required, or what their options are if a request is denied. The result is delayed therapy, abandoned prescriptions, and eroded trust.



For providers, the burden is both operational and clinical. Practices dedicate entire staff workflows to navigating approval processes and dealing with a disconnected ecosystem. Prior authorization frequently surfaces after clinical decisions have already been made, creating rework, surprise denials, and workflow disruption. Criteria are often buried in unstructured formats such as narrative PDFs with inconsistent terminology, making compliance a guessing game.



For payers, the challenge is credibility. Utilization management exists to ensure that care is safe, evidence-based, and affordable. But when the process itself contributes to worse outcomes, including delayed access to lifesaving medications, high abandonment rates, and growing congressional scrutiny, the tool undermines the very goals it was designed to serve.

Across the ecosystem, fragmentation compounds every problem. Medical and pharmacy benefits operate in silos. Data does not flow between systems. Standards for criteria, required documentation, and decision rationale vary across plans and PBMs. No single stakeholder can fix the problem alone, and no one has sufficient visibility to diagnose it fully.

VOICES FROM THE ROOM: WHAT THE BREAKOUT SESSIONS REVEALED

Five facilitated breakout groups examined prior authorization from different vantage points: the patient journey, the prescriber workflow, technology and standards, outcomes-driven measurement, and the integration of medical and pharmacy utilization management.

While each group approached the challenge differently, the same core message emerged across the room: prior authorization cannot be meaningfully redesigned through isolated fixes. It requires a shared language, clearer accountability, more transparent criteria, stronger interoperability, and a coordinated view of the patient journey.



The breakout discussions surfaced five recurring insights that directly informed the six-principle framework that follows:

01

PA must become visible and understandable.

Patients and providers need to know where a request stands, what information is required, why a decision was made, and what happens next. Transparency is not simply an administrative improvement; it is foundational to trust.

02

PA must support clinical decisions instead of interrupting them.

Participants emphasized that PA requirements often appear after a prescribing decision has already been made, creating rework, delay, and frustration. The future state requires decision support to be embedded earlier in the clinical workflow.

03

Shared standards are essential.

Across groups, participants identified inconsistent criteria, fragmented documentation, and variable data requirements as major barriers to progress. Without a common structure for PA criteria and required information, automation and interoperability will remain limited.

04

Outcomes must matter more than process metrics alone.

The groups challenged the industry to move beyond measuring PA by turnaround time or denial rates alone. Time-to-therapy, abandonment, safety, total cost of care, and clinical value must become part of how PA performance is evaluated.

05

Patients have one care journey, not separate benefit silos.

Participants repeatedly pointed to the divide between medical and pharmacy benefits as a source of fragmentation. A more holistic model of utilization management requires coordinated workflows, shared accountability, and aligned incentives across the full patient pathway.

As one theme echoed across the room, the opportunity is not only technical. It is relational and structural: the technology exists, but the trust, standards, incentives, and cross-stakeholder alignment must be built deliberately.⁹

“ There is so much more alignment than you really think is out there—and so much we can accomplish when we do it together. We don’t need to depend on the government for the changes that we need. It depends on us. ”

— Adriana Ramírez, Esq., President & Chief Operating Officer
Closing Remarks, Abarca Forward 2026⁹



A NEW FRAMEWORK FOR MOVING FORWARD

The participants at Abarca Forward 2026 did not merely identify problems. Across five facilitated breakout groups, each tackling a distinct design challenge, they worked toward a single unifying question: What must be true for prior authorization to function as trusted clinical decision support, anchored in shared standards, common language, and a more coordinated future for utilization management? The insights from those sessions were synthesized into a six-principle framework organized under three interconnected domains—Experience, Infrastructure, and Performance—with two guiding principles in each domain. The framework defines the conditions required for a more trusted, coordinated, and outcomes-driven prior authorization system.

EXPERIENCE: MAKING PA CLEAR AND HUMAN

This domain was shaped primarily by the Patient Journey and Prescriber Journey groups. Both converged on the same diagnosis: prior authorization is experienced as an opaque, interruptive barrier—by patients who cannot see where their request stands, and by prescribers whose clinical decisions are disrupted after the fact. The principle is simple: PA should not feel like a black box. Patients and providers must be able to see where a request stands, what is required, what the rationale is, and what happens next. For this to work, criteria and documentation requirements must be transparent and accessible, status updates must be proactive, decision rationale must be clearly communicated, and there must be one visible journey rather than fragmented communication across actors. The expected impact is reduced uncertainty, fewer status calls, lower abandonment, and improved trust.

Equally important, PA should support clinical decisions rather than interrupt them. Decision support must be available at the point of prescribing, not after care decisions have been made. Criteria and covered alternatives should be visible during prescribing, low-value or predictable authorizations should be automated or removed, and required information should be pre-populated when possible. Human review should be reserved for complex or high-risk decisions.

INFRASTRUCTURE: BUILDING CONSISTENCY AND TRUST

The second domain addressed the structural foundation. Consistency requires shared standards. Without common structure for criteria and required data, PA will remain inconsistent and unpredictable. A shared structure for PA criteria must exist. A minimum set of required data elements must be clearly defined. Criteria must be structured rather than hidden in PDFs or narrative-only formats, and stakeholders must align on terminology and definitions. The expected impact is fewer incomplete submissions, fewer repeated questions, and more predictable decisions.

Information must also move reliably and responsibly. Borschow emphasized that “the future of prior authorization is not so much the interoperability of the data but a better workflow for the exchange of data that can lead to decision-making. It’s really about having the data in real time when you need to make these decisions.”⁸ Systems must exchange structured information rather than chasing documents. Privacy, consent, and security standards must be defined and enforced. Accountability must be clear, especially when technology is involved, and decisions must be auditable and explainable.

PERFORMANCE: MEASURING WHAT MATTERS

This domain was shaped primarily by the Outcomes-Driven PA and Medical and Pharmacy Integration groups. Both arrived at the same conclusion from different angles: the system is not currently measuring what matters, and without aligned incentives and shared accountability, no amount of structural reform will produce lasting change. The third domain ensures PA creates measurable value. But before value can be measured, it must be defined—and the sessions made clear that value means something different to every stakeholder in the room. For a physician, it is time saved and clinical autonomy. For a patient, it is timely access and certainty. For a payer, it is cost and safety. For a PBM, it is efficiency and accuracy. A shared definition of value, anchored in total cost of care, is a prerequisite for any meaningful measurement. Once defined, clear outcome measures must include time-to-therapy, abandonment rates, safety events, and total cost. Performance data must be tracked and shared. Rules must evolve when evidence shows better pathways, and incentives must reward appropriate, outcome-improving decisions. Critically, if a PA program cannot demonstrate that it is changing outcomes—if it is approving 99% of requests without meaningful clinical differentiation—that is itself a measurable signal that the program is not creating value and should be reduced or eliminated.⁹

Finally, patients have one care journey, not two benefit silos. Utilization management must be organized around the care pathway with shared accountability. Decisions must consider total cost of care rather than siloed budgets. Medical and pharmacy workflows must be coordinated, with data feeding into a unified view. And accountability for time-to-therapy must be explicitly assigned—no stakeholder currently owns this metric, and no one is being measured on it. Reform requires not just better technology but aligned business incentives that reward good prescribing, reduce abandonment, and penalize unnecessary delay. The expected impact is fewer duplicative processes, faster therapy access, and reduced fragmentation.

These three domains are interconnected. Experience depends on the infrastructure being in place, while performance depends on experience and infrastructure working in alignment. Together, the six principles describe a prior authorization system that is transparent, embedded in clinical workflow, built on shared standards, governed responsibly, measured by outcomes, and organized around patient pathways.

IMPLICATIONS FOR STAKEHOLDERS

This is not a problem that any single actor can solve independently, nor is it one that requires government mandate to begin addressing.

Health plans and PBMs must lead on transparency, making criteria accessible, decisions explainable, and performance data visible. They must invest in structured, standards-based criteria and move away from proprietary formats that create friction for providers.

Providers must engage in standards development and commit to adopting shared data exchange workflows. Embedding PA into clinical decision-making requires provider systems that can consume and act on structured criteria in real time. Technology partners must prioritize

interoperability over proprietary advantage. As Borschow noted: “Everyone’s so focused on mandates and proprietary systems and products trying to generate a competitive advantage. This is not an area where we should be focused on competitive advantage. This is about making the healthcare system better for everyone.”⁸

Employers and plan sponsors should demand measurable PA performance metrics from their partners and use purchasing power to incentivize adoption of the principles outlined here.

Policymakers should recognize that industry alignment is possible and support standards adoption, while allowing stakeholders the room to drive solutions collaboratively rather than through top-down mandates alone.

WHAT THE ROOM AGREED ON

The session closed with genuine momentum. Across five breakout groups and the closing plenary, participants converged on five cross-stakeholder commitments intended to translate the six-principle framework into continued action. These commitments are not additional principles; they reflect the relationships, accountability, coordination, and follow-through needed to advance the framework beyond the event.



Build cross-stakeholder relationships deliberately. Jason Borschow closed the day with a direct ask: leave with three new relationships. The trust required to redesign prior authorization will not come from policy mandates; it will come from the conversations that happen between the people in this room after they leave it.



Establish accountability for time-to-therapy. There must be a defined, measured, and incentivized standard for how long it takes a patient to receive a prescribed therapy. No stakeholder currently owns this metric. Someone must.



Unify or create interoperability between medical and pharmacy benefit pathways. A patient has one care journey. The system should reflect that. Medical and pharmacy PA processes must be coordinated—either unified or genuinely interoperable—around the patient pathway.



Convene the standard-setters. One PBM, one provider, one payer committing to build a shared PA standard outside of government mandate would create the proof of concept the industry needs. The technology is ready. The will must follow.



Sustain the dialogue. The most consistent theme across every group was that alignment exists but dissipates without continued dialogue. **Abarca Forward must be a catalyst, not an endpoint.**

CONCLUSION

Prior authorization will continue to exist. The question is not whether to eliminate it, but whether the industry has the collective will to redesign it so that it serves its intended purpose: ensuring safe, effective, evidence-based care while respecting the time, trust, and outcomes of every patient it touches.

The framework that emerged from Abarca Forward 2026 represents something rare in healthcare: genuine cross-stakeholder alignment on both the diagnosis and the direction. The six principles, spanning experience, infrastructure, and performance, describe a PA system that is transparent, embedded in clinical workflow, built on shared standards, governed responsibly, measured by outcomes, and organized around patient pathways.

Technology now gives the industry a practical path to make prior authorization more intelligent, coordinated, and member-centered. By reducing manual burden and enabling more timely, data-informed decisions, it allows clinicians to focus where they add the greatest value: determining clinical appropriateness, supporting access to the right therapy, and improving outcomes for members and payers alike.

The investment, the conviction, and the technology are already in place. What remains is the trust and alignment to act. The moments at Abarca Forward when providers, payers, and technology leaders realized they were far more aligned than they assumed suggest that momentum is not only possible; it is within reach.

The opportunity is systemic, not isolated. And the time to act is now.



ABARCA PERSPECTIVE

Applying the Framework: What We Are Learning with Darwin PAtH

The analysis above belongs to the industry. This panel shares how Abarca is applying it in our own operations, where Darwin PAtH, part of Darwin H/I, is enabling the evolution of our Better PAtH programs. We offer it as a working example of the principles in practice, not as a finished answer.

- **Make PA visible and understandable.** Darwin PAtH builds a structured case for each request, so the criteria, the documentation, and the rationale behind a recommendation can be seen and traced by the reviewer.
- **Support clinical decisions instead of interrupting them.** Intelligent intake and automated case creation assemble the information up front, so clinicians spend their time on judgment rather than on gathering documents.
- **Build on structure, not PDFs.** Criteria are structured inside the workflow rather than left in narrative documents, a prerequisite for any shared standard the industry adopts.
- **Keep decisions explainable and accountable.** Lower-complexity cases move faster, complex cases are routed to the right clinical review, and a clinician always makes the final decision.
- **Measure what matters.** Better PAtH programs are designed to deliver savings, and we are working to connect prior authorization activity to outcomes such as time-to-therapy, not turnaround time alone.
- **Treat the patient's journey as one journey.** Coordinating medical and pharmacy pathways is where we, like the rest of the industry, have the furthest to go.

WHAT WE ARE LEARNING

The principles hold up in practice, and they are easier to apply when intelligence is built into the workflow rather than added on top of it. Every organization's path will look different. The principles should not.

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This white paper is based on the proceedings of Abarca Forward 2026, Abarca Health’s fifth annual anticonference, held in February 2026. The framework, insights, and participant quotes presented here were drawn from the afternoon co-creation session.