

# Benchmarking commercial prior authorization program design using a quantitative index: Part 1

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## Executive summary

Prior authorization (PA) is a practice used widely in health insurance markets in the United States. It is the process whereby certain services covered under a health insurance policy are required to be approved for payment by the insurer before a provider renders the service. It has been the subject of debate among stakeholders, including providers, legislators, patients, insurers, and advocacy groups.

Critics say that PA is expensive and contributes to delays in patient care or denials of payment, potentially putting patients at risk. They also note a lack of consistency among insurers across the industry, adding complexity and administrative burden to the system. Proponents counter that, despite the administrative expense, it is necessary to control medical and prescription drug costs and to improve quality and safety for patients. Since complete elimination of the process would result in increases in premiums and patient out-of-pocket expense<sup>1</sup>, reforms in response to the criticisms seem to be the more viable policy path.

In this paper, we derive a quantitative index that uses three components, each aligning with a policy priority in PA reform efforts<sup>2</sup>. We believe this index can be a valuable tool for stakeholders looking to improve industry consistency, efficiency, and both the patient and provider experience with minimal loss of cost control. The measures and the corresponding policy priorities are summarized in Figure 1

**FIGURE 1: QUANTITATIVE PA MEASURES AND CORRESPONDING POLICY PRIORITIES**

QUANTITATIVE MEASURE AVAILABLE FROM PUBLIC DATA	POLICY PRIORITY
Total # HCPCS codes subject to review	Administrative expense
Volume of services subject to review	Potential for adverse patient impact
\$ Volume of medical spend subject to review	Medical cost control

The three measures in Figure 1 can be analyzed separately, weighted according to policy priorities, and combined into a single composite index we call the prior authorization index (PAI). As developed, a higher PAI indicates that a particular insurer's PA program contains a selection of procedure codes that yields a better balance of the policy priorities noted above relative to an insurer with a lower PAI.

1. Busch, F.S., & Fielek, P. (2023, November 29). Potential impacts on costs and premiums related to the elimination of prior authorization requirements in Massachusetts. Milliman. [https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/11-29-23\\_MAHP-Prior-Authorization-Impact.pdf](https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2023-Articles/11-29-23_MAHP-Prior-Authorization-Impact.pdf) and Busch, F., & Muller, S. (2023, March 30). Potential impacts on commercial costs and premiums related to the elimination of prior authorization requirements. Milliman. <https://us.milliman.com/en/insight/potential-impacts-elimination-of-prior-authorization-requests>.

2. See Prior authorization in Medicaid at <https://www.macpac.gov/wp-content/uploads/2024/08/Prior-Authorization-in-Medicaid.pdf>. Although specific to Medicaid, this brief describes reform efforts that hold across all markets (commercial, Medicare, Medicaid).

**Overall results:** Using a single, consistent claims data set across all insurers<sup>3</sup>, we analyzed 23 commercial insurers' PA code lists to determine the percentage of HCPCS codes, utilization, and medical spend subject to review. After computing the PAI, we found that:

- Insurers with a PAI above the 50<sup>th</sup> percentile have 43% fewer HCPCS codes subject to review compared to the average of the bottom 50<sup>th</sup> percentile.
- HCPCS codes selected by insurers with the higher PAIs subjected 72% fewer services to PAs.
- Although the best performers reviewed far fewer HCPCS codes and services than the bottom performers, the potential medical cost savings associated with those reviews were only 17% lower than those of the bottom performers. This indicates that insurers with higher PAI scores focus on services that are, on average, more expensive per service<sup>4</sup>.

These results are summarized in Figure 2.

**FIGURE 2: COMPARISON OF TOP 50% AND BOTTOM 50% PAI PERFORMERS BY QUANTITATIVE MEASURE**

	% OF HCPCS CODES SUBJECT TO REVIEW	% OF UTILIZATION SUBJECT TO REVIEW	% OF MEDICAL SPEND SUBJECT TO REVIEW
(a) Bottom 50% PAI Scores	23%	11%	24%
(b) Top 50% PAI Scores	13%	3%	20%
(c) = (b) / (a) -1 % Difference	-43%	-72%	-17%

We also found large variations between insurers' composite PAIs and between components of the index, indicating that commercial insurers take markedly different approaches to designing PA programs and selecting HCPCS codes for review. This wide variation supports the critics' claims of a lack of uniformity across the industry, contributing to administrative burden and cost. Some of these variations might be explained by nonquantitative criteria such as clinical and administrative considerations not captured in the PAI.

Case studies of anonymized insurers, indicated by the letters A through W, illustrate the different approaches and outcomes of insurers' code selections:

**FIGURE 3: POLICY PRIORITIES ALIGNING WITH AVAILABLE QUANTITATIVE MEASURES**

COMPANY	% OF HCPCS CODES	% OF UTILIZATION	% OF MEDICAL SPEND	PAI
O	3%	1%	9%	2.03
K	3%	6%	2%	0.78
L	20%	14%	22%	0.69
C	19%	2%	24%	1.44
S	83%	7%	49%	0.73

3. Data used is from Milliman's proprietary commercial data set that contains ~20 million commercial lives from all 50 states

4. It is possible that other considerations such as quality or safety were part of the inclusion criteria as well. The outcome, however, remains that codes for higher cost services dominate code lists of insurers with higher PAIs.

**Key observations from Figure 3:**

- Companies O and K both review 3% of the HCPCS codes but achieve very different outcomes in utilization and medical spend. Effective coded selection allows Company O to minimize the potential for adverse patient interactions by impacting only 1% of services while retaining control over 9% of medical spend. Company K impacts utilization more and retains control over less medical spend.
- Companies L and C review a much higher number of HCPCS codes (~20%). Targeted code selection allows Company C to impact a much smaller number of services and higher medical spend control (24% versus 22%).
- Company S, an outlier, reviews nearly 83% of HCPCS codes. This broad review focuses on services that are used less but, on average, cost more than those not reviewed, yielding 49% of spend being reviewed.

## Introduction

Prior authorization (PA) is a managed care process employed by health insurers. It involves medical and pharmacy claims reviews and subsequent payment determinations based on various criteria. In recent years, PA has been in the spotlight in the healthcare industry. It is not particularly popular with medical providers and patients, being cited as a primary reason for patient care delays, increased administrative costs, and negative patient experiences.<sup>5</sup>

At the same time, proponents argue that it is a necessary process for controlling costs, promoting evidence-based care, and protecting patient safety, given today's predominantly fee-for-service healthcare system. Both positive and negative aspects of PA exist with respect to patient safety, administrative cost and complexity, and promotion of appropriate care.

- **Patient safety**

Both proponents and opponents of PA present arguments about the potential risks for patients. Opponents cite PA as a primary cause of delays in care and for appropriate care not being received at all. Proponents argue that monitoring utilization of various services and requiring justification, documentation, and prior approval reduces patient exposure to over-utilization and potential harm. Moreover, payment for certain services is often coupled with approval of an alternative care path that is less invasive or risky.

- **Administrative cost and complexity**

PA requires resources from both the provider and payer sides of the process. Opponents argue these additional resources increase overall system administrative costs for little to no return on investment. In addition, providers have reported increases in medical costs due to step-therapy requirements generating additional office visits and other costs.

Proponents argue that despite the emphasis on value-based care and other non-volume-based provider reimbursement methods, the majority of the U.S. healthcare system can still be characterized as a system of third-party payers paying on a fee-for-service basis. This "pay-for-volume" system implies that both patients and providers may essentially "spend" on medical care in ways that they would not otherwise do if they were paying for it directly. Without some oversight mechanism such as PA, costs and ultimately insurance premiums will increase.<sup>6</sup> Thus, the cost of PA is seen as justified by proponents who believe the medical cost savings generated by PA programs more than make up for the cost to administer the programs themselves.

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5. O'Reilly, K.B. (2023, March 29). 1 in 3 doctors has seen prior auth lead to serious adverse event. American Medical Association. Retrieved April 16, 2026, from <https://www.ama-assn.org/practice-management/prior-authorization/1-3-doctors-has-seen-prior-auth-lead-serious-adverse-event>.

6. Our previous studies have shown that removing prior authorization as an industry practice wholesale will increase premiums and patient out-of-pocket spending in the commercial (employer and individual markets) by between 9% and 23% and patient out-of-pocket spending by similar magnitudes. See Potential impacts on costs and premiums related to the elimination of prior authorization requirements in Massachusetts (retrieved April 16, 2026, from <https://us.milliman.com/en/insight/potential-impacts-costs-premiums-elimination-prior-authorization-massachusetts>) and Potential impacts on commercial costs and premiums related to the elimination of prior authorization requirements (retrieved April 16, 2026, from <https://us.milliman.com/en/insight/potential-impacts-elimination-of-prior-authorization-requests>).

- **Promotion of appropriate care**

Providers are subject to a dizzying array of PA requirements across commercial payers. This lack of consistency contributes to the administrative cost and complexity noted above. Insurers, on the other hand, might argue that their PA programs, though admittedly different from those of other insurers, are designed with forethought to promote evidence-based medicine while enhancing patient safety and controlling costs.

As a matter of policy, wholesale elimination of PA is unlikely as a viable option due to cost implications alone.<sup>7</sup> In lieu of that, reform and process improvement efforts by payers, largely in response to state and federal government focus, are being implemented to address some of the negative aspects of PA noted above.<sup>8 9</sup>

## A quantitative framework for evaluating PA efficiency

PA program design is driven by clinical, financial, and operational criteria. At a very high level, the rationale for PAs could be summarized as follows:

- **Clinical/therapeutic:** Services subject to review do not meet medical necessity criteria or have an alternate therapeutically equivalent care path that is either more conservative, less invasive, more cost-effective, or safer.
- **Cost:** Services subject to review exceed predetermined cost limits or have an alternate, therapeutically equivalent care path that is less expensive.
- **Administrative:** Services subject to review could be duplicates, fall outside of age or sex appropriate standards, exceed either policy limits or do not have sufficient diagnosis or other coding attached in order to be approved for payment. This category also includes the review of claims for potential fraud, waste, and abuse (FWA).

Publicly available data does not provide enough detail to evaluate the clinical criteria that form the backbone of an insurer's PA program. The same is true for criteria related to FWA. Moreover, this information does not lend itself to quantitative analysis, even if the data is available.

However, what is available is the outcome of the considerations noted above, namely, the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are selected for PA review by insurers.<sup>10</sup> We gathered the publicly available lists of HCPCS codes for 23 commercial health insurers<sup>11</sup> effective during 2025. These 23 insurers ranged from large national payers to smaller regional players. By mapping all 23 of these code lists to nationwide claims experience from Milliman's Consolidated HCG Sources Dataset (CHSD), we obtained the service utilization counts and the paid amounts of services that are subject to PA and those that are not.

We then evaluated select quantitative measures across all insurers that, though conveniently available from the data, can also reasonably be associated with an aspect of PA that is often targeted for reform (see Figure 4).

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7. Ibid

8. Japsen, B. (2026, January 1). In 2026, health insurers to push simplicity and speed of approvals. Forbes. Retrieved April 16, 2026, from <https://www.forbes.com/sites/brucejapsen/2026/01/01/in-2026-health-insurers-to-push-simplicity-and-speed-of-approvals/>.

9. Minemyer, P. (2025, June 23). Insurers pledge to smooth out the prior authorization process. Fierce Healthcare. Retrieved April 16, 2026, from <https://www.fiercehealthcare.com/payers/insurers-pledge-smooth-out-prior-authorization-process>.

10. HCPCS codes are assigned to professional services rendered in inpatient, outpatient, and office settings (CPT codes). They are also assigned to other services, supplies, or products not covered by CPT codes (e.g., J-codes for ambulance, durable medical equipment).

11. We gathered qualitative information related to inpatient admission review practices for the same insurers as well as lists of medications by NDCs subject to review for 8 insurers. We performed our analysis only on the HCPCS codes as the inpatient information is qualitative only and uniform across all insurers, meaning that without exception, all insurers require prior authorization for inpatient stays. Moreover, the NDC lists were primarily from insurers on the individual exchanges, which may not be representative of the much larger commercial employer markets.

**FIGURE 4: POLICY PRIORITIES ALIGNING WITH AVAILABLE QUANTITATIVE MEASURES**

QUANTITATIVE MEASURE AVAILABLE FROM DATA	PROXY FOR:
Total # HCPCS codes subject to review	Administrative expense
Volume of services subject to review	Potential for adverse patient impact
Volume of medical spend subject to review	Total cost control

- **Percentage of total HCPCS codes subject to review**<sup>12</sup>

The total number of HCPCS codes an insurer subjects to review provides a proxy for administrative expenses associated with PA. Since each code (or set of related codes) represents the development and maintenance of a different set of clinical rules and rationale for documentation and approval, reducing the number of codes should be associated with cost reduction for both payers and providers.

Moreover, the number of HCPCS codes subject to review is correlated with more PA requests, although, as discussed below, the total volume of requests is also related to the specific HCPCS codes chosen.

- **Volume of services with HCPCS codes subject to review as a percentage of the total services**

This measure can serve as a reasonable proxy for the potential for adverse patient impacts such as delays or denial of care. Not all services are used with the same frequency; therefore, the HCPCS code selection impacts patients' exposure to adverse effects from PA. The higher the volume of utilization of services subject to review, the greater the potential for an adverse event.

- **Volume of medical costs associated with HCPCS codes subject to review as a percentage of total medical spend**

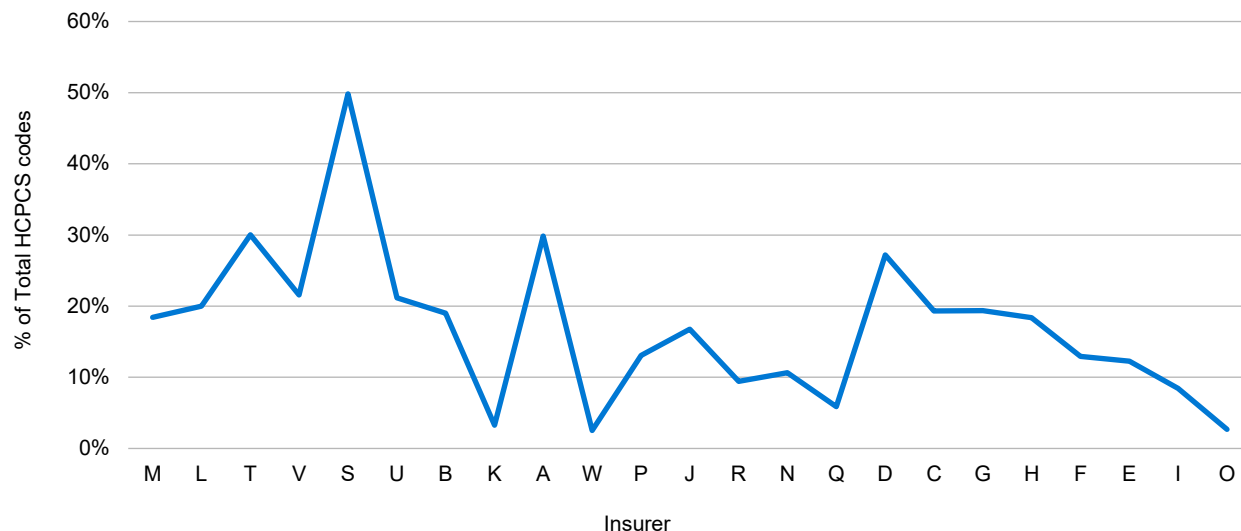
This measure can serve as a proxy for overall medical cost control that insurers retain under their programs. It is a function of the first two measures above: the total number of HCPCS chosen for review and the total utilization of those services. However, it also adds in the element of the per-service cost of each service that is subject to review.

### HCPCS codes subject to PA review

Figure 5 displays the number of HCPCS codes subject to PA as a percentage of total HCPCS codes for each anonymized insurer in our sample, indicated by the letters A through W. The range is substantial: out of a total unique code count of 13,167 coming from CHSD data, PA is applied to as few as 300 codes (~3%) and to as many as almost 11,000 codes (83%). Even without the clear outlier of insurer S, the range across the remaining insurers is 3% to 30% of codes.

12. Industry groups such as the AMA, AHIP, and BCBSA have all identified reducing the number of HCPCS codes subject to review as a policy priority. See Consensus statement on improving the prior authorization process (Retrieved April 16, 2026, from <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>).

**FIGURE 5: PERCENTAGE OF TOTAL HCPCS CODES SUBJECT TO PA BY ANONYMIZED INSURER**



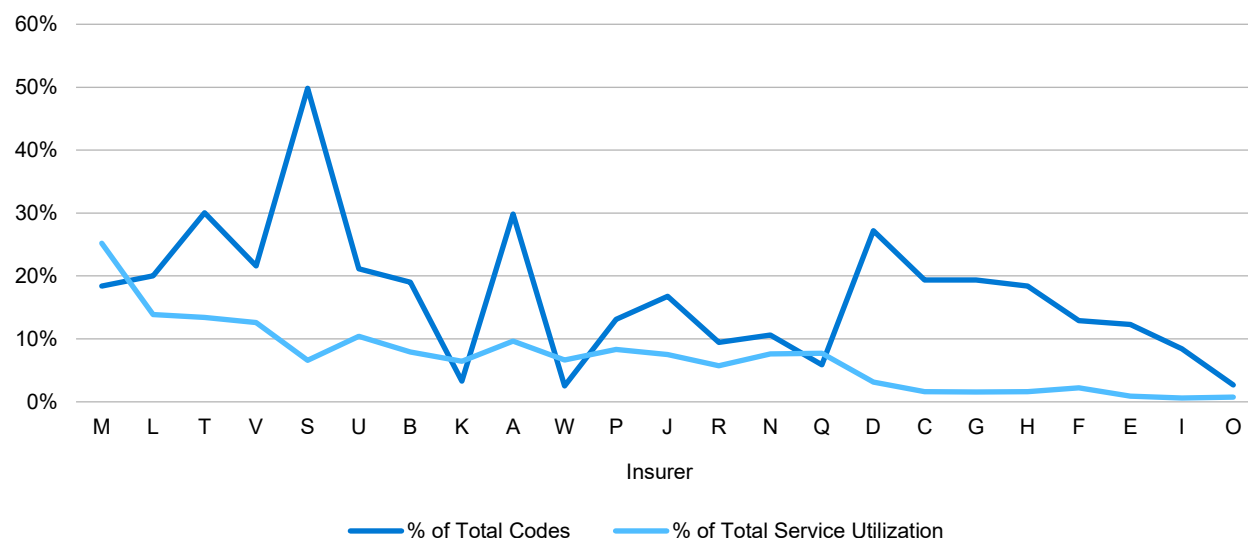
Note: Insurer S's percentage of total codes of 83% has been capped at 50% for display purposes.

As noted previously, insurers choose codes using multiple criteria, including clinical, cost, and operational considerations, the details of which are not publicly available. This degree of variance lends weight to critics' argument that there is no consistency between insurers.<sup>13</sup>

**Utilization of services with HCPCS codes subject to PA review**

Figure 6 displays the percentage utilization of services associated with the HCPCS codes subject to PA review, overlaid with the percentage of total codes from Figure 5.

**FIGURE 6: PERCENTAGE OF SERVICES SUBJECT TO PA REVIEW BY ANONYMIZED INSURER**



13. Even under agreed-to reforms by a large number of insurers (see 50+ insurers pledged to reform prior authorization. What's next?, retrieved April 16, 2026, from <https://www.advisory.com/daily-briefing/2025/06/25/prior-authorization>), reforms are in principle only. There is no single governing body that would or could drive specific criteria for a uniform selection of HCPCS codes subject to prior authorization review for all commercial insurers across the country. Moreover, an insurer's medical management expertise is a source of competitive advantage (or disadvantage), the details of which are, and will likely remain, closely held.

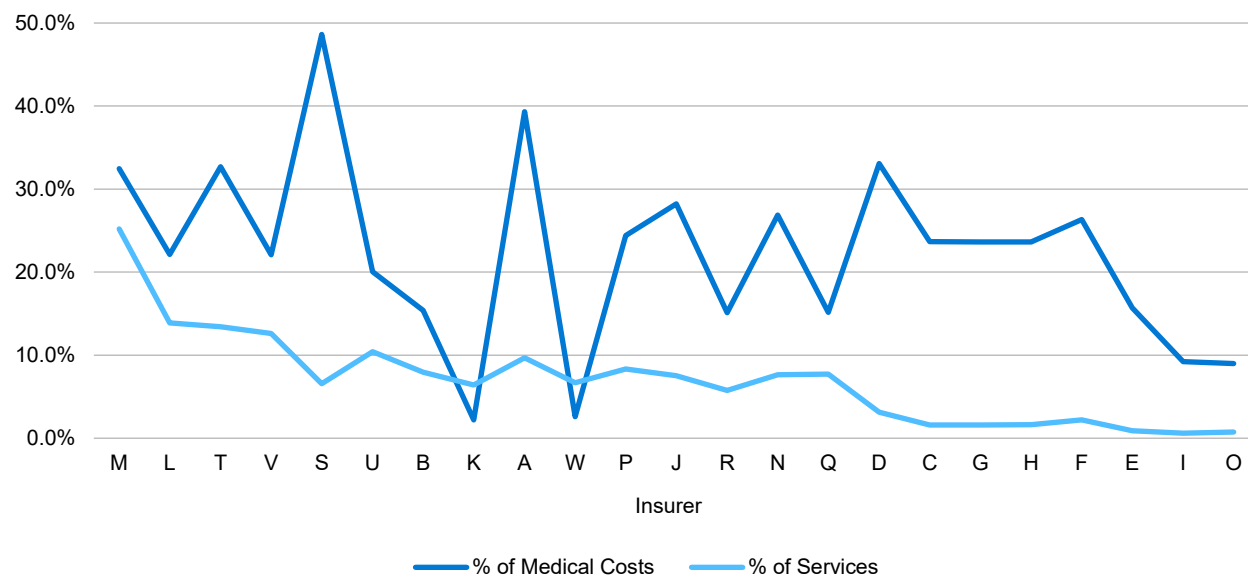
As can be seen in Figure 6, there is a weak relationship (27% correlation) across our 23 insurers between the percentage of total HCPCS codes subject to review and the associated utilization of services with these codes. In other words, a smaller number of codes reviewed does not always equate to proportionally fewer services reviewed. For example, insurer S subjects 83% of HCPCS codes to review, yet these codes account for only 6.6% of utilized services. In contrast, insurer M reviews approximately 18% of HCPCS codes, but those codes represent approximately 25% of utilized services.

Recall that this analysis uses a single, consistent data set that reasonably represents an industry average or benchmark, so these differences are not attributable to insurer-specific practices or population differences. Rather, differences are driven by the volume of HCPCS codes reviewed and the specific codes chosen. Although not necessarily efficient, in some cases, insurers may choose to subject certain low-utilization HCPCS codes to review, possibly for clinical reasons or because they have high instances of fraud.

### Medical costs associated with HCPCS codes subject to PA review

Finally, Figure 7 shows the percentage of medical costs associated with each insurer's PA code list.

**FIGURE 7: PERCENTAGE OF MEDICAL COSTS SUBJECT TO PA REVIEW BY ANONYMIZED INSURER**



Again, differences exist between the percentage of utilization and the percentage of medical costs because each of the various HCPCS codes subject to review by the insurer has a different cost per service.<sup>14</sup>

## Balancing competing priorities with an index

The previous measures are, as noted earlier, not only obtainable from public data but can also serve as reasonable quantitative proxies for competing priorities in PA reform and optimization efforts. Since policy priorities are often trade-offs, this suggests combining components into a composite index that numerically represents this reality. Weights can also be assigned to each quantitative measure to represent the relative importance of each policy priority.

14. This will be examined in more detail in Part 2 of this paper.

Figure 8 summarizes the development of this index using the components described above:

**FIGURE 8: DEVELOPMENT OF A COMPOSITE INDEX**



Based on this, we can design an index using the three components as follows:

$$Index = \frac{\% \text{ of Medical Spend}}{(\% \text{ of HCPCS} \times \% \text{ of Utilization})}$$

Because the components of the index are all percentages, this formula can be expressed in logarithmic form, allowing for the components to be additive and weights assigned to each. The final PAI takes the following form:

$$PAI = \ln(\% \text{ Medical Spend}) \times W_1 - \ln(\% \text{ HCPCS}) \times W_2 - \ln(\% \text{ Utilization}) \times W_3$$

Figure 9 displays all three components of the index, weighted equally, and the resulting PAI. The companies are then sorted from lowest to highest index. Companies in gray are the subject of additional commentary below Figure 9.

**FIGURE 9: PAIS OF 23 COMMERCIAL INSURERS**

COMPANY	WEIGHT = 33% % OF HCPCS CODES	WEIGHT = 33% % OF UTILIZATION	WEIGHT = 33% % OF MEDICAL SPEND	PAI
M	18%	25%	32%	0.65
L	20%	14%	22%	0.69
T	30%	13%	33%	0.70
V	22%	13%	22%	0.70
S	83%	7%	49%	0.73
U	21%	10%	20%	0.74
B	19%	8%	15%	0.77
K	3%	6%	2%	0.78
A	30%	10%	39%	0.87
W	3%	7%	3%	0.91
P	13%	8%	24%	1.04

COMPANY	WEIGHT = 33% % OF HCPCS CODES	WEIGHT = 33% % OF UTILIZATION	WEIGHT = 33% % OF MEDICAL SPEND	PAI
J	17%	8%	28%	1.04
R	9%	6%	15%	1.11
N	11%	8%	27%	1.17
Q	6%	8%	15%	1.17
D	27%	3%	33%	1.22
C	19%	2%	24%	1.44
G	19%	2%	24%	1.45
H	18%	2%	24%	1.46
F	13%	2%	26%	1.51
E	12%	1%	16%	1.65
I	8%	1%	9%	1.73
O	3%	1%	9%	2.03

Note: Companies in gray are the subject of additional commentary below.

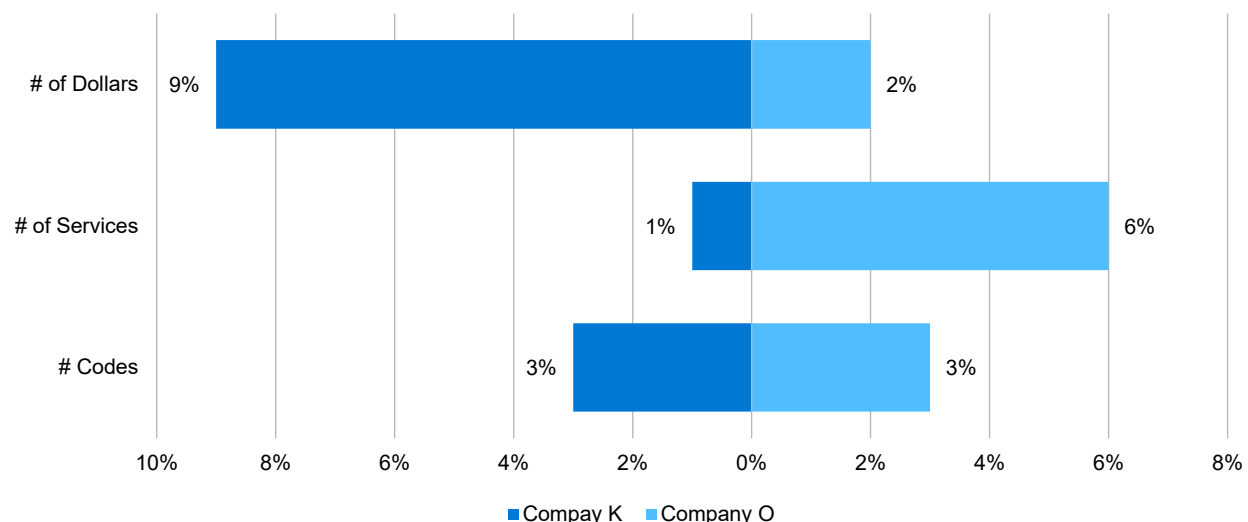
The range of PAI components and actual index values across insurers lends support to provider complaints of the lack of consistency across the industry. Specific case studies also provide insight:

**CASE STUDY 1: COMPANY O VERSUS COMPANY K**

In terms of the index, the best performer is Company O, which minimizes administrative expense by subjecting a small fraction of total HCPCS codes (3%) to review. Those codes only impact 1% of utilization (low patient impact) while managing to be attached to a reasonably high amount of medical spend (9%). This suggests a highly targeted approach, the results of which demonstrating that careful selection of codes can maximize cost control while minimizing negative impacts on patients and providers.

Contrast this with Company K, which has nearly the same number of HCPCS codes subject to review yet has a greater potential for negative patient impacts and controls far less medical spend (just 2%). Company K’s results highlight the risk of broad code selection without strategic focus, leading to higher administrative costs and less effective spend management.

FIGURE 10: CASE STUDY 1



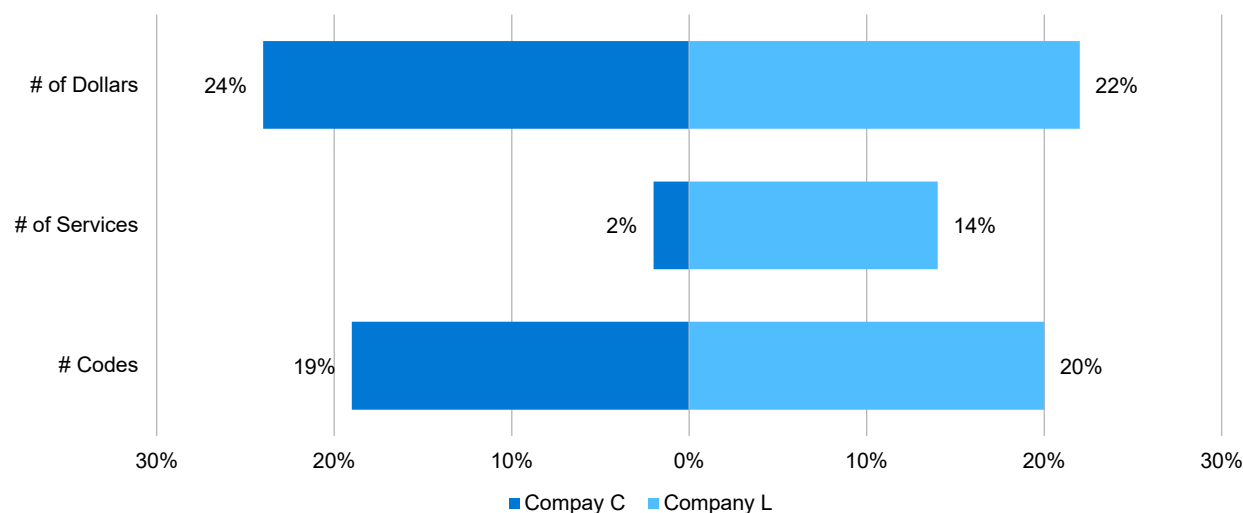
### CASE STUDY 2: COMPANY L VERSUS COMPANY C

Both companies C and L have a larger number of codes subject to review than in Case Study 1 (19%–20% of codes). Likewise, they both allow for greater control of medical spend (both greater than 20%). Yet once again, they perform much differently in terms of the index. The differentiator here is the percentage of utilization impacted, which is much higher for Company L (14% versus 2% for Company C).

Company L reviews a high percentage of codes and related services, which may increase administrative burden and patient impact, but achieves strong cost control (22%). Company L may benefit from refining its code selection to reduce unnecessary administrative work and potential for adverse patient interactions.

Company C reviews a similar percentage of codes but impacts far less utilization (2%), while controlling a high percentage of spend (24%). This suggests a more refined approach focusing on high-cost, low-volume services. Company C’s strategy shows that it is possible to achieve cost control with minimal potential for patient disruption by targeting the right codes.

FIGURE 11: CASE STUDY 2



### CASE STUDY 3: COMPANY S

Company S is the largest outlier in the 23-company sample, for several reasons. This company subjects 83% of HCPCS codes—nearly all of the available codes in our data set—to review. To put this in context, the next highest is 30%. Remarkably, this 83% of codes manages to affect only 7% of utilization, yet commands an impressive 49% control of medical spend. This is by far the highest in the sample. This indicates Company S places a high priority on cost control but a much lower priority on administrative expenses associated with its PA program.

#### Characteristics of high performers

Figure 12 summarizes how the lower PAI performers compare to the top PAI performers.

FIGURE 12: DIFFERENCES IN MEASURES BETWEEN HIGHER AND LOWER PERFORMERS

	% OF HCPCS CODES SUBJECT TO REVIEW	% OF UTILIZATION SUBJECT TO REVIEW	% OF MEDICAL SPEND SUBJECT TO REVIEW
Bottom half	23%	11%	24%
Top half	13%	3%	20%
% difference	-43%	-72%	-17%

- Top performers target fewer codes (13%/23% – 1 = 43% fewer).
- Top performers target fewer services to minimize the potential for adverse patient interactions (3%/11% – 1 = 72% fewer).
- Top performers target codes that are relatively higher cost per service. This can be seen in the high performers having less emphasis on cost control (20%/24% – 1 = 17% lower), but this difference is smaller than that of the other two measures.

The weights represent the relative priority of each measure for an insurer. The composite PAI illustrated uses equal weights between the components. However, different insurers may have different priorities and may want to understand how their programs compare to other programs with similar priorities. As an example, if the weight placed on cost-control increases, then Company O will begin to perform comparatively worse, as its cost-control component is relatively low at 9%.

## Strengths and limitations of the PAI

As with most index measurement tools, the PAI has strengths and limitations. Below, we outline the key advantages, limitations, and other considerations associated with the PAI.

### STRENGTHS

#### 1. Provides a quantitative measure for benchmarking

Benchmarking quantitative aspects of PA can serve as a tool in industry-wide reform efforts and process improvements across insurers. Assuming insurers and other stakeholders agree that the measures included in the PAI are relevant, the PAI can serve to decrease the wide variations observed and promote more uniformity across the commercial health insurance market.

#### 2. Provides quantitative results of clinical decisions

As mentioned previously, PA program design is a function of multiple sets of considerations, with clinical considerations arguably the most prominent. The results of those clinical decisions, however, have cost, utilization, and administrative impacts. The PAI can be used as a tool to understand the impact of decisions made based on clinical criteria.

#### 3. Flexibility to emphasize policy priorities

Because the PAI uses the natural logarithm of percentages, which can then be weighted, it allows for benchmarking based on insurer-specific operational priorities or industry-specific policy priorities. The weighting of the PAI components can be used as an agreed-upon priority that all insurers in the industry can measure against.

#### 4. Simply and easily interpretable

The usefulness of any index is in its clarity and usability by decision makers. The PAI provides an intuitive method with easy-to-understand components derived from publicly available data and, when applied to a uniform data set, provides valid comparisons across insurers.

## LIMITATIONS

### 1. Index components may be weak proxies for policy priorities

The number of HCPCS codes chosen for PA review is not a complete proxy for administrative expense. Each review may have different degrees of complexity and resource utilization that a quantitative index may not capture. An improved index might involve weighting HCPCS codes with an estimate of review complexity and associated expense. Moreover, with the advent and rapid rise of AI in decision-making support for medical management personnel, administrative expenses related to PA could change dramatically in the near future.

### 2. The PAI does not consider other reasons for PA review

The selection of a particular HCPCS code may make sense from a clinical perspective but may result in penalization in the PAI. But, as noted above, the PAI can, at a minimum, show the results of such decisions.

### 3. The PAI's focus is on code selection, not program execution

It is conceivable that two insurers could equally meet the PAI but have materially different results due to how strictly each insurer interprets and applies the clinical criteria associated with each code.

## Conclusion

Calls for reform of PA practices are being heard by payers.<sup>15</sup> As with many issues, changes responsive to these calls are tradeoffs: optimization exercises designed to balance competing priorities. As a composite index, the PAI is a quantitative expression of this important policy process. Although the PAI, as with any index, is not perfect, it does provide a standardized, quantitative measure that can produce comparable results between insurers and across the industry. Benchmarking is often the precursor to more best practices being adopted across the industry, driving much-needed consistency and standardization.

The PAI uses numerical components that are reasonable proxies for key PA features, making it easy for company leadership and clinicians to understand. The PAI can serve as one tool that can be combined with other criteria available to insurers, such as their clinical criteria and the FWA processes.

The PAI provides analysis and actionable information that many insurers are likely currently not unaware of. With additional drill-down into more detailed categories of care, such as ambulatory surgeries and imaging, insurers can obtain even more detail on what is driving their performance and potential changes they need to make.

In Part 2 of this white paper series, we explore the drivers of PAI performance at a more detailed category level and the components of the PAI.

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15. AHIP. (2026, April 6). Final letter to CMS: Clear communication of prior authorization. Retrieved April 16, 2026, from <https://ahiporg-production.s3.amazonaws.com/documents/Final-Letter-to-CMS-Clear-Communication-of-Prior-Authorization-4.6.2026.pdf>.

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