Prior Authorization in Medicaid: Regulating Artificial Intelligence

Issue Brief #3 in Prior Authorization Series

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Introduction

Automated systems are shaping the way all of us access and receive health care. Too often algorithms, not physicians, are answering the question of who gets treated. Insurers regularly use artificial intelligence (AI) and other forms of across the coverage process: deciding eligibility, routing requests to different departments, making coverage decisions, filling in records and forms, analyzing patient information, and increasingly, making recommendations about medical necessity. Unsurprisingly, state Medicaid agencies and Medicaid managed care organizations (MCOs) also use these tools to process prior authorization requests. AI not only exacerbates common problems with the prior authorization process (for more information, see Issue Brief #1 in this series), it also creates an entirely new set of concerns.[1]

AI is often promoted as a streamlining solution to many of the problems inherent in the prior authorization process, especially as a way to reduce paperwork and to speed up care approvals. In practice, these solutions remain mostly aspirational.[2] In fact, automation may not generate overall administrative savings at all.[3] Worse, the expansion of AI can leave patients in the dark about the prior authorization process and leave patients even more vulnerable to wrongful denial without their knowledge.[4] Because Medicaid serves historically marginalized people, the risks of AI-driven prior authorization are especially serious. These systems often rely on historical insurance data from across the system (not just Medicaid) –

[1] Brit Vanneman, *Prior Authorization in Medicaid: Issue Brief 1 – Prior Authorization and the Critical Need for Reform* (Nov. 2025), https://healthlaw.org/wp-content/uploads/2025/11/Vanneman_Prior-Auth-Issue-Brief-1_11242025.pdf.
[2] *See, e.g.*, Michelle M. Mello et al., *The AI Arms Race in Health Insurance Utilization Review*, 45 HEALTH AFF. 1 (2026), *available at* https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00897.
[3] Mello et al., *supra* note 2.
[4] *Id.*

data embedded with long-standing inequities and biases related to access to health care services.[5] AI holds promise to reduce some inefficiencies, but only if effectively regulated.[6]

This brief explores how AI is used in prior authorization, why AI use specifically raises equity and due process concerns in Medicaid, and where existing safeguards do not go nearly far enough. It also includes a review of recent state regulatory efforts and the current federal administration's efforts to undermine state autonomy on this issue.

Defining Artificial Intelligence

AI is typically an umbrella term that refers to all kinds of technology that enables "computers and machines to mirror human learning and decision-making."[7] For purposes of this brief and its use in prior authorization, AI includes algorithms, which the Medicaid and CHIP Payment and Access Commission (MACPAC) defines as "a procedure or set of rules that is applied to a dataset to achieve a certain function or purpose," as well as more advanced AI systems, which "can, for a given set of human-defined objectives, make predictions, recommendations, or decisions influencing real or virtual environments."[8]

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[5] Raj M. Ratwani, Karey Sutton & Jessica E. Galarraga, *Addressing AI Algorithmic Bias in Health Care*, JAMA VIEWPOINT (2024), https://jamanetwork.com/journals/jama/fullarticle/2823006?guestAccessKey=3b97c280-5f58-4e5a-9069-2fe23971765a&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=olf&utm_term=090424&adv=000003260885.

[6] *Id.*

[7] Consumer Representatives to the Nat'l Ass'n of Ins. Comm'rs, *Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management* (Nov. 2024), https://healthlaw.org/wp-content/uploads/2024/11/20241111_Role-of-AI-in-UM_508_FINAL-v2.pdf.

[8] NHeLP principles that address AI and other forms of automated decision-making are laid out in our ADS principles guide. Elizabeth Edwards & David Machledt, *Principles for Fairer, More Responsive Automated Decision-Making Systems* (May 15, 2023), https://healthlaw.org/resource/principles-for-fairer-more-responsive-automated-decision-making-systems/. *See, also*, Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Automation in the Prior Authorization Process* (Feb. 27, 2025), https://www.macpac.gov/wp-content/uploads/2025/02/07_February-Slides_Automation-in-the-Prior.pdf. For a more technical definition, see the definition from the Organisation for Economic Co-operation and Development: "AI can include complex algorithms based on advanced statistical modeling, simple algorithms that automate decision trees, process automation, data matching, data mining, surveillance technologies that involve computerized analysis, like facial recognition,

Surveys show that 84 percent of major health plans in 16 states use AI or machine learning in some capacity across commercial, primarily for utilization management.[9] Thirty-seven percent use AI specifically for prior authorization and 56 percent use AI for utilization management more broadly (including prior authorization, concurrent utilization, and post-payment review).[10]

AI use in Medicaid prior authorization is less frequently talked about or studied, but it is certainly just as - if not more - widespread. According to a recent MACPAC survey, all 7 participating states and most MCOs within those states indicated they use automation to make medical necessity determinations, typically rules-based processes and algorithms.[11] Despite "widespread use" of AI, MACPAC found "limited transparency into how automation is being used and its impact on beneficiaries and the program."[12]

Payers and providers, including Medicaid MCOs and state agencies, deploy AI in a variety of ways in the prior authorization process. Some use automation to fill in the blank – that is to create text or summaries based on *existing* information. In the case of prior authorization requests or responses, this type of automation often pulls information from a patient's record.[13] These tools can ease administrative burden on providers. For example, they can gather required clinical information from a patient's electronic health record (EHR) or flag missing information before paperwork is submitted to the payer.[14] While these tools can

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different forms of machine learning, large language models, and generative AI." Organisation for Economic Co-operation and Development, *OECD AI Principles Overview* (n.d.), available at https://oecd.ai/en/ai-principles (last visited October 21, 2024).

[9] Mello et al., *AI Arms Race in Health Insurance Utilization Review*, supra note 2 (Citing National Association of Insurance Commissioners, *Health Insurance Artificial Intelligence Machine Learning Survey Results* (May 2025), https://content.naic.org/sites/default/files/inline-files/NAIC%20AI%20Health%20Survey%20Report%20.pdf)).

[10] *Id.*

[11] Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Automation in the Prior Authorization Process* (Feb. 27, 2025), https://www.macpac.gov/wp-content/uploads/2025/02/07_February-Slides_Automation-in-the-Prior.pdf.

[12] Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Report to Congress: Automation in the Prior Authorization Process* (June 2026), https://www.macpac.gov/publication/automation-in-medicaid-prior-authorization/.

[13] MACPAC, *Automation in the Prior Authorization Process*, *supra* note 12.

[14] Mello et al., *AI Arms Race in Health Insurance Utilization Review*, supra note 2 (providing five examples of these provider-facing tools: 1) Authorization Manager by Waystar, a predictive and generative tool that "determines need for authorization, pulls EHR data to populate and submit forms"; 2) Intelligent Authorizations by Notable Health, a generative tool

reduce administrative burden, they also reflect just how burdensome prior authorization is for providers, who have implemented AI tools to adapt to processes that require significant time investment.

Even straightforward tasks like collecting and summarizing data from EHRs are *still* vulnerable to errors. For example, these tools have been known to copy incorrect information and often overlook potentially important context that is not a straightforward pull – like a person's preferences, support network, or other socioeconomic factors. This is especially problematic when providers (or multiple providers) use different EHR systems and when EHR records may not exist for specific conditions or events. EHR standards usually vary not just across vendors, but also within the same hospital systems, leading to "disjointed, incomplete records" that negatively impact the accuracy of AI performance.[15]

Other automation and AI, like those payers use to make prior authorization decisions, pose even greater risks to beneficiaries and their access to timely care.[16] For prior authorization decisions, state Medicaid agencies or MCOs typically use AI to analyze historical claims and other datasets, which are usually not representative. The tool looks for patterns and predicts an outcome, and that prediction informs whether a service or treatment request is approved or denied.

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that "pulls EHR data to populate and submit forms"; 3) Authorization Advisor for AKASA, a generative tool that "pulls EHR data, and a chatbot finds answers to medical necessity questions using EHR"; 4) Myndshift PA Platform by Myndshift, a generative tool that "completes narrative form fields" and "validates payer rules; and 5) Doximity GPT by Doximity, a generative tool that "drafts request letters and appeals.")

[15] Issues that GAO described 10 years ago related specifically to Electronic Health Records (EHR) have yet to be resolved. These include "(1) insufficiencies in health data standards, (2) variation in state privacy rules, (3) accurately matching patients' health records, (4) costs associated with interoperability, and (5) the need for governance and trust among entities." U.S. Gov't Accountability Off., Electronic Health Records: *Nonfederal Efforts to Help Acehive Health Information Interoperability*, GAO-15-817 (Sep. 2015), available at: https://www.gao.gov/products/gao-15-817. *See, also*, U.S. Gov't Accountability Off., *Artificial Intelligence in Health Care: Benefits and Challenges of Machine Learning Technologies for Medical Diagnostics*, GAO-22-104629 (Sep. 2015); John D. Halamka et al., *Early Experiences with Personal Health Records*, 15 J. AM. MED. INFORMATICS ASS'N 1 (2008).

[16] Mello et al., *AI Arms Race in Health Insurance Utilization Review*, *supra* note 2 (noting the examples of payer-facing AI tools for PA, including: 1) AuthAI Intelligent UM (Availity) which is a predictive tool that "[c]lassifies requests to enable real time rule-based approval and routing" and 2) Clinical Intelligence by Cohere Health, a predictive tool that "[a]uto-approves routing musculoskeletal and cardiology requests based on policy data.")

In the prior authorization process, AI can:

- Compile, summarize, and analyze data to process prior authorization requests;
- Apply clinical and coverage criteria to prior authorization requests (often without transparency about who sets those criteria);
- Decide how much human review a request receives, or bypass it entirely;
- Issue or accelerate approvals and denials, sometimes in "real time"; and/or
- Generate recommendations and supporting materials, including for appeals.

Further complicating coordination, most AI tools are designed for either provider use or payer use, not both. This approach pits one AI system against another, with no clear clinical benefit and ultimately driving up the cost of care. Blue Cross Blue Shield recently announced that AI has added nearly $1 billion in extra administrative costs.[17] Even if AI lowers the cost of each prior authorization request, cheaper reviews may contribute to more services or treatments subject to prior authorization. That means more delays and denials, and worsened health outcomes.[18]

Rather than deescalate utilization management, providers and payers are now engaged in an "arms race," where each side deploys technology in response to the other.[19] Caught between the two sides using AI, patients often suffer the consequences.

Key Harms of AI-Driven Prior Authorization

Using AI for prior authorization processing can exacerbate challenges that stem from prior authorization use more generally. These include an overemphasis on cost containment, inadequate clinical oversight, limited transparency, potential for bias and discrimination, and variation in technical capacity.[20] Other challenges, like privacy, cybersecurity risks and the

[17] BlueCross BlueShield, *Press Release: Analysis Examines AI in Hospital Billing as Spike in Complex Patients Adds Nearly $1 billion in Extra Costs* (Sept. 24, 2026), https://www.bcbs.com/about-us/association-news/bcbsa-analysis-ai-coding-tools-affects-healthcare-costs.
[18] Jacob Murphy et al., *Adverse Effects of Health Plan Prior Authorization on Clinical Effectiveness and Patient Outcomes: A Systematic Review*, 139 AM. J. MED. 24 (Jan. 2026), https://pubmed.ncbi.nlm.nih.gov/40912445/5.00897.
[19] Mello et al., *AI Arms Race in Health Insurance Utilization Review*, *supra* note 2; Scott Howell, Perry T. Yin, & James C. Robinson, *Quantifying the Economic Burden of Drug Utilization Management on Payers, Manufacturers, Physicians, and Patients*, 40 HEALTH AFFS. 1206 (2021), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2021.00036.
[20] MACPAC, *Automation in the Prior Authorization Process*, *supra* note 12.

potential for distorted outcomes, are more unique to the AI tools themselves.[21] AI tools can also complicate appeals processes or systematize wrongful denials. The lack of regulatory oversight and enforcement related to prior authorization generally, and AI use in prior authorization processes specifically, create additional challenges for reining in abuses.

Bias at Scale

AI-driven systems are only as reliable as the data they are trained on. Medicaid disproportionately serves people with low incomes, people with disabilities and other chronic or complex conditions, children with special health care needs, and older adults who rely on long-term services and supports.[22] AI systems are poorly suited to this context because they typically draw on and learn from historical claims and utilization data that is not as diverse as the Medicaid population.[23] Often this source does not include Medicaid beneficiaries. Because the characteristics and health care needs of the Medicaid population can differ substantially from higher income groups, the skewed data can lead to inappropriate outcomes. Even Medicaid-specific utilization data reflects decades of inequity, underuse of care, and wrongful denials that affect some Medicaid subpopulations more than others. Medicaid data often capture patterns of access and spending rather than underlying medical need, which means the AI model can reproduce, or even amplify, structural disparities even when the tool appears neutral on its face.[24]

The Centers for Medicare & Medicaid Services (CMS) launched a pilot program earlier this year to implement prior authorization in Medicare known as WISeR (short for Wasteful and Inappropriate Service Reduction). The Electronic Frontier Foundation's investigation into the

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[21] In some popular discourse, this phenomenon is referred to as an AI "hallucination," but we avoid that term as it could be seen to reinforce stigma around mental health.

[22] Alice Burns, Elizabeth Hinton, Robin Rudowitz & Maiss Mohamed, *10 Things to Know About Medicaid*, KFF (Feb. 18, 2025), https://www.kff.org/medicaid/10-things-to-know-about-medicaid.

[23] *See, e.g.*, Elizabeth Edwards, Nat'l Health Law Program, *Preventing Harm from Automated Decision Making Systems in Medicaid* (June 14, 2021), https://healthlaw.org/preventing-harm-from-automated-decision-making-systems-in-medicaid/ (discussing examples of harm and citing through hyperlinks and related resources other examples harmful ADS and sources of bias, including related cases), Laleh Seyyed-Kalantari et al., *Underdiagnosis Bias of Artificial Intelligence Algorithms Applied to Chest Radiographs in Underserved Patient Populations*, 27 NATURE MED. 2176 (2021).

[24] Raj M. Ratwani, Karey Sutton & Jessica E. Galarraga, *Addressing AI Algorithmic Bias in Health Care*, 332 JAMA 1051, 1051–52 (2024), https://jamanetwork.com/journals/jama/fullarticle/2823006; Stephanie S. Gervasi et al., *The Potential for Bias in Machine Learning and Opportunities for Health Insurers to Address It*, 41 HEALTH AFFS. 372, 372 (2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01287.

pilot found that many of the vendors described using data sources like provider behavior, patient demographics, utilization management datasets, provider and payer performance metrics, and historical claims data.[25] As EFF reports, "[w]hether these sources could introduce bias or give too much weight to population-level patterns depends on how vendors use them to inform individual decisions. But we don't yet have these important details about vendors' data and algorithms."

We do know that when AI is trained on static, nonrepresentative, or outdated data, AI systems do not correct them. AI incorporates and can even amplify biases.[26] Researchers have shown, for example, algorithms often overlook Black patients and other underserved groups because the data training these models is shaped by a long history of unequal access and treatment.[27]

Moreover, AI vendors often have access only to structured electronic health record data about a beneficiary, which commonly excludes information about social determinants of health, functional limitations, unpaid caregiver supports, or housing instability. These omissions matter because they can cause AI tools to underperform when predicting needs for historically underserved populations, including Medicaid enrollees.[28]

Developers often attempt to reduce bias.[29] Common methods include adjusting the training data, changing which factors the model relies on, removing variables that can act as stand-ins for race or income, testing whether the model performs differently for different groups, and/or

[25] Lena Cohen & Matthew Guariglia, *New Records Obtained by EFF Expose More Problems with Medicare's AI Experiment*, Electronic Frontier Foundation (Oct. 27, 2026), available: https://www.eff.org/deeplinks/2026/10/new-records-obtained-eff-expose-more-problems-medicares-ai-experiment.
[26] Gervasi et al., *supra* note 24; Donna M. Christensen, Jim Manley & Jason Resendez, *Medical Algorithms Are Failing Communities of Color*, HEALTH AFFS. (Sept. 9, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210903.976632; Laleh Seyyed-Kalantari et al., *Underdiagnosis Bias of Artificial Intelligence Algorithms Applied to Chest Radiographs in Under-Served Patient Populations*, 27 NATURE MED. 2176, 2176–82 (2021), https://www.nature.com/articles/s41591-021-01595-0.
[27] *Id.*
[28] Gervasi et al., *supra* note 24; Mello et al., *AI Arms Race in Health Insurance Utilization Review*, *supra* note 2.
[29] Mirjam Pot, Kieusseyan & Barbara Prainsack, *Not All Biases Are Bad: Equitable and Inequitable Biases in Machine Learning and Radiology*, 12 INSIGHTS INTO IMAGING 1 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC7872878/.

monitoring the tool after it is deployed.[30] To audit when plans apply inappropriate clinical criteria within prior authorization decisions, qualified clinicians could review underlying medical records for a sample of cases (both approved and denied) to compare answers against the tool.

However, these steps have limitations, including that they are costly and still depend on the quality and completeness of the underlying data.[31] Even robust mitigation attempts are unlikely to resolve every issue that poor quality baseline data presents. And the fact is that in many cases, insurers ignore even basic attempts at testing for bias and bias mitigation when developing and deploying new AI tools.

Complicated Appeals Processes Obscure Systematic Wrongful Denials

As noted above, errors in prior authorization data are well documented across payers. For example, in 2022, CMS reported that 80% of prior authorization denials in Medicare Advantage were approved on resubmission.[32] Audits of Medicaid denials have also produced evidence of systematic wrongful denials by managed care companies, including due to the misapplication of clinical criteria.[33] Investigative reporting has also revealed how these managed care plans use automated systems to quickly deny care at scale.[34]

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[30] Ratwani, Sutton & Galarraga, supra note 5; Michael P. Cary Jr. et al., *Mitigating Racial and Ethnic Bias and Advancing Health Equity in Clinical Algorithms: A Scoping Review*, 42 HEALTH AFFS. 1359, 1359–68 (2023), https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00553.
31 *Id.*; Gervasi et al., *supra* note 24.
[32] Jeanne Fuglesten Biniek et al., *Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024*, KFF (Jan. 28, 2026), https://www.kff.org/medicare/medicare-advantage-insurers-made-nearly-53-million-prior-authorization-determinations-in-2024/; Boris Vabson, Andrew L. Hicks & Michael E. Chernew, *Medicare Advantage Denies 17 Percent of Initial Claims; Most Denials Are Reversed, but Provider Payouts Dip 7 Percent*, 44 HEALTH AFFS. 702 (2025).
[33] HHS, Office Inspector Gen., *Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization* (Dec. 2022), https://www.oversight.gov/sites/default/files/oig-reports/HHSOIG/32000201.pdf; Rob Sand, Office of Auditor of State of Iowa, *Report on a Review of Medicaid Member Appeals and Managed Care Organization Contract Compliance for the Period July 1, 2013 through August 31, 2019* (Oct. 20, 2021), https://www.auditor.iowa.gov/reports/file/66425.pdf.
[34] Patrick Reader, Maya Miller & David Armstrong, *How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them*, ProPublica (Mar. 25, 2023), https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims; Casey Ross & Bob Herman, *Denied by AI: How Medicare Advantage Plans Use Algorithms to Cut Off Care for Seniors in Need*, STAT (Mar. 13, 2023), https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/.

Despite this evidence, overall appeal rates remain extremely low. Medicaid beneficiaries appealed only 2% of MCO prior authorization denials in 2019.[35] According to MACPAC, a combination of factors discourage Medicaid beneficiaries from seeking appeals, despite having a due process right to challenge denials.[36] These include: appeals processes that are "challenging and burdensome to navigate," delayed denial notices that do not arrive in time to appeal within regulatory time frames, and notices that are "unclear and difficult to understand."[37]

A lack of clear notice may violate a Medicaid beneficiary's constitutional and Medicaid rights to understand the criteria used to make the decisions that affect access to care.[38] Medicaid guarantees beneficiaries timely and adequate notice, clear and specific reasons for adverse actions, meaningful opportunities to appeal, and continued benefits in many circumstances.[39] AI-driven prior authorization threatens these protections when decisions are cloaked behind automation, obscured rationales, or confusing, incomplete notices generated without regard to legal or accessibility standards.[40] Beneficiaries should know when AI is in use, how it is deployed, and what data and criteria the tools apply to produce data outputs.

Missing or Vague Clinical Criteria

Both in denial notices and at the time of plan selection, beneficiaries (and their providers) need access to clinical criteria, including the specific evidence-based, medical standards the AI tool applies to prior authorization decisions. Access to clinical criteria is also necessary to decide whether to appeal a denial or to present a rationale on appeal. Unfortunately, MCOs have acknowledged difficulty in "conveying clinical and legal language to beneficiaries," which

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[35] HHS, Office Inspector Gen., *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care* (July 2023), https://oig.hhs.gov/documents/evaluation/3157/OEI-09-19-00350-Complete%20Report.pdf.

[36] Medicaid & CHIP Payment & Access Comm'n, *Denials and Appeals in Medicaid Managed Care*, in Report to Congress on Medicaid and CHIP 21 (Mar. 2024), https://www.macpac.gov/wp-content/uploads/2024/03/MACPAC_March-2024-WEB-Final-508.pdf.

[37] *Id.*

[38] Jane Perkins, *Demanding Ascertainable Standards: Medicaid as a Case Study*, 3 CLEARINGHOUSE REV. 1 (Mar. 2016), https://healthlaw.org/resource/demanding-ascertainable-standards-medicaid-as-a-case-study/; *see generally* Nat'l Health Law Program, *Fairness in Automated Decision-Making Systems*, https://healthlaw.org/algorithms (Last visited Oct. 28, 2024).

[39] *Id.*

[40] *Id.*

means beneficiaries may lack adequate access to both the criteria used and the ways that those criteria are applied to AI-informed decisions.[41]

Federal regulations will require all Medicaid plans to post the clinical evidence that is necessary to obtain prior authorization approval by January 1, 2027, but that alone will not resolve these problems.[42] Medicare's WISeR pilot shows why. One AI vendor denied more requests than it approved in the program's first few months, and CMS questioned the vendor about "denials that appear inaccurate or inconsistent with applicable criteria."[43] Therefore, simply posting clinical evidence requirements will not protect against a tool that does not apply those criteria.

Even with transparent clinical criteria, AI cannot replace the crucial function of an individualized clinical review, especially for denials of care. Current managed care regulations require that adverse decisions be made by an individual who has "appropriate expertise."[44] A handful of states require individuals, not AI, to make the final call in any adverse decisions about covered care (this is known commonly as "human-in-the-loop review"). But having a human decisionmaker review denials does not necessarily alleviate concerns about AI's role in prior authorization.

Even where human reviewers nominally make decisions about denials, many payers still exploit loopholes or ambiguities to weaken the review.[45] They may pay reviewers who are not in the same field or practice specialty as the requesting clinician or hire reviewers who have faced malpractice claims or license restrictions.[46] In some cases, the human decision maker may not even have an active license to practice medicine. To combat this problem, some states set professional or training requirements for humans in the loop.[47]

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[41] Medicaid & CHIP Payment & Access Comm'n, *Denials and Appeals in Medicaid Managed Care*, in Report to Congress on Medicaid and CHIP 21 (Mar. 2024), https://www.macpac.gov/wp-content/uploads/2024/03/MACPAC_March-2024-WEB-Final-508.pdf.
[42] 42 C.F.R. § 431.80(b); 42 C.F.R. § 438.242(b)(7).
[43] Lena Cohen & Matthew Guariglia, *supra* note *25.*
[44] 42 C.F.R. § 438.210(b)(3) (2024).
[45] Patrick Rucker, David Armstrong & Doris Burke, *Doctors with Histories of Big Malpractice Settlements Work for Insurers, Deciding If They'll Pay for Care*, ProPublica (Dec. 15, 2023), https://www.propublica.org/article/malpractice-settlements-doctors-working-for-insurance-companies.
[46] *Id.*
[47] *See, e.g.*, H.B. 2175, 57th Leg., 1st Reg. Sess., 2025 Ariz. Sess. Laws ch. 165 (Ariz. 2025) (codified at Ariz. Rev. Stat. Ann. §§ 20-3103, 20-3407); S.B. 63, 2026 Reg. Sess., 2026 Ala.

Moreover, most AI systems select, summarize, or prioritize information, so human reviewers may only see what the system surfaces. In some cases, human reviews have reportedly lasted only seconds, raising serious questions about whether they meet basic standards of medical judgment or due process.[48] When reviewers are incentivized to make quick decisions, they are also more likely to defer to AI-generated recommendations, a phenomenon known as automation bias.[49] Compounded by time pressure generated by pushing reviewers to process requests in mere seconds to a couple minutes, human review can become a rubber stamp and not a meaningful safeguard.[50] States should monitor whether the human in the loop is giving into automation bias or making other errors.[51] For example, the state might require regular reliability tests to ensure that human reviewers' decisions meet clinical guidelines and are consistent over time.[52]

Limited Transparency for Beneficiaries and Regulators

In most cases, beneficiaries, state regulators, and even federal agencies are not told when and how state Medicaid programs or managed care organizations use AI. Beyond existing due process requirements, the only relevant federal standard is the 2024 Interoperability Rule (See Brief #2 in this series). It requires more detailed information in denial notices, but it says nothing specific about AI. These regulations also require data reporting to identify aggregate rates of appeal and overturn on prior authorization decisions. While aggregated data can help flag broad, systemic trends and is a good first step for reporting requirements, it often cannot identify problems tied to specific services. Many of the most consequential denials occur in high-cost or specialized services that represent only a small share of total prior authorization requests. As a result, aggregated data may not accurately show patterns of harm.

Acts No. 2026-589; Act of May 27, 2026, ch. 124, 3 §6, 2026 Minn. Laws (codified at Minn. Stat. §62M.08, subd. 3); H.B. 481, 2026 Reg. Sess., 2026 Va. Acts ch. 925 (codified at Va. Code Ann. §§38.2-3407.15:2, 38.2-3407.15:8).

[48] Rucker, Miller & Armstrong, *supra* note 34.

[49] *See, e.g.,* Kate Goddard, Abdul Roudsari, & Jeremy C. Wyatt, *Automation Bias: A Systematic Review of Frequency, Effect Mediators, and Mitigators*, 19 J. AM. MED. INFORM. ASS'N 121 (2012), https://pmc.ncbi.nlm.nih.gov/articles/PMC3240751/.

[50] Patrick Rucker, *A Doctor at Cigna Said Her Bosses Pressured Her to Review Patients' Cases Too Quickly. Cigna Threatened to Fire Her*, ProPublica, Apr. 29, 2024, https://www.propublica.org/article/cigna-medical-director-doctor-patient-preapproval-denials-insurance.

[51] Hannah Quay-de la Vallee & Kevin De Liban, Ctr. Democracy & Tech. & Benefits Tech Advocacy Hub, *Rethinking the Loop: Encircling Public Benefits AI with Human Oversight*, 27-44 (2025), https://cdt.org/wp-content/uploads/2025/09/2025-09-22-Humans-in-the-Loop-CDT-Civic-Tech-report-final.pdf.

[52] *Id.*

AI often hides patterns of harm from advocates and discourages beneficiaries from meaningfully challenging denials. Short deadlines, confusing notices, language and literacy barriers, non-accommodating systems, and lack of support to individuals navigating the process – problems that are already widespread in Medicaid – make matters worse for prior authorization decisions. Many wrongful denials go unchallenged because beneficiaries lack time, information, and resources. Especially in the case of opaque algorithms, beneficiaries (and their providers) often cannot tell what information is missing and why it matters. As a result, there are likely fewer complaints to help identify problems. This suggests that regulators should not rely on a complaints-driven oversight approach.

States could conduct meaningful audits of a sample of decisions to inform whether clinical guidelines are correctly applied. If the audit finds problems, the state could then examine the criteria used for the algorithm. The HHS Office of the Inspector General found that only 13 of 37 state Medicaid agencies reviewed regularly audit MCO prior authorization denials.[53]

Given the ample evidence of systemic denials by some MCOs, states should be doing more to make the appeals process simple and accessible. That includes improving the clarity and timeliness of notices and making it easier, per federal regulation, for providers to find the clinical criteria needed for approval and submit documents electronically for rapid turnaround.

In addition, states should consider the value of independent external medical reviews for AI denials, particularly when appeals are already so uncommon. As of 2023, only 14 states offer individuals the option to request an independent external medical review when their prior authorization appeal is denied, a process that happens automatically for Medicare enrollees.[54] And even in those states that offer external medical review, only 5% of upheld denials are reviewed.[55] While automatic external review would not solve the problem that too few individuals appeal, it would help to flag situations where plans issue blanket denials that get automatically overturned on review.

Overall, the lack of transparency makes it more difficult for regulators to monitor and enforce prior authorization decision making, especially when algorithms are involved. States typically have limited access to AI tools used in the prior authorization process, much less the details or resources to investigate potential harms. States are not powerless to act, but it will require the state to invest in oversight.

[53] HHS OIG Report, *supra* note 35.
[54] *Id.*
[55] *Id.*

Research Does Not Justify AI Use in Prior Authorization

AI tools can speed up painfully slow prior authorization timelines and ease burdens on providers. But a growing body of research shows they are not immune from the problems built into to prior authorization, or into AI generally.[56] For example, one recent review found that AI has indeed shown some limited "operational gains," but most of the supporting research has "high analysis bias, limited generalizability, [and] inadequate validation…"[57] Existing research also rarely looks at "patient- and provider-centered outcomes," "long-term system impact," or "demographic bias," and when it has, the research shows disparities.[58]

Despite "the effusive marketing claims by insurers and technology vendors, rigorous evidence that AI tools improve efficiency, accuracy, staff experience, or other metrics has yet to surface."[59] That gap is particularly troubling given how quickly the industry is deploying these tools to make high-stakes decisions. In fact, in response to reported issues with the WISeR program rollout, CMS sent requests for information or corrective action plans that highlighted systemwide "delays, technical failures, and a lack of communication with providers."[60]

Even still, vendors argue that AI's value lies in speeding up approvals for routine or clearly appropriate care. Cohere's Chief Data and AI Officer suggested a process where:

> "clinically trained AI can gather physician notes and claims history, evaluate requests against evidence-based guidelines, and return real-time approvals for appropriate care, giving submitting providers quicker answers while enabling clinicians to focus on complex cases that truly require human review."[61]

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[56] MACPAC identified several positive benefits regarding the use of AI in prior authorization, including administrative efficiencies, faster processing times, and standardization. MACPAC, *Automation in the Prior Authorization Process*, *supra* note 12; Mousavi T, Tohme Shaya F, Cooke CE, *Artificial intelligence in prior authorization and coverage decisions: A systematic review of methods, evidence gaps, and future implications for patient access*, 32 J MANAG CARE SPEC PHARM. 1135 (Sept. 2026), https://www.jmcp.org/doi/10.18553/jmcp.2026.32.9.1135.

[57] *Id.*

[58] *Id.*

[59] Mello et al., AI Arms Race in Health Insurance Utilization Review, *supra* note 2.

[60] Lena Cohen and Matthew Guariglia, *supra* note *25.*

[61] Gigi Yuen, *Why Prior Authorization Reform Will Fall Short Without Clinically Trained Agentic AI*, Healthcare IT Today (Jan. 20, 2026), https://www.healthcareittoday.com/2026/01/20/why-prior-authorization-reform-will-fall-short-without-clinically-trained-agentic-ai/.

This framing exposes a deeper flaw: if AI can reliably identify care that payers should always approve, why is prior authorization required for those services in the first place? Public distrust reflects these unanswered questions. Nearly two-thirds of U.S. adults have low confidence that health systems will use AI responsibly.[62] Lowering the per-transaction burden likely only increases the use of prior authorization and broadens the arms race.

Regulation and Oversight: States Take the Lead

While federal oversight of AI lags (see Issue Brief #2 and below), states have spearheaded efforts to regulate AI. State legislation frameworks vary widely, including both industry-wide and context-specific regulation.[63] Broad consumer protection laws which cover high-risk AI uses like health care decisions, usually offer the strongest enforcement tools. But they are losing steam. To narrow the scope, some states have proposed legislation to limit how government agencies employ AI (e.g., public benefits decisions), yet these are still rarely enacted. Legislation limiting insurer use of AI in utilization management like prior authorization has had more success (though most of these laws apply only to private insurance).

Broad Regulation of AI Using Consumer Protections: Colorado, Texas

Even after changes, **Colorado**'s framework remains a leading model for treating AI in health care as a civil rights and consumer protection issue. Since 2021, Colorado has regulated commercial insurers' use of predictive models and algorithms through SB 21-169.[64] Under this law, insurers cannot use external consumer data (like credit scores) or tools built on them in a way that unfairly discriminates. Insurers must maintain governance and risk-management frameworks, test these tools for discriminatory outcomes, and correct any problems they find.

The law, however, has limited reach. Prior authorization AI tools that run on clinical records or claims data may fall outside the scope entirely. It also does not address whether a denial is clinically appropriate. It does not give beneficiaries notice or appeal rights, and enforcement rests with the Division of Insurance. Perhaps most significantly for low-income individuals, it does not apply to Medicaid at all.

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[62] Peng Nong & Jacob Platt, *Patients' Trust in Health Systems to Use Artificial Intelligence*, 8 JAMA NETWORK OPEN e2460628 (2025), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2830240.

[63] For an example of model principles, see Consumer Representatives to the Nat'l Ass'n of Ins. Comm'rs, *Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management* (Nov. 2024), https://healthlaw.org/wp-content/uploads/2024/11/20241111_Role-of-AI-in-UM_508_FINAL-v2.pdf.

[64] S.B. 21-169, 73d Gen. Assemb., 1st Reg. Sess., 2021 Colo. Sess. Laws (codified at Colo. Rev. Stat. § 10-3-1104.9).

In 2024 Colorado enacted a stronger AI-related law. SB 24-205, the Concerning Consumer Protections in Interactions with Artificial Intelligence Systems Act, was at the time one of the most significant AI laws in the country.[65] The law applied to "high risk" AI use, including health care services and insurance. Rather than focusing narrowly on insurance, it established baseline consumer protections against algorithmic discrimination. The law imposed several duties, including that:

- Developers and deployers use reasonable care to protect consumers from discrimination.
- Developers give deployers information about known limitations and bias mitigation.
- Deployers tell consumers when a high-risk AI system is used. With an adverse decision, deployers must disclose the principal reasons, the system's role, the type and source of data used to make the denial, and offer a chance to correct data and to appeal, with human review if technically feasible.
- Deployers have risk management programs and conduct annual impact assessments.[66]

The 2024 law likely would have reached Medicaid prior authorization, yet it never took effect. A special legislative session pushed back implementation, due to concerns about overreach and its broad application.[67] In April 2026, xAI sued to block the law and the US Department of Justice intervened seeking to invalidate this approach.[68] These actions in Colorado may have chilled broad consumer-facing legislation this year. At least six states attempted and failed to pass similar legislation in 2026.[69]

In May 2026, Colorado repealed SB 24-205 and replaced it with SB 26-189. The new version of the law, which goes into effect on January 1, 2027, applies to "covered automated decision-

[65] Consumer Protections for Artificial Intelligence, S.B. 24-205, 74th Gen. Assemb., 2d Reg. Sess. (Colo. 2024) (codified at Colo. Rev. Stat. §§ 6-1-1701 to -1707)., repealed and reenacted by S.B. 26-189, 75th Gen. Assemb., 2d Reg Sess. (Colo. 2026).
[66] *Id.*
[67] CASRAI Editorial Bd., The Colorado AI Act: What It Requires, https://casrai.org/guides/colorado-ai-act-explained (last visited Nov. 10, 2026); Marianna Goodland, Gov. Polis Convenes New Working Group to Address Colorado's Lingering AI Law Challenges, Colo. Pol. (Oct. 16, 2025), https://www.coloradopolitics.com/2025/10/15/gov-polis-convenes-new-working-group-to-address-colorados-lingering-ai-law-challenges (last visited Nov. 10, 2026).
[68] Justice Department Intervenes in xAI lawsuit Challenging Colorado's 'Algorithmic Discrimination' Law, U.S. Dept. of Justice Off. Public Affairs (Apr. 24, 2026), https://www.justice.gov/opa/pr/justice-department-intervenes-xai-lawsuit-challenging-colorados-algorithmic-discrimination.
[69] Hawaii (HI SB 2967), Louisiana (LA HB 734), New Mexico (NM HB 28), New York (NY SB 1169), Vermont (VT HB 792), Washington (WA HB 2157, among others).

making technology" that processes personal data to generate predictions, classifications, scores, or similar outputs that "materially influence" consequential decisions.[70] It does not include a duty of "reasonable care" to prevent discrimination. It also drops requirements for risk management and impact assessments. Instead, it requires transparency measures: notice, plain-language explanations within 30 days of an adverse outcome, a right to correct inaccurate data, and meaningful human review to the extent commercially reasonable.[71]

Unfortunately, these protections will rarely reach Medicaid beneficiaries facing AI-driven prior authorization denials. First, the law retains an insurer safe harbor, and more sweeping, HIPAA-covered entities are largely exempt. That group includes state Medicaid agencies, Medicaid managed care plans, and their vendors. Even if it applied, entities would have 60 days to cure any violations and there is no private right of action (only Attorney General oversight).[72] *Note: Colorado also enacted a narrower law reaching both commercial and Medicaid managed care prior authorization decisions: HB 26–1139 (discussed below).*[73]

Texas has a narrower consumer protection law. The 2025 Texas Responsible Artificial Intelligence Governance Act (TRAIGA) bars AI tools that *intentionally* discriminate against consumers. The law requires all state agencies, including the Medicaid agency, to disclose AI systems at the time of use.[74] It also bars state agencies and any person from developing or deploying AI tools with the intent to "unlawfully discriminate." While it does not protect people with private insurance or those enrolled in MCOs (nearly all Medicaid beneficiaries in Texas), it does protect a very small number of Medicaid beneficiaries in FFS.[75] The state's Attorney General is able to seek civil penalties ranging from $10,000 to $200,000 for violations. How enforcement works against state agencies under this framework is unclear.

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[70] Many of the transparency protections in the first bill were eliminated, though it still includes requirements for notices, disclosures, and a consumer rights framework. Importantly, the new law prevents developers from contracting away their liability for discrimination. While there is no private right of action, the Attorney General may enforce it. S.B. 26-189, 75th Gen. Assemb., 2d Reg. Sess., 2026 Colo. Rev. Stat. §§ 6-1-1701-1709).

[71] *Id.*

[72] *Id.*

[73] H.B. 26-1139, 75th Gen. Assemb., 2d Reg. Sess. (Colo. 2026).

[74] Tex. H.B. 149, 89th Leg., R.S. (2025); Off. Of the Att'y Gen. of Tex., Consumer AI Rights, https://www.texasattorneygeneral.gov/consumer-protection/file-consumer-complaint/consumer-ai-rights (last visited Nov. 10, 2026).

[75] Tex. Leg. Budget Bd., Medicaid Overview 3 (Feb. 11, 2023), https://lbb.texas.gov/Documents/HAC_Summary_Recs/88R.pdf (reporting that 97% of Texas Medicaid beneficiaries receive services through managed care and 3% through FFS).

Regulation of AI in Public Benefits: New York

These state laws typically govern when and how a state government or agency can use AI while making public benefits decisions. Few states have enacted these laws; yet this may be the most direct way to protect Medicaid beneficiaries against wrongful AI denials.

New York attempted to regulate the state's use of AI for functions related to public benefits. The Legislative Oversight of Automated Decision-making in Government (LOADinG) Act, originally SB 7543, would have required human review and impact assessments before a state agency could use an automated decision-making system, including the state Medicaid agency. And, because the agency is ultimately responsible for managed care decisions, it would likely cover the deployment of AI by Medicaid MCOs. However, those requirements were repealed twice before taking effect.[76] Nevertheless, legislation that includes Medicaid prior authorization decisions in laws regulating AI in public benefits decisions remains a promising approach.

Targeted Regulation of AI in Utilization Management

These setbacks and mounting pressure from AI vendors have pushed states to narrow their focus to regulating specific use cases of AI in health care settings. During a time when public concern about prior authorization transparency has increased, many states are developing regulation at this intersection of AI and prior authorization.

In 2025, **Maryland** passed one of the most detailed statutory frameworks governing AI use in utilization management, though it does not apply to Medicaid fee for service (FFS).[77] HB 820 states that any AI denial must come from a human (not just banning AI as the "sole basis"). It defines AI broadly and applies regulations not just to payers, but also when a payer works through a contractor that uses AI, ensuring payers cannot contract away their responsibilities.

It also imposes substantive limits on how AI may be used. AI tools must base decisions on:

- An enrollee's individual medical and clinical history, including any relevant clinical information;
- Specific circumstances "as presented" by the requesting provider; and
- Individualized clinical consideration (beyond generalized datasets or algorithmic outputs).

[76] See Act of Dec. 21, 2024, ch. 674, 2024 NY Laws (enacting N.Y. State Tech. Law. §§ 401-404), amended by Act of Feb. 14, 2025, ch. 96., 2025 N.Y. Laws (limiting disclosures to employment tools); Act of Dec. 19, 2025, ch. 711, 2025 N.Y. Laws (adding art. 5), repealed by Act of Feb. 13, 2026, ch. 86, 2026 N.Y. Laws.

[77] H.B. 820, 447th Gen. Assemb., Reg. Sess. 2025 Md. Laws ch. 747 (codified at Md. Code Ann., Ins. §§ 15-10A-06, 15-10B-05.1).

Maryland requires quarterly reporting from carriers on adverse decisions, including the type of service at issue and whether the decision involved the use of AI (or algorithms or other software). This compliance data, some disaggregated, in addition to grievance outcomes related to prior authorization or AI, must be submitted to the insurance commissioner for an annual report to the Governor and General Assembly. These reports are typically posted publicly. Most importantly, Maryland's law requires equitable applications and prohibits software tools that result in "unfair discrimination" – unfair is not defined – or that directly or indirectly cause harm to an enrollee. Follow up legislation enacted this year, known as HB 1563, lets the Insurance Commissioner examine patterns of adverse decisions, including via AI use.

Other states have taken smaller steps to regulate AI in utilization management by:

- Banning AI as the "sole" basis for denial and/or requiring some human-in-the-loop for denials;
- Relying on voluntary disclosure of AI use by payers, including aggregated information;
- Requiring some transparency when AI is used in prior authorization;
- Providing some governance or oversight, but without enforcement or penalties;
- Or acknowledging application of other laws to UM decisions (without additional discrimination protections).

Banning AI for Denials and/or Modifications:

Texas and California ban any AI involvement in a denial.[78] Texas prohibits AI from even partially making or contributing to an adverse determination and any denial must cite the source of screening criteria, though MCOs may use AI to streamline approvals. California goes a step further by prohibiting AI from contributing to any denial, delay, or modification of care, even in part. In a more limited approach, **Nebraska, Washington, Iowa, Georgia,** and **Minnesota** prohibit AI from being the "sole basis" for denying care (and in some cases, delaying care), which means a human must be in the loop to deny care.[79]

[78] S.B. 815, 89th Leg., Reg. Sess. (Tex. 2025) (amending Tex. Ins. Code ch. 4201); S.B. 1120, 2023-2024 Reg. Sess. (Cal. 2024) (amending Cal. Health & Safety Code § 1367.01 and Cal. Ins. Code § 10123.135).

[79] L.B. 77, 109th Leg., 1st Sess. (Neb. 2025) (Ensuring Transparency in Prior Authorization Act); E2SSB 5395, 69th Leg., 2026 Reg. Sess., 2026 Wash. Sess. Laws ch. 157); H.F. 2635, 91st Gen. Assemb., 2026 Iowa Acts ch. 1087 (codified at Iowa Code §§ 249A.5-.6, 514F.8, 5141.13).; S.B. 444, 158th Gen. Assemb., Reg. Sess. (Ga. 2026) (codified at O.C.G.A. § 33-46-7.1); Act of May 27, 2026, ch. 124, 3 .§6, 2026 Minn. Laws (codified at Minn. Stat. §62M.08, subd. 3).

Qualifying Human-in-the-Loop Review:

Arizona, Alabama, Colorado, Minnesota, Nebraska, Virginia, and Washington require certain qualifications for humans in the loop. In these states, a physician or medical director review any prior authorization denial based on medical necessity.[80] In Arizona, a medical director must review denials. However, the law leaves unresolved questions about who qualifies as a medical director and whether specialty expertise is required. In Alabama, a licensed professional – not AI – must make every denial and AI use must be disclosed in writing. Enforcement runs through the Department of Insurance. Colorado's new law, effective January 1, 2027, requires human approval of AI-assisted medical necessity denials.

Requiring Individualized Review:

Arizona, Alabama, Colorado and Utah require individualized decision-making for prior authorization requests.[81] In Alabama, AI decisions must be individualized– in other words, based on the patient's medical history and circumstances. In Arizona, during a review, a medical director must use independent medical judgment and may not rely solely on recommendations from any other source, including AI (though not mentioned by name). The law does not say what criteria reviewers may use, but insurers must certify each year that AI does not rely solely on group data and that it does not discriminate.[82]

Nondiscrimination Protections

Colorado requires carriers to ensure that "[t]he artificial intelligence system is not used in any way that discriminates against individuals in violation of other state or federal laws."[83]
California requires that AI tools are applied fairly and equitably and are also open to state regulators.[84] In **Alabama**, insurers must certify that their AI tools do not discriminate.[85]

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[80] H.B. 2175, 57th Leg., 1st Reg. Sess., 2025 Ariz. Sess. Laws ch. 165 (Ariz. 2025) (codified at Ariz. Rev. Stat. Ann. §§ 20-3103, 20-3407); S.B. 63, 2026 Reg. Sess., 2026 Ala. Acts No. 2026-589; Act of May 27, 2026, ch. 124, 3 §6, 2026 Minn. Laws (codified at Minn. Stat. §62M.08, subd. 3); H.B. 481, 2026 Reg. Sess., 2026 Va. Acts ch. 925 (codified at Va. Code Ann. §§38.2-3407.15:2, 38.2-3407.15:8).
[81] H.B. 2175, 57th Leg., 1st Reg. Sess., 2025 Ariz. Sess. Laws ch. 165 (Ariz. 2025) (codified at Ariz. Rev. Stat. Ann. §§ 20-3103, 20-3407); S.B. 63, 2026 Reg. Sess., 2026 Ala. Acts No. 2026-589; H.B. 26-1139, 75th Gen. Assemb., 2d Reg. Sess. (Colo. 2026); S.B. 319, 66th Leg., 2026 Gen. Sess. (Utah 2026) (codified at Utah Code Ann. § 31A-22-650).
[82] 2025 Ariz. Sess. Laws ch. 165 (Ariz. 2025) (codified at Ariz. Rev. Stat. Ann. §§ 20-3103, 20-3407).
[83] H.B. 26-1139, 75th Gen. Assemb., 2d Reg. Sess. (Colo. 2026).
[84] S.B. 815, 89th Leg., Reg. Sess. (Tex. 2025) (amending Tex. Ins. Code ch. 4201); S.B. 1120, 2023-2024 Reg. Sess. (Cal. 2024) (amending Cal. Health & Safety Code § 1367.01 and Cal. Ins. Code § 10123.135).
[85] S.B. 63, 2026 Reg. Sess., 2026 Ala. Acts No. 2026-589.

Mandating Transparency:

Indiana and **Utah** both passed laws in 2026 to ensure beneficiaries know when AI has made a prior authorization denial.[86] Indiana requires disclosure when AI is used in a prior authorization denial. In Utah, which focuses on transparency more broadly, insurers must also post prior authorization statistics.

Creating Reporting / Auditing Structures for Oversight:

Nebraska requires disclosure of AI use to the Department of Insurance, network providers, and enrollees, and on the public website.[87] Nebraska and **Texas** authorize the Department of Insurance to audit AI using existing authorities.[88] Covered plans in **Colorado** must report information to either the Division of Insurance or Department of Human Services and are subject to periodic audits.[89]

No state that we examined spells out specific penalties, nor grant beneficiaries (including Medicaid beneficiaries) a private right of action to enforce protections. Enforcement typically relies on existing insurance regulatory authority, thus limiting oversight and effectiveness.

Application to Medicaid:

No state law surveyed applies to the state Medicaid agency's own FFS prior authorization decisions. **Maryland, Texas, California, Georgia, and Minnesota** only reach Medicaid managed care plans. The remaining state laws do not appear to cover Medicaid at all.

More Comprehensive Approaches in Pending Legislation:

Pennsylvania's HB 1925 (2025) is one of the most comprehensive and promising models for regulating AI in health care utilization management. It would regulate AI use by insurers regulated by the Department of Insurance as well as all Medicaid beneficiaries in MCOs, which is 92 percent of Pennsylvania's Medicaid population.[90] Though not yet law, the bill recently

[86] H.E.A. 1271, 124th Gen. Assemb., 2d Reg. Sess., Pub. L. No. 88-2026 (Ind. 2026) (codified at Ind. Code ch. 27-1-52); S.B. 319, 66th Leg., 2026 Gen. Sess. (Utah 2026) (codified at Utah Code Ann. § 31A-22-650).
[87] L.B. 77, 109th Leg., 1st Sess. (Neb. 2025) (Ensuring Transparency in Prior Authorization Act).
[88] S.B. 815, 89th Leg., Reg. Sess. (Tex. 2025) (amending Tex. Ins. Code ch. 4201).
[89] H.B. 26-1139, 75th Gen. Assemb., 2d Reg. Sess. (Colo. 2026).
[90] Pennsylvania's current legislative session ends on November 30, 2026, and the bill has not advanced in the Senate, so it will likely need reintroduction next session. PA H.B.1925, LegiScan, https://legiscan.com/PA/bill/HB1925 (last visited Nov. 10, 2026).

passed the Pennsylvania House by a bipartisan 144-59 vote, with 41 Republicans joining all Democrats in support.[91]

The proposed legislation includes extensive transparency and oversight requirements. Covered entities must disclose AI use to all beneficiaries in plain language and maintain public information about their use. Utilization review determinations must consider the beneficiary's individual medical and clinical history and any circumstances that the requesting provider presents. The bill bars AI from replacing independent clinical judgment. It requires that AI systems are applied "fairly and equitably" (including in compliance with future HHS regulations), periodically reviewed and updated, and designed to avoid foreseeable, material risks of harm. Payers must also file annual compliance statements, including evidence of the above requirements. It extends obligations to third-party vendors and creates parallel duties (and civil penalties) for providers conducting utilization reviews, requiring independent judgment free from AI recommendations.

From an oversight standpoint, Pennsylvania's proposal is most notable for its enforcement provisions. The Department may issue civil penalties, even for negligent (not only intentional) violations. Other enforcement mechanisms include corrective action plans, classification of violations as unfair insurance practices, and associated legal remedies within that framework including injunctions on any activity that violates any provision of the bill. Still, the bill does not have a private right of action meaning people who are harmed may not sue.

North Carolina's HB 565 would bar AI as the sole decision-maker for prior authorization (and covers utilization review denials generally).[92] It would directly amend the state's Medicaid statute to apply to MCOs, in addition to regulating commercial insurance. The bill passed the House 110–01 in April and is currently pending in the Senate.

Other State Action

Apart from legislation, states have also started to regulate AI harms using other protections. For example, **Texas** secured a "first-of-its-kind-settlement" against an AI healthcare

[91] H.B. 1925, Printer's No. 3963, 209th Gen. Assemb. Reg. Sess. (Pa. 2026) (as passed by House, Sept. 30, 2026); *Pennsylvania House Passes Bill Requiring Patients Be Informed of AI Use in Health Care Decisions*, Ctr. Square (Sept. 30, 2026), https://justthenews.com/nation/states/center-square/house-passes-bill-requiring-patients-be-told-ai-use-health-care.

[92] H.B. 565, Gen. Assemb., 2025 Sess. (N.C. 2025) (5th ed., Senate Judiciary Comm. Substitute adopted June 23, 2026).

technology company for deceptive claims about the accuracy of its healthcare AI products.[93] The **New York** Attorney General brought an enforcement action against United Behavioral Health alleging violations of mental health parity laws, including use of an algorithm that allegedly led to denials of needed mental health care.[94] State attorney generals have also issued AI guidance, urged the federal government to take action, and taken steps to limit or prevent discrimination from such systems including in health care.[95] Governors have issued executive orders and taken other steps to protect people from harm.[96] **Tennessee** has established a council and **Washington** established a task force to oversee the use of AI in the state.[97]

Additionally, as of August 2026, at least 27 states, Washington, D.C., and Puerto Rico have adopted the National Association of Insurance Commissioners (NAIC)'s Model Bulletin, which is a framework that state Departments of Insurance can use to regulate AI in their insurance markets, including health insurance.[98] The model bulletin sets forth how the agency will

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[93] Texas Att'y Gen., *Attorney General Ken Paxton Reaches Settlement in First-of-its-Kind Healthcare Generative AI Investigation* (Sept. 18, 2024), https://www.texasattorneygeneral.gov/news/releases/attorney-general-ken-paxton-reaches-settlement-first-its-kind-healthcare-generative-ai-investigation.

[94] Manatt, Phelps, & Phillips, LLP, *Mental Health Parity Update: NQL and NY AG Actions Highlight Ongoing Scrutiny of NQTLs*, Health Highlights (Sept. 14, 2024), https://www.manatt.com/insights/newsletters/health-highlights/mental-health-parity-update-dol-and-ny-ag-actions.

[95] Crowell & Moring LLP, *States Are Taking Action on Artificial Intelligence. It Is a Trend That Is Likely to Continue* (Jan. 22, 2025), https://www.crowell.com/en/insights/client-alerts/states-are-taking-action-on-artificial-intelligence-it-is-a-trend-that-is-likely-to-continue; N.C. Dep't of Just., *Attorney General Stein Urges Federal Government to Restrict AI in Telemarketing* (Jan. 18, 2024), https://ncdoj.gov/attorney-general-stein-urges-federal-government-to-restrict-ai-in-telemarketing/; Cal. Off. of Att'y Gen., *Legal Advisory: Application of Existing California Laws to Artificial Intelligence in Healthcare* (2024), https://oag.ca.gov/system/files/attachments/press-docs/Final%20Legal%20Advisory%20-%20Application%20of%20Existing%20CA%20Laws%20to%20Artificial%20Intelligence%20in%20Healthcare.pdf.

[96] Nat'l Governors Ass'n, *Legal and Regulatory Considerations for States Related to Artificial Intelligence* (May 5, 2025), https://www.nga.org/updates/legal-and-regulatory-considerations-for-states-related-to-artificial-intelligence/.

[97] MACPAC, *Automation in the Prior Authorization Process*, *supra* note 12.

[98] Nat'l Ass'n of Ins. Comm'rs, Implementation of NAIC Model Bulletin: Use of Artificial Intelligence Systems by Insurers (Nov. 3, 2026), *Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management* (Nov. 2024), https://content.naic.org/sites/default/files/legal-adoption-map-ai-model-bulletin.pdf.

govern the development and use of AI and explains the information that the Department will request during an audit.

MACPAC also suggests that states use existing oversight and contracting mechanisms to increase transparency and ensure compliance.[99] We will discuss these tools in a future brief.

Suggestions for Strong Guideposts for State Regulation of AI

No matter the mechanism, future state approaches to regulating AI in prior authorization should:

- Explicitly apply protections to all Medicaid beneficiaries potentially subject to prior authorization, including those in managed care and fee-for-service;
- Differentiate requirements for different use cases of AI as they apply to the prior authorization process;
- Prohibit altogether AI involvement in prior authorization denials and delays;
- Require truly independent clinical judgment and designate specific qualifications, periodic reliability testing and other standards for human reviewers, including by mitigating any financial incentive structures that could create conflicts of interest;
- Require detailed notices to beneficiaries explaining when and how AI was involved in the prior authorization process, how the tool applied specific clinical criteria, what information the tool and/or a human reviewer considered, and an easy-to-follow, step-by-step guide to appealing;
- Mandate detailed, disaggregated reporting on when and how AI is used – broken down by service, procedure, item, or drug; and by denial, appeal, timeliness, and longer-term health outcomes;
- Mandate full, periodic audits and inspections of AI tools, including datasets; and
- Create liability for harms from AI tools, including an explicit private right of action.

Federal Actions Restrain State Governance

At the same time states are moving forward adopting frameworks governing AI, some federal proposals seek to limit states' ability to do so. Last year, congressional Republicans proposed sweeping legislation that would have barred states for ten years from enforcing any laws

[99] MACPAC, *Automation in the Prior Authorization Process*, *supra* note 12.

regulating AI.[100] Although the provision was ultimately removed from the One Big Beautiful Bill Act (OBBBA) after bipartisan pushback, its momentum is deeply concerning. It reflects a growing effort to shield AI deployment from accountability, to preempt promising state consumer and civil rights protections, and to prioritize "industry freedom" over patient safety at exactly the moment states are beginning to address harmful uses of AI in Medicaid.

The Administration's 2025 Executive Order on AI, "Ensuring a National Policy Framework for Artificial Intelligence," seeks to limit states' ability to enact and enforce their own AI safeguards.[101] The EO directed the Department of Justice to challenge state laws it views to conflict with the as-yet-undetermined federal AI policy. It also encourages DOJ to target state laws considered "onerous or excessive." Although not health-policy specific, the EO squarely targeted state legislation that regulates AI systems and automated decision-making in health care, even if its legality is questionable.[102] More recently, the White House released a framework for federal regulation of AI that qualified the language in the EO, noting that the national standard:

> "should respect key principles of federalism and not preempt the traditional police powers retained by the states to enforce laws of general applicability against AI developers and users, including particular laws to protect children, prevent fraud, and protect consumers."[103]

Still, at minimum the EO threatens to weaken enforcement of state protections and to push states toward less meaningful reforms that are easier for payers to evade.

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[100] Elizabeth Edwards & Brit Vanneman, *Big Government Republican Bill Keeps States from Reining in Bad AI: A 10-Year License for Unfettered Harm*, Nat'l Health L. Program (May 15, 2025), https://healthlaw.org/big-government-republican-bill-keeps-states-from-reining-in-bad-ai-a-10-year-license-for-unfettered-harm/.

[101] Exec. Order No. 14365, 90 Fed. Reg. 58,499 (Dec. 11 2025), https://www.whitehouse.gov/presidential-actions/2025/12/eliminating-state-law-obstruction-of-national-artificial-intelligence-policy/. There has also been subsequent action under scrutiny. *See, also*, Exec. Order No. 14409, 91 Fed. Reg. 34,565 (June 5, 2026).

[102] *Legal Issues Raised by the Proposed Executive Order on AI Preemption*, LAWAI (Nov. 19, 2025), https://law-ai.org/legal-issues-raised-by-the-proposed-executive-order-on-ai-preemption/.

[103] The White House, *National Policy Framework: Artificial Intelligence* 4 (Mar. 2026), https://www.whitehouse.gov/wp-content/uploads/2026/03/03.20.26-National-Policy-Framework-for-Artificial-Intelligence-Legislative-Recommendations.pdf.

The Trump administration is also pushing to expand the use of AI in health care. As noted above, CMS, through its Innovation Center, launched WISeR, a pilot program tested in 6 states to apply AI in prior authorization to certain items and services in traditional Medicare.[104] HHS hopes to set a precedent with the program, which launched on January 1, and to expand AI to more HHS programs, likely including Medicaid. Provider groups, including the American Medical Association, have strongly criticized WISeR.[105] Recent media reports have documented problems with implementation and the incentive structure in the pilot.[106] This summer, an attempt to pass a resolution to block and overturn the program in the Senate failed along party lines.[107] Most recently, the Electronic Frontier Foundation released records from CMS showing that the pilot has resulted in thousands of denials and widespread delays.[108]

HHS recently released a revised AI Strategy, which Secretary Kennedy suggested is the "template for the utilization of AI" across the federal government, and indicates HHS' commitment to being "all in" for AI.[109] HHS also released an information request "seeking broad public input on how HHS can accelerate the adoption and use of artificial intelligence as part of clinical care for all Americans."[110] Most troubling, HHS asks how existing regulations could be changed or removed to speed up AI adoption, without proposing any new

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[104] Ctrs. for Medicare & Medicaid Servs., *Wasteful and Inappropriate Service Reduction (WISeR) Model*, CMS Innovation Ctr., https://www.cms.gov/priorities/innovation/innovation-models/wiser.
[105] Am. Med. Ass'n, *Letter from the American Medical Association to Abe Sutton, Deputy Administrator & Dir.*, Ctr. for Medicare & Medicaid Innovation, Regarding the WISeR Model (July 16, 2025), https://searchlf.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/lfcts.zip/2025-7-16-Letter-to-Sutton-re-WISer-Model-v2.pdf.
[106] 172 Cong. Rec. S41 (daily ed. July 16, 2026) (Roll Call Vote No. 199), https://www.senate.gov/legislative/LIS/roll_call_votes/vote1192/vote_119_2_00199.htm.
[107] Senate Comm. on Fin. (Ranking Member), *Wyden, Murray, Gillibrand Lead Democrats in New Bill to Halt Trump Administration's Looming Medicare AI Prior Authorization Takeover* (Dec. 16, 2025), https://www.finance.senate.gov/ranking-members-news/wyden-murray-gillibrand-lead-democrats-in-new-bill-to-halt-trump-administrations-looming-medicare-ai-prior-authorization-takeoverdemocrats-fight-to-save-medicare.
[108] Centers for Medicare & Medicaid Services*, WISeR FOIA Response - Combined Records* (Sept. 9, 2026) (produced in *Electronic Frontier Foundation v. Centers for Medicare & Medicaid Services* (D.D.C. filed March 25, 2026)).
[109] U.S. Dep't of Health & Hum. Servs., *Artificial Intelligence Strategy* (Dec. 4, 2025), https://www.hhs.gov/sites/default/files/hhs-artificial-intelligence-strategy.pdf.
[110] U.S. Dep't of Health & Hum. Servs., *HHS Announces Request for Information to Harness Artificial Intelligence to Deflate Health Care Costs and Make America Healthy Again* (Dec. 19, 2025), https://www.hhs.gov/press-room/hhs-ai-rfi.html.

safeguards.[111] That puts longstanding patient and civil rights protections at risk. These HHS activities are concerning because they treat AI adoption as the objective, rather than improved patient outcomes or better, more efficient care delivery.

Once AI-enabled prior authorization is normalized in these spaces, vendors can point to it as the "new, federally accepted standard." This will make it harder for states to regulate. The combination of rapid AI expansion with shrinking oversight creates serious risk for Medicaid enrollees nationwide.

Conclusion

Ultimately, when AI is used to automate prior authorization, it does not merely replicate existing flaws. It creates significant harm and shifts risk onto the very people Medicaid is designed to protect. While some states are making headway, most laws do not apply to Medicaid, and others may not do enough to curb systematic wrongful denials. Without the immediate adoption of strong and enforceable guardrails explicitly connected to Medicaid regardless of delivery system, AI will not fix costly delays and denials due to prior authorization in Medicaid. It will more likely entrench and amplify prior authorization's worst problems. State policymakers cannot wait for federal action or industry self-regulation. They must act now to ensure that Medicaid beneficiaries, not algorithms, remain at the center of coverage decisions.

[111] Brit Vanneman, Elizabeth Edwards & Shandra Hartly, *NHeLP Response to HHS RFI on Accelerating the Use of AI in Clinical Care*, Nat'l Health L. Program (Feb. 25, 2026), https://healthlaw.org/resource/nhelp-response-to-hhs-rfi-on-accelerating-the-use-of-ai-in-clinical-care/.