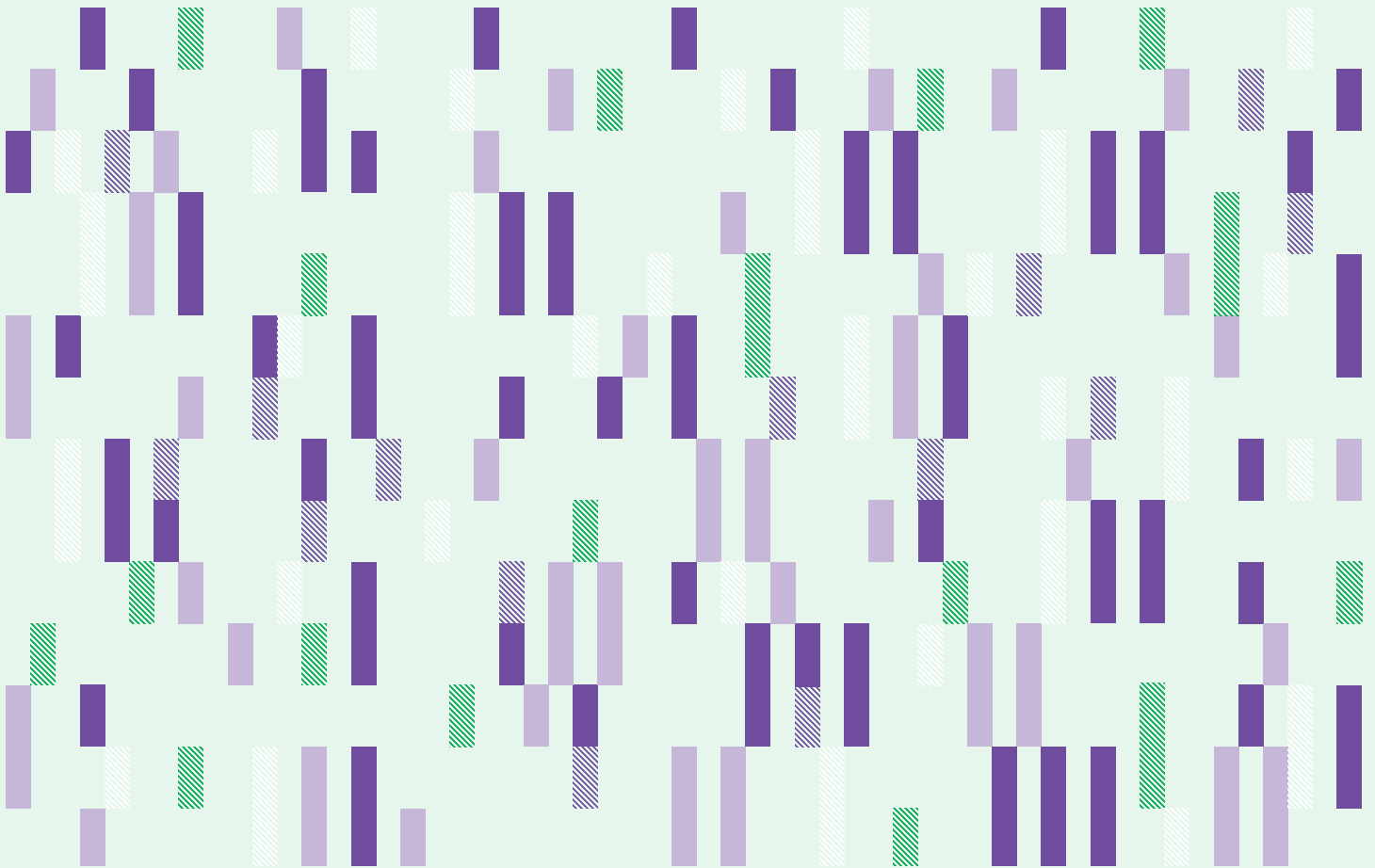


# Administrative AI: Current Use and Potential Impact

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# Executive Summary

Health systems, health plans, and policymakers are enthusiastic about the potential of emerging AI tools to address administrative waste in the U.S. healthcare system. New capabilities that enable activities such as documentation using ambient scribes, chart abstraction, billing, and parsing of complex health plan policies have generated high expectations that technology will drive meaningful administrative efficiency gains.

In January 2026, the Peterson Health Technology Institute (PHTI) convened senior leaders from health systems, health plans, technology developers, investment firms, and federal agencies to discuss how technology and policy can enable AI to reduce administrative costs, accelerate payment cycles, and promote appropriate high-value care.

The workshop focused on two administrative use cases where AI adoption is accelerating: (1) prior authorization and (2) medical billing. The workshop was held under the Chatham House Rule to encourage candid dialogue.

Of the estimated \$350 billion in U.S. healthcare administrative waste annually, \$266 billion is attributed to administrative complexity and \$59–\$84 billion to fraud and abuse.<sup>1</sup> Billing and transaction costs are a significant driver of administrative complexity, with the cost per healthcare bill in the United States far exceeding that of peer nations.<sup>2</sup> This is a result of unique payment rules, documentation requirements, and compliance standards that vary across health plans.

Health plans and healthcare providers are increasingly deploying AI tools to facilitate burdensome administrative processes. For example, in prior authorization, providers are using AI tools to automate submissions, while plans use AI to triage and evaluate prior authorization requests. In medical billing, providers use ambient scribing and AI-assisted coding tools to capture increasing clinical complexity and automate billing, while health plans use AI to assist reviewing and processing claims.

Though we are still in the early stages of administrative AI adoption, it has become clear that rapid AI deployment by both providers and health plans to support prior authorization and medical billing transactions risks increasing levels of system activity without reducing costs. Under existing incentive structures, AI automation could increase the volume of prior authorization back-and-forth, rather than making the process more efficient. AI-assisted coding tools could accelerate coding intensity and charge capture, which—even if accurate—would have an inflationary impact on healthcare costs.

Against this backdrop, participants gathered to explore the following questions:

- How can AI simplify and reduce administrative processes by removing wasteful steps, while maintaining necessary oversight and accountability?
- To what extent has current adoption reduced administrative friction?
- What market-shaping actions can mitigate inflationary risk to ensure that AI adoption delivers net savings?

The following takeaways emerged from the discussion:

### **Prior Authorization**

- 1** AI may reduce the cost for individual organizations to execute prior authorizations, but it has not reduced overall system-level costs.
- 2** Real-time prior authorization at the point of care is an emerging model, but current proofs of concept are narrow and not yet scalable.
- 3** Data standards and digitization of medical policies can reduce information asymmetry, but AI's impact is limited by variation across medical policies.
- 4** AI is exposing and exacerbating fundamental issues within the underlying prior authorization process.

### **Medical Billing**

- 1** Provider deployment of AI is increasing billing intensity and inflating medical spending.
- 2** Health plans are beginning to respond to AI-driven increases in billing intensity with across-the-board downcoding and other reimbursement reductions, but the impact of these cuts is not yet known.
- 3** Reimbursement policy is the strongest lever to drive administrative efficiencies and system-level cost savings.

The discussion reinforces a core reality: as currently deployed, AI in healthcare administrative processes is likely to achieve only some of its goals—such as reducing the manual effort for organizations to execute prior authorization requests and submit billing claims—while simultaneously increasing healthcare costs. When applied on top of flawed administrative workflows, data complexity, and incentive structures, AI exacerbates the underlying issues. Realizing the potential for AI to reduce administrative waste will require redesigning the processes on which the technology is being deployed.

# Prior Authorization

Prior authorization plays a critical role in utilization management. Most health plans require advanced approval for select healthcare services and medications to promote evidence-based, guideline-driven care and to control costs. The process is estimated to reduce as much as 5% of medical and drug spending.<sup>3,4</sup>

The prior authorization process is administratively burdensome because of inconsistent requirements across health plans and operational inefficiencies (Exhibit 1).

## A Targeted Experiment: Prior Authorization in Traditional Medicare

Traditional Medicare has historically not employed prior authorization for utilization management. Through the WISeR (Wasteful and Inappropriate Service Reduction) Model, CMS is now testing the use of targeted prior authorization—leveraging AI and machine learning technologies—in Traditional Medicare for a limited set of services that have a high risk of waste or inappropriate use. This is a notable policy change and a closely watched test case for how technology, including AI, can be applied to reduce wasteful utilization.

### Exhibit 1: Illustrative Sources of Administrative Complexity in Prior Authorization

Lack of Consistent, Transparent Requirements Across Health Plans	
<b>Varying prior authorization requirements</b>	There are more than 5,000 procedure codes requiring prior authorization across four major U.S. insurers; of those, only 3% require prior authorization across all four payers. <sup>5</sup>
<b>Varying medical necessity policies</b>	Definitions of medical necessity are inconsistent across plans, as are the clinical guidelines and procedural steps required to demonstrate it. Within a health plan, determinations can vary based on the discretion and interpretation of individual reviewers.
<b>Benefit design and intermediaries</b>	Employers and plan sponsors shape benefits packages; intermediary vendors (e.g., clinical criteria vendors) control the intellectual property of medical policies.
Operational Inefficiencies	
<b>Enrollment data lag</b>	Prior authorization requires verifying patient enrollment in a health plan. Delays in enrollment data availability limit providers' ability to confirm coverage status at the point of care.

<b>Data mismatches</b>	Inconsistent or erroneous data across health plan and provider systems (e.g., provider names, addresses, plan names), which are often due to manual input.
<b>Manual submission process</b>	Only 40% of prior authorization transactions are automated; the majority still rely on manual, phone- or fax-based workflows. <sup>6</sup>
<b>Electronic health record (EHR) workflow limitations</b>	EHR vendors control most workflows used to identify patient coverage and match requests to health plan policies, limiting providers' ability to directly access payer-specific prior authorization requirements at the point of care.

This complexity creates friction for health plans, providers, and patients alike. Across health plans, one in 10 prior authorization submissions are initially denied.<sup>7,8</sup> Of the 12% of Medicare Advantage denials that are appealed, 82% are ultimately overturned.<sup>9</sup>

Workshop participants noted that back-and-forth disagreement can result from misalignment with clinical criteria, administrative criteria, or both, as illustrated in Exhibit 2. These ongoing exchanges drive delays in care for patients<sup>10</sup> and high costs for providers and health plans: each prior authorization submission cycle is estimated to cost health plans \$40–\$50 and providers \$20–\$30.<sup>11</sup>

**Exhibit 2: Types of Prior Authorization Requests**

		Clinical Criteria	
		ALIGNED	NOT ALIGNED
Administrative Criteria	ALIGNED	<p><b>Straightforward</b> <i>(Lowest cost)</i></p> <p>Request aligns with medical necessity criteria and is supported by complete and accurate documentation. Payers are well-positioned to adjudicate in real time.</p>	<p><b>Clinically Contentious</b> <i>(High cost)</i></p> <p>Request includes complete and accurate documentation but requires nuanced clinical interpretation or adjudication. Often involves high-cost, high-risk, or borderline indications and may need to be escalated to peer-to-peer review.</p>
	NOT ALIGNED	<p><b>Administratively Burdensome</b> <i>(Medium cost)</i></p> <p>Request aligns with medical necessity criteria but is delayed or denied due to clerical or data quality issues (e.g., mismatched eligibility data, documentation gaps); resolvable with additional information.</p>	<p><b>Clinically Contentious and Administratively Burdensome</b> <i>(Highest cost)</i></p> <p>Request requires nuanced clinical interpretation and includes clerical or data quality issues. Requires both clinical escalation and administrative remediation.</p>

Whether any given prior authorization request is “straightforward” or complex is often not apparent at the point of submission. Data errors, such as mismatched eligibility information, can obscure whether a request meets clinical criteria, making it difficult to determine upfront whether a request is administratively burdensome, clinically contentious, or both (Exhibit 2). This distinction often only becomes apparent during the review process.

While speeding up straightforward requests can reduce administrative friction and care delays, the greatest opportunity for efficiency gains depends on reliably identifying contentious or burdensome requests at the point of care and submission. Minimizing the number of prior authorizations that enter multistep review cycles is essential for decreasing administrative costs.

There is shared stakeholder interest in improving prior authorization. Participants agreed on the need to deliver accurate coverage information at the point of care, enable faster and clearer decisions, reduce care delays, and better manage costs across the system. Momentum is building, driven by shared recognition of

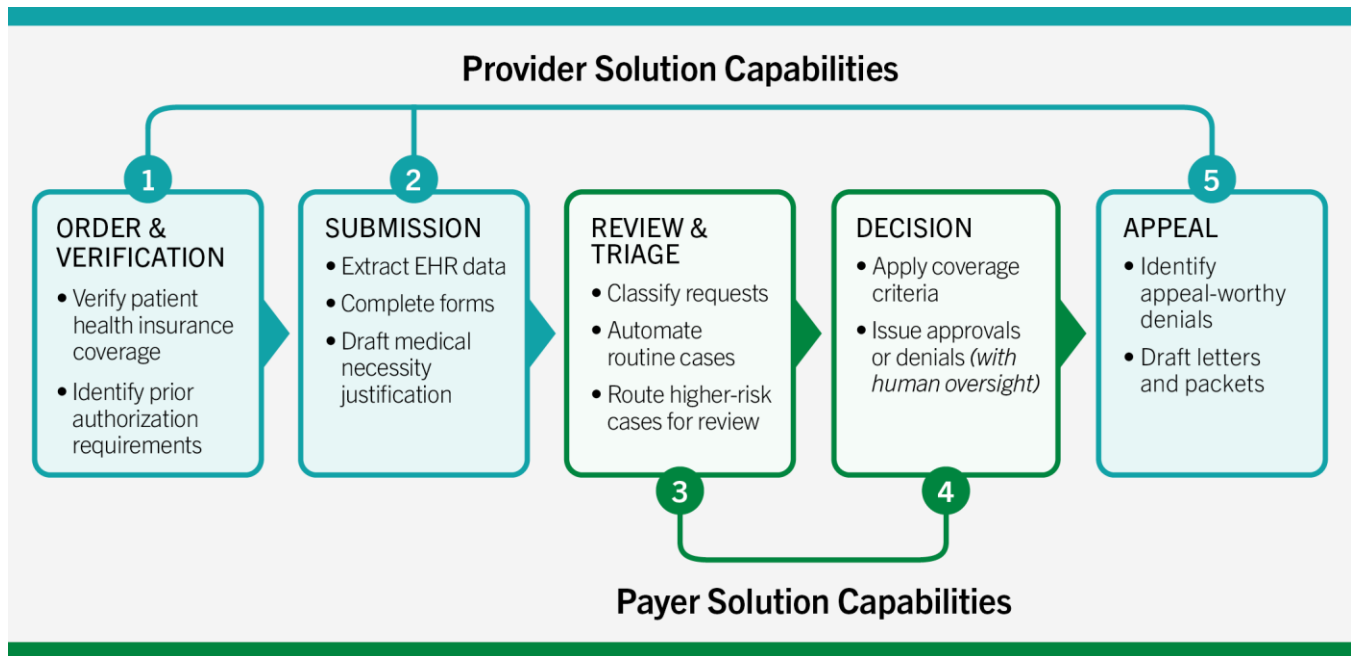
these inefficiencies, advances in AI, and growing policy attention. **How can technology and policy together enable AI to deliver system-level efficiency gains and cost savings?**

**Takeaway 1: AI may reduce the cost for individual organizations to execute prior authorizations, but it has not reduced overall system-level costs.**

Both plans and providers are making substantial investments to deploy AI tools.<sup>12</sup> On the provider side, for example, AI solutions can draft medical necessity justifications, complete submission forms, and generate appeals. On the health plan side, AI solutions triage requests by complexity and resolution pathways and provide decision support (Exhibit 3), among other capabilities.

“AI tools are flooding the system. Bots don’t get tired of asking questions, so my review queue keeps growing.”  
—Healthcare provider describing back-and-forth on prior authorization requests

**Exhibit 3: Simplified View of AI Solutions in the Market Today**



These tools enable providers to submit more complete requests with less effort, and health plans to process higher volumes of submissions at a lower cost per decision. While insurers and vendors have reported that AI can expedite steps in the prior authorization process, there is no evidence yet that this translates to lower average cost per claim factoring in the cost of the AI solution.<sup>13</sup> As such, participants raised concern that optimizing each side of the transaction risks making the overall process more activity-intensive, rather than more efficient (Exhibit 4).

#### Exhibit 4: Risks of Current AI Deployment in Prior Authorization

<b>Increased system activity</b>	Several participants reported observing “bot wars,” or automated back-and-forth exchanges that multiply the volume of communications per prior authorization.
<b>Limited impact on the most clinically contentious cases</b>	Complex prior authorization requests are often difficult to identify and address at the point of submission, limiting the potential for AI to accelerate resolution. This reduces the impact AI can have on requests that drive the greatest administrative burden and cost.
<b>Capital investment offsets organizational savings</b>	Internal efficiency gains at the health plan or provider level may not translate into net savings if they are offset by the capital investment required to deploy and maintain AI solutions. It is too soon to tell.
<b>Unintended consequences</b>	Participants raised concerns that AI could have unintended consequences: AI-supported medical necessity justifications, for example, could drive higher approval rates and increased medical expenditures.

#### Takeaway 2: Real-time prior authorization at the point of care is an emerging model, but current proofs of concept are narrow and not yet scalable.

While current AI tools automate individual steps within the existing prior authorization workflow, emerging solutions aim to complete the full authorization process during the patient visit. Real-time adjudication models—such as the Optum Real platform<sup>14</sup> and a Highmark and Abridge product development collaboration<sup>15</sup>—aim to integrate clinical documentation, policy matching, and authorization determination at the point of care, compressing the prior authorization process from days into minutes.

These models also aim to deliver actionable guidance to providers in real time, instead of an approval or denial (e.g., flagging that a request for 18 physical therapy sessions exceeds the standard of care, but that 12 may be immediately approvable). This may reduce the number of misaligned requests by flagging documentation needs and standard of care guidelines during the patient visit (Exhibit 5).

**Exhibit 5: Illustrative Impact of Emerging Models by Type of Prior Authorization**

		Clinical Criteria	
		ALIGNED	NOT ALIGNED
Administrative Criteria	ALIGNED	<p><b>Straightforward</b> <i>(Lowest cost)</i></p> <p><b>Example:</b> Provider requests an MRI for a patient with documented lower back pain that meets clinical criteria. The real-time model confirms alignment with medical necessity criteria and documentation requirements, issuing approval at the point of care.</p>	<p><b>Clinically Contentious</b> <i>(High cost)</i></p> <p><b>Example:</b> Provider requests 18 physical therapy sessions, but the standard of care guideline supports 12. The real-time model flags the discrepancy at the point of care, noting potential for immediate approval for 12 sessions and providing requirements to support a request for additional sessions.</p>
	NOT ALIGNED	<p><b>Administratively Burdensome</b> <i>(Medium cost)</i></p> <p><b>Example:</b> Provider requests a follow-up imaging study that meets medical necessity criteria, but the submission is missing documentation. The real-time model flags the data to capture during the visit, allowing the provider to correct and resubmit.</p>	<p><b>Clinically Contentious and Administratively Burdensome</b> <i>(Highest cost)</i></p> <p><b>Example:</b> Provider requests an off-label oncology drug with incomplete supporting documentation. The real-time model flags both the requirements to meet medical necessity criteria and the documentation gaps.</p>

Early pilots suggest real-time adjudication models could reduce initial denials and accelerate approvals of prior authorization requests. Self-reported pilot results of Optum Rx's PreCheck Prior Authorization with Cleveland Clinic reported an 88% reduction in appeals and a 68% reduction in denials caused by missing information.<sup>16</sup> Building the evidence base for whether these types of early results can be scaled affordably and broadly into additional clinical settings and contexts is critical.

The gap between these proofs of concept and a production-ready, generalizable solution is substantial. Real-time adjudication requires reconciling fragmented medical policies across health plans; navigating proprietary medical necessity criteria; managing variation in clinical complexity; and building infrastructure for real-time, bidirectional data exchange. Expanding this model from pilots and narrow use cases to a scalable solution across a broad, multistakeholder market will likely require further policy intervention.

### **Takeaway 3: Data standards and digitization of medical policies can reduce information asymmetry, but AI's impact is limited by the variation across medical policies.**

Current policy efforts focus on standardizing and digitizing prior authorization data and infrastructure.<sup>17</sup> Finalized in 2024, the CMS Interoperability and Prior Authorization Rule (CMS-0057-F) requires Medicare Advantage, Medicaid fee-for-service, Medicaid managed care, Children's Health Insurance Program (CHIP), and federally facilitated Marketplace plans to implement a prior authorization application programming interface (API) by January 1, 2027. The API enables providers to determine prior authorization requirements, retrieve documentation templates, and receive decisions electronically in real time. The rule also establishes decision timeframes, requiring health plans to respond to urgent prior authorization requests within 72 hours and nonurgent requests within seven days.<sup>18</sup>

Building on CMS-0057-F, in June 2025, more than 50 health plans committed to voluntary reforms to simplify and improve the prior authorization process. Key pledges include reducing the volume of services subject to prior authorization requirements, enhancing the transparency of determinations, and expanding real-time responses to at least 80% of electronic prior authorization requests with complete documentation by 2027.<sup>19</sup>

Workshop participants noted that CMS-0057-F and health plan pledges primarily support real-time adjudication of straightforward prior authorizations or resolution of prior authorizations delayed by administrative misalignment, such as unclear documentation or data requirements.

Participants identified several near-term opportunities to strengthen current data standardization and policy digitization efforts, including:

- Extend requirements for standardized electronic transaction types to additional health plan (e.g., commercial health plans) types;
- Establish requirements for EHR vendor integration of standardized prior authorization APIs;
- Require health plans to publish machine-readable medical policy and escalation pathways to allow providers (and AI tools) to identify requirements before submission;
- Require clear decision rationale, shifting responses from binary approvals and denials to structured next steps; and
- Monitor denial patterns by service type to identify policy gaps and improve decision responses.

Participants acknowledged that realizing the benefits of these standards also requires EHR integration. Because prior authorization workflows are embedded in EHR design, provider access to authorization requirements at the point of care depends on how EHR vendors integrate these standards into their platforms.

While digitization of medical policies can help reduce friction driven by information asymmetry, it does not address the variation in medical necessity criteria across health plans that drive clinically contentious and complex cases.

Each health plan defines medical necessity according to its own clinical guidelines, benefit design, and coverage rules—and digitizing the exchange of this information does not standardize or ensure transparency of its content. As a result, a request that is straightforward for one plan may be contentious for another.

“The data standards in CMS-0057 govern how payers’ exchange information, not what is included in their medical necessity requirements. As a result, impact is limited.”

—Investor describing the impact of federal policy initiatives on prior authorization workflows

Participants acknowledged that meaningful convergence would require fundamentally restructuring how health plans define and operationalize medical necessity criteria.

#### **Takeaway 4: AI is exposing and exacerbating fundamental issues within the underlying prior authorization process.**

The application of AI to prior authorization reveals deeper structural limitations that technology alone cannot resolve.

The discussion raised fundamental questions about what AI should solve for within the prior authorization workflows. **Before investing in technology to make a process run faster, is there a need to reconsider the design of the overall process?**

Participants suggested potential structural alternatives to prior authorization that may accomplish utilization management goals, such as prepayment review (i.e., monitoring appropriateness after care delivery) or offering providers a discounted payment rate to bypass upfront review requirements entirely. Both alternatives would represent a fundamental restructuring of health insurance business models — which would require significant policy and industry alignment to adopt and implement.

# Medical Billing

Medical billing is a resource-intensive process that requires providers to convert narrative clinical encounters into standardized diagnosis and procedure codes for reimbursement. The current process—where documentation informs billing—creates the incentive for providers to document as completely as possible to maximize payment.

AI tools are rapidly reshaping the medical billing process. While there are many opportunities, discussion focused on the proliferation of ambient scribes, which automate how a patient visit is captured and translated into medical claims submissions. AI-enabled tools can now thoroughly document patient visits. Better documentation increases the proportion of visits that can be coded as higher complexity, which in turn increases billing.

While the proportion of higher-complexity office visits has been growing steadily over the past decade, in part because of an aging and more complex patient population, AI documentation and coding tools will likely accelerate this trend.<sup>20</sup> Recent studies have documented increases in coding intensity of inpatient and outpatient visits following adoption of AI scribing tools.<sup>21</sup>

As a near-term response, some health plans are deploying their own AI tools and revising payment policies, raising the risk of automated coding practices escalating administrative back-and-forth.<sup>22</sup>

The key question the workgroup grappled with is: **How can AI-enabled documentation and coding solutions be deployed to improve accuracy and reduce administrative burden while avoiding medical cost inflation?**

## **Takeaway 1: Provider deployment of AI is increasing billing intensity and inflating medical spending.**

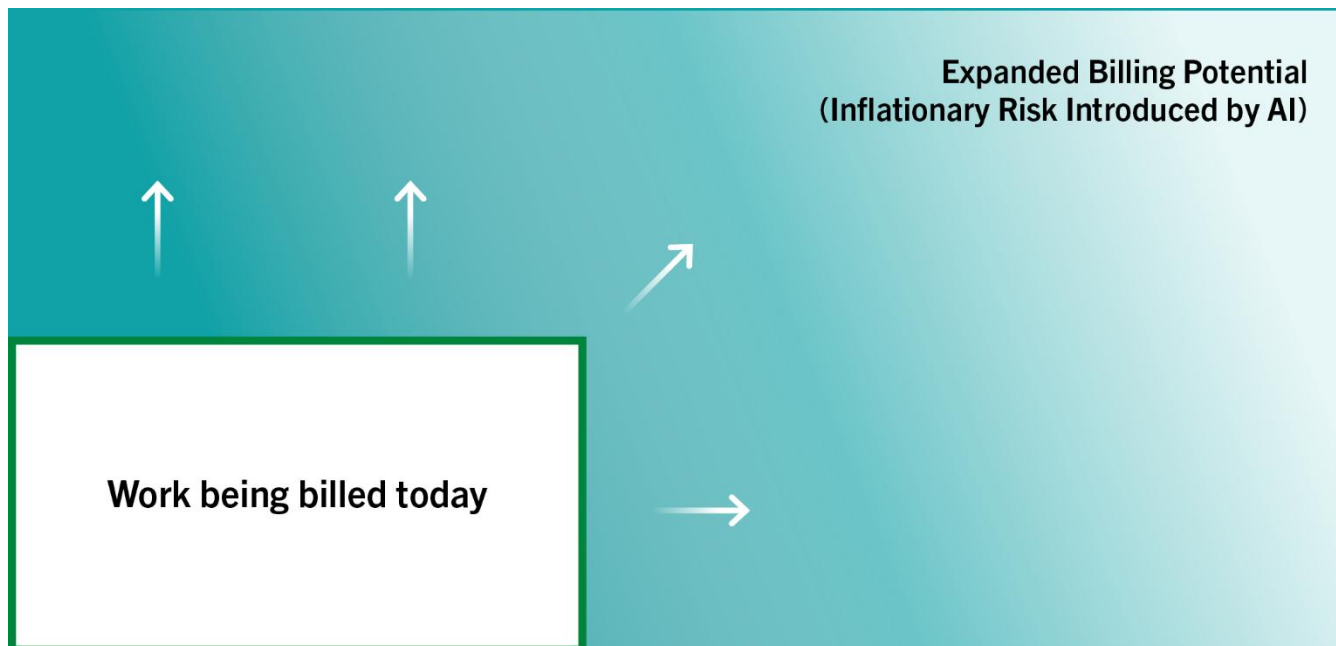
AI scribes and automated coding tools are now standard across health systems. In a recent survey of large health systems, all reported adopting AI tools for clinical documentation.<sup>23</sup>

These tools deliver modest time savings for physicians—approximately two hours per physician annually—and enable more complete capture of patient complexity.<sup>24</sup>

Adoption of AI scribes enables increases in billing intensity across evaluation and management (E/M) and diagnostic related group (DRG) complexity add-on codes (Exhibit 6).

## Exhibit 6: More Complete Documentation Impacts Medical Costs

*Illustrative only; not to scale*



One multihospital health system found that after deploying an AI scribe in its ambulatory and emergency department settings, the improved documentation and coding led to a 5% increase in Level 5 encounters and a 7% increase in level 4 encounters for established patients.<sup>25</sup> This translated to an average revenue increase of \$1,004 per provider per month.

The full impact of AI-enabled documentation and coding tools is not available in claims data given reporting lags, but health plan participants described an immediate increase in coding intensity when AI tools were activated. Major insurers are citing "aggressive" provider coding as a factor driving higher medical expenditures in 2025 and early 2026.<sup>26,27</sup> This creates near-term actuarial challenges and raises longer-term questions about how we pay for healthcare services.

AI is accelerating growth in higher-complexity billing, which has already strained affordability in recent years. The result is a trajectory that payers and patients cannot continue to absorb.

### **Takeaway 2: Health plans are beginning to respond to AI-driven increases in billing intensity with across-the-board downcoding and other reimbursement reductions, but the impact of these cuts is not yet known.**

AI-driven growth in billing intensity is prompting health plans to respond. Reported health plan responses include deploying algorithms to identify and automatically adjust outlier high-complexity E/M codes that appear inconsistent with clinical documentation, reducing reimbursement for select modifiers, and comparing submitted E/M levels against peer providers with similar patient populations.<sup>28,29</sup> These approaches vary across payers, are not well documented, and their impact on total cost of care is not yet known.

Health plan responses are also generating pushback from providers and state legislators. Several health plans have paused, delayed, or rescinded policies following provider opposition and state regulatory

scrutiny.<sup>30</sup> In the 2026 legislative session, Missouri and Indiana introduced bills to restrict AI-enabled downcoding by health plans in response to provider concerns.<sup>31,32</sup>

Health plan responses may also disproportionately harm providers that have not adopted AI documentation and coding tools: these providers may face revenue reductions from health plan policies, despite not having benefited from AI-driven billing gains. Data from the Office of the National Coordinator for Health Technology (ONC) suggest providers who have not adopted these tools are disproportionately smaller, more rural, critical access, and independent.<sup>33</sup>

More broadly, the parallel deployment of AI by healthcare providers and health plans may escalate costs for patients and employers (Exhibit 7). One direct mechanism is through increased cost sharing, as coding complexity of a patient’s visits increases, their share of the bill will also increase. Additionally, as health plans continue to react and anticipate this growth, annual premiums will increase as plans set higher rates in response to increased billing. The scale and complexity of AI-driven billing inflation exceed what individual health plan responses can address.

**Exhibit 7: AI-Driven Billing Inflation May Raise Costs for Patients and Employers**

<b>Impact</b>	<b>Illustrative Example</b>
<b>Cost Sharing Increases</b>	AI captures more diagnosis and procedure codes in a routine patient visit. The visit is coded at a higher E/M level, raising the billed amount and the patient’s coinsurance payment.
<b>Premium Increases</b>	An employer’s group plan increases premium in anticipation of AI-driven medical inflation, passing costs onto patients and employers.

### Takeaway 3: Reimbursement policy is the strongest lever to drive administrative efficiencies and system-level cost savings.

Current health plan responses are likely not sufficient to address AI-driven medical inflation; a coordinated policy response is needed.

Determining the appropriate response requires careful analysis of how AI is impacting medical charges, patient outcomes and equity, and provider compensation.

- **Medical charges:** Higher charges reflecting improved coding without additional care delivery or improved quality of care raises questions about necessary guardrails to prevent medical inflation.
- **Patient outcomes and equity:** More accurate documentation could direct greater resources to higher-need patients and lead to improved patient outcomes, which could justify increased charges.
- **Provider compensation:** More accurate coding could rebalance payments across providers, ensuring those serving complex populations are compensated appropriately.

Participants suggested potential near-term guardrails to detect and understand drivers of medical inflation, as well as payment reforms to recalibrate the price of medical services in response to deployment of AI. Potential solutions could include transparency requirements, oversight mechanisms, and coding and pricing adjustments (Exhibit 8). Participants generally supported adjusting the price of medical services to address medical inflation.

“We have a sicker population and AI is helping us capture more of it. The cost will explode unless we bring prices down. It’s basic math – there’s nothing else you can do.”

—Health plan discussing responses to medical inflation

#### Exhibit 8: Potential Policy Solutions to Detect and Address Inflationary Trends

Potential Policy Solutions to Detect and Curb Inflationary Trends	
<b>Transparency Requirements</b>	Require disclosure of when AI tools are used to generate or support medical coding, enabling payers and regulators to identify patterns of coding inflation.
<b>Oversight and Monitoring</b>	Implement oversight frameworks (e.g., cost growth targets, audits) to detect and constrain inflationary coding or utilization trends before they compound across health plans and markets.
Potential Payment and Pricing Reforms	

<p><b>Price and Coding Adjustments</b></p>	<p>In the near term, consider price adjustments to level 4 and 5 E/M codes for practices that exhibit sudden increases in coding intensity and select DRGs with increased coding intensity to address unbudgeted actuarial challenges.</p> <p>In the longer term, payers may consider revaluing Current Procedural Terminology (CPT) codes, relative value units (RVUs), and DRG payment levels to reflect how AI tools are changing the effort, time, and complexity involved for specific services.</p>
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To inform policy action, future research is needed to better understand the drivers, scale, and impact of AI-driven medical inflation.

Without deliberate policy action to establish guardrails and reform payment rates, AI risks exacerbating current inflationary trends in medical billing. Moreover, the emergence of AI tools for clinical care—discussed at the first workshop<sup>34</sup>—make revisiting the question of how we pay for clinical care all the more pressing.

## Looking Ahead

This convening represents the second in PHTI's series of workshops on AI adoption in healthcare. The first workshop focused on evidence and policy requirements for scaling clinical applications of AI and a third workshop will examine payment models for AI—exploring how reimbursement structures can be designed to reward AI adoption that delivers measurable improvements in care quality and total cost of care, rather than volume and administrative complexity.

PHTI will continue to synthesize findings across the workshop series and engage health system leaders, health plans, policymakers, and technology developers in building actionable frameworks to promote AI innovation, while ensuring its benefits are broadly shared, inflationary risks are actively managed, and patients and employers see relief from the administrative costs in U.S. healthcare today.

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