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Addiction Providers Cautious on Promised Prior Auth Changes

By **Ashleigh Hollowell** | August 27, 2025

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Forty-eight health plans voluntarily signed onto a commitment to simplify prior authorizations across all of health care in June.

Changes to the scope of prior authorizations won't immediately take effect in the behavioral health space. Still, some experts told Behavioral Health Business they worry whether this will happen at all or if the commitments are just empty promises without accountability.

They're not alone. KFF News found that 61% of poll respondents think it is not likely insurance companies will follow through on this initiative.

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"I'm really skeptical that a pledge from the insurance companies is going to result in increased access to care," Lindsey Vuolo, vice president of health law and policy, Partnership to End Addiction, told BHB. "They continue to make reforms and push the insurance companies to do more to cover addiction treatment, substance use treatment, behavioral health broadly, but we just continue to see that it's not equating to people having greater access to care. I want to be hopeful, but given how difficult it has been with parity compliance and enforcement, I don't think it is super likely this is going to translate to greater access."

The Partnership to End Addiction is a New York-based nonprofit that focuses on providing research and resources for families and communities affected by addiction and suppressing the prevalence of substance use disorders (SUDs).

When prior authorization barriers result in treatment delays for patients with SUDs, their risk of having a fatal overdose rises. It's a major reason why providers, patients, legal groups and investors in the space have pushed for prior authorization removals for years.

During the June press conference on the pending 2026 prior authorization reforms, Centers for Medicare and Medicaid Services Administrator Dr. Mehmet Oz reiterated that code reductions and performance targets will streamline care for physical conditions first, followed by behavioral health and pharmacy operations.

Historically, prior authorization in behavioral health has hindered access to inpatient treatment, approval for therapy and medication-assisted treatment (MAT) for opioid use disorder (OUD) – requiring providers to submit extensive clinical documentation justifying the need for medical necessity. Some states have taken matters into their own hands and removed prior authorization barriers for OUD treatment. But by and large, these barriers still exist.

While prior authorization is intended to prevent or minimize unnecessary services and contain costs, it can be particularly harmful for patients with SUDs because the window to get needed care is much smaller than for some

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other conditions, Kurt Isaacson, CEO of Spectrum Health Systems, explained.

"If you have an SUD and you raise your hand and say, 'I'm ready for treatment,' then as a provider you damn well better get them into treatment fast, or all kinds of bad things will happen," Isaacson told BHB. "They'll start to use again. They can overdose, they can die, but they won't be accessing treatment… [the prior authorization reforms] are good, but it has to be enforced in one way or another. I just fear that there's going to be insurance companies that say, 'we're not going to do this.'"

Spectrum Health Systems is a nonprofit SUD and behavioral health treatment provider based in Westborough, Massachusetts.

Insurance companies hold a lot of power, and without an accountability piece to these reforms, it's hard for providers to predict how care might change or if administrative burdens will actually be reduced.

"I think the biggest challenge in overseeing payers is that they have a good deal of negotiation power and resources to design how they deliver benefits in a way that's advantageous and efficient for the company," Leslie Gordon, director of health care at the U.S. Government Accountability Office, told BHB. "CMS oversight tools are also limited in terms of data and capacity to examine everything that happens."

Oz noted that one tool CMS does intend to implement as part of the prior authorization reforms is a digital platform dubbed "Fast Healthcare Interoperability Resources." The platform, he said, will standardize the exchange of data between insurers and providers, enabling real-time decision-making on any procedure or type of care that may require prior authorization approvals, rather than wading through weeks of paperwork and back-and-forth documentation.

If that does come to fruition in a meaningful way, Isaacson said providers should prepare for "a greater influx of clients."

Payer perspectives

Cigna's (NYSE: CI) health service division, Evernorth, has been an early advocate for removing routine prior authorizations for patients.

In 2022, Evernorth removed prior authorizations for SUD intensive outpatient programs (IOPs) and just this year, in January 2025, it rolled them back for partial hospitalization programs (PHPs) for SUD treatment.

"We've been taking these steps for several years now and really are continuing to look at how we continue to walk down the path to minimize these barriers, while we find better ways to help people and identify the high-quality providers," Dr. Doug Nemecek, chief medical officer of behavioral health, Evernorth Health Services, told BHB.

Since removing these prior authorization requirements, Nemecek said it has led to better patient outcomes and "optimizes the chance that they have the outcome that they really deserve."

"By pulling all of that together in both removing the administrative burden from the authorizations to get care and helping people navigate their way to those high-quality providers, that combination really has improved access and allowed people to have a simpler way to access care when they need it," Nemecek said.

For health plans considering rolling back prior authorizations, he recommends focusing on the quality of care and demonstrating outcomes.

"Ultimately, this allows us to continue to manage the affordability and the costs in a way that everybody wins," Nemecek said." The provider, the provider wins, the health plan wins, and ultimately, the most important of that is the patient wins as well because they got better care."

CVS Health, which owns Aetna, one of the major health insurance providers that signed onto the commitment to roll back prior authorizations beginning next year, boasts already having "one of the shortest lists of treatments and procedures requiring prior authorization in the industry."

But even with its 95% approval rate in 24 hours or less for eligible prior authorizations, Dr. Taft Parsons, chief psychiatric officer for CVS Health, told BHB that the company is committed to the reforms.

“Our focus is shifting from pre-service review to real-time data sharing and outcome-based oversight,” Parsons said. “This allows us to monitor treatment progress, identify care gaps and intervene when needed to support clinical quality and appropriateness of care.”

CVS Health and Aetna, he says, will also focus on expanding digital tools to streamline the process for prior authorizations.

Care coordination programs like Aetna Behavioral Health 360 will be utilized by providers and patients to meet growing demands and triage care by looking at outcomes data. This way, as access is expanded once prior authorizations are reduced, the company is doing so with clinical accountability, he said. The program also pairs members with case managers so their care approval process is not something that goes into a void without follow-up.

CVS Health and Aetna also offer a provider differentiation program, which reduces prior authorization requirements for high-performing providers, including behavioral health specialists.

As prior authorization reforms get underway as a result of insurer commitments, Parsons said Aetna will be tracking engagement, readmission reduction, care trends, and system efficiencies to monitor the effectiveness of the rollbacks.

Ultimately, though, these changes could reconfigure how payer contracting is done, and move some providers closer to value-based arrangements.

“What we’re going to see over the next couple of years is really an expansion of innovative ways to contract,” Nemecek said. “Instead of just contracting for the service, how do we contract based on quality, based on the data and in ways that really can align the substance use disorder facilities and programs and providers and with the health

plans in a way that makes it simple and easy to remove the prior auth."

Potential pitfalls

Providers told BHB they will be watching for regulatory consistency, standardization and lowered care barriers to determine the success of the insurers' commitments.

Even if prior authorizations are removed for substance use treatment and other behavioral health care, it's unlikely to move the needle on parity and could be used to downplay other real issues in the space, like the impact of Medicaid cuts.

"We're very, very worried about the changes that Medicaid is going to have on this population," Vuolo said. "It's going to be important that we make sure they're not using this to say 'Hey, we got rid of prior authorization' as a distraction to a much bigger issue. I think it remains to be seen what is going to happen."

If prior authorization removals do drive up service demands, it could also become a resource issue for providers.

"I think it's the volume issue and the resource issue," Isaacson said. "I can sit here and say that I think it's a great idea to go down this road, but if we can't deliver on the resources and the treatment, then it's all for naught."

Spectrum Health Systems, he said, is already anticipating hiring more nurses, counselors and recovery specialists in anticipation of rising service demands.

"We just have to be a little bit more creative, and it's probably going to be a little bit more expensive," Isaacson said.

Denials, of course, will still happen, but at what rate and what cost, remains to be seen.

"I think we all need to work towards transparency and sharing of information so knowing what the requirements are, and having them make sense," Gordon said. "I think, when providers get caught in a cycle that they're not

expecting in terms of having to resubmit or file an appeal in the case of some of the more intensive services, that's failing. I think it'll take really seeking clarity around what is actually required and why, in order to hold prior authorization to its aim of ensuring that the services provided are medically necessary, well coordinated and done in a very timely way so that it does not interfere with access."

Companies featured in this article:

Aetna, CVS Health, Evernorth, Government Accountability Office, Spectrum Health Systems, The Partnership to End Addiction

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Ashleigh Hollowell

Ashleigh Hollowell is a professional journalist who has spent her career covering a range of local news, contributing to independent magazines and trade publications, and providing in-depth national health care reporting. Her work has appeared in Becker's Hospital Review, VentureBeat, PopSugar, MSN Singapore, and related outlets. She received her bachelor's degree from Colorado State University-Pueblo and her master's from Syracuse University. In her free time, she volunteers with local organizations, enjoys hiking, reading, and yoga.

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