

5 Takeaways From Health Insurers' New Pledge to Improve Prior Authorization

Prior authorization, which forces some people to delay care or abandon treatment, may continue to pose serious health consequences.

June 26, 2025 By Lauren Sausser, Phil Galewitz and KFF Health News

Nearly seven months after the fatal shooting of an insurance CEO in New York drew widespread attention to health insurers' practice of denying or delaying doctor-ordered care, the largest U.S. insurers agreed Monday to streamline their often cumbersome preapproval system.

Dozens of insurance companies, including Cigna, Aetna, Humana, and UnitedHealthcare, agreed to several measures, which include making fewer medical procedures subject to prior authorization and speeding up the review process. Insurers also pledged to use clear language when communicating with patients and promised that medical professionals would review coverage denials.

While Trump administration officials applauded the insurance industry for its willingness to change, they acknowledged limitations of the agreement.

"The pledge is not a mandate," Mehmet Oz, administrator of the Centers for Medicare & Medicaid Services, said during a news conference. "This is an opportunity for the industry to show itself."

Oz said he wants insurers to eliminate preapprovals for knee arthroscopy, a common, minimally invasive procedure to diagnose and treat knee problems. Chris Klomp, director of the Center for Medicare at CMS, recommended prior authorization be eliminated for vaginal deliveries, colonoscopies, and cataract surgeries, among other procedures. Health insurers said the changes would benefit most Americans, including those with commercial or private coverage, Medicare Advantage, and Medicaid managed care.

The insurers have also agreed that patients who switch insurance plans may continue receiving treatment or other health care services for 90 days without facing immediate prior authorization requirements imposed by their new insurer.

But health policy analysts say prior authorization — a system that forces some people to delay

care or abandon treatment — may continue to pose serious health consequences for affected patients. That said, many people may not notice a difference, even if insurers follow through on their new commitments.

“So much of the prior authorization process is behind the black box,” said Kaye Pestaina, director of the Program on Patient and Consumer Protections at KFF, a health information nonprofit that includes KFF Health News.

Often, she said, patients aren’t even aware that they’re subject to prior authorization requirements until they face a denial.

“I’m not sure how this changes that,” Pestaina said.

The [pledge from insurers](#) follows the killing of UnitedHealthcare CEO Brian Thompson, who was shot in midtown Manhattan in early December on the way to an investor meeting, forcing the issue of prior authorization to the forefront.

Oz acknowledged “violence in the streets” prompted Monday’s announcement. Klomp told KFF Health News that insurers were reacting to the shooting because the problem has “reached a fever pitch.” Health insurance CEOs now move with security details wherever they go, Klomp said.

“There’s no question that health insurers have a reputation problem,” said Robert Hartwig, an insurance expert and a clinical associate professor at the University of South Carolina.

The pledge shows that insurers are hoping to stave off “more draconian” legislation or regulation in the future, Hartwig said.

But government interventions to improve prior authorization will be used “if we’re forced to use them,” Oz said during the news conference.

“The administration has made it clear we’re not going to tolerate it anymore,” he said. “So either you fix it or we’re going to fix it.”

Here are the key takeaways for consumers:

1. Prior authorization isn’t going anywhere.

Health insurers will still be allowed to deny doctor-recommended care, which is arguably the [biggest criticism](#) that patients and providers level against insurance companies. And it isn’t clear how the new commitments will protect the sickest patients, such as those diagnosed with cancer, who need the most expensive treatment.

2. Reform efforts aren’t new.

Most states have already [passed at least one law](#) imposing requirements on insurers, often intended to reduce the time patients spend waiting for answers from their insurance company and

to require transparency from insurers about which prescriptions and procedures require preapproval. Some states have also enacted “gold card” programs for doctors that allow physicians with a robust record of prior authorization approvals to bypass the requirements.

Nationally, rules proposed by the first Trump administration and [finalized by the Biden administration](#) are already set to take effect next year. They will require insurers to respond to requests within seven days or 72 hours, depending on their urgency, and to process prior authorization requests electronically, instead of by phone or fax, among other changes. Those rules apply only to certain categories of insurance, including Medicare Advantage and Medicaid.

Beyond that, some insurance companies committed to improvement long before Monday’s announcement. Earlier this year, UnitedHealthcare pledged to reduce prior authorization volume by 10%. Cigna announced its own set of improvements in February.

3. Insurance companies are already supposed to be doing some of these things.

For example, the Affordable Care Act already requires insurers to communicate with patients in plain language about health plan benefits and coverage.

But denial letters remain confusing because companies tend to use jargon. For instance, AHIP, the health insurance industry trade group, used the term “non-approved requests” in Monday’s announcement.

Insurers also pledged that medical professionals would continue to review prior authorization denials. AHIP claims this is “a standard already in place.” But recent lawsuits allege otherwise, accusing companies of denying claims in a matter of seconds.

4. Health insurers will increasingly rely on artificial intelligence.

Health insurers issue millions of denials every year, though most prior authorization requests are quickly, sometimes even instantly, approved.

The use of AI in making prior authorization decisions isn’t new — and it will probably continue to ramp up, with insurers pledging Monday to issue 80% of prior authorization decisions “in real-time” by 2027.

“Artificial intelligence should help this tremendously,” Rep. Gregory Murphy (R-N.C.), a physician, said during the news conference.

“But remember, artificial intelligence is only as good as what you put into it,” he added.

Results from a survey published by the American Medical Association in February indicated 61% of physicians are concerned that the use of AI by insurance companies is already increasing denials.

5. Key details remain up in the air.

Oz said CMS will post a full list of participating insurers this summer, while other details will become public by January.

He said insurers have agreed to post data about their use of prior authorization on a public dashboard, but it isn't clear when that platform will be unveiled. The same holds true for "performance targets" that Oz spoke of during the news conference. He did not name specific targets, indicate how they will be made public, or specify how the government would enforce them.

While the AMA, which represents doctors, applauded the announcement, "patients and physicians will need specifics demonstrating that the latest insurer pledge will yield substantive actions," the association's president, Bobby Mukkamala, said in a statement. He noted that health insurers made "past promises" to improve prior authorization in 2018.

Meanwhile, it also remains unclear what services insurers will ultimately agree to release from prior authorization requirements.

Patient advocates are in the process of identifying "low-value codes," Oz said, that should not require preapproval, but it is unknown when those codes will be made public or when insurers will agree to release them from prior authorization rules.

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