Feds Move to Rein In Prior Authorization, a System That Harms and Frustrates Patients

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When Paula Chestnut needed hip replacement surgery last year, a pre-operative X-ray found irregularities in her chest.

As a smoker for 40 years, Chestnut was at high risk for lung cancer. A specialist in Los Angeles recommended the 67-year-old undergo an MRI, a high-resolution image that could help spot the disease.

But her MRI appointment kept getting canceled, Chestnut's son, Jaron Roux, told KHN. First, it was scheduled at the wrong hospital. Next, the provider wasn't available. The ultimate roadblock she faced, Roux said, arrived when Chestnut's health insurer deemed the MRI medically unnecessary and would not authorize the visit.

"On at least four or five occasions, she called me up, hysterical," Roux said.

Months later, Chestnut, struggling to breathe, was rushed to the emergency room. A tumor in her chest had become so large that it was pressing against her windpipe. Doctors started a regimen of chemotherapy, but it was too late. Despite treatment, she died in the hospital within six weeks of being admitted.

Though Roux doesn't fully blame the health insurer for his mother's death, "it was a contributing factor," he said. "It limited her options."

Few things about the American health care system infuriate patients and doctors more than prior authorization, a common tool whose use by insurers has exploded in recent years.

Prior authorization, or pre-certification, was designed decades ago to prevent doctors from ordering expensive tests or procedures that are not indicated or needed, with the aim of delivering cost-effective care.

Originally focused on the costliest types of care, such as cancer treatment, insurers now commonly require prior authorization for many mundane medical encounters, including basic imaging and prescription refills. In a 2021 survey conducted by the American Medical Association, 40% of physicians said they have staffers who work exclusively on prior authorization.

So today, instead of providing a guardrail against useless, expensive treatment, pre-authorization prevents patients from getting the vital care they need, researchers and doctors say.

“The prior authorization system should be completely done away with in physicians’ offices,” said Dr. Shikha Jain, a Chicago hematologist-oncologist. “It’s really devastating, these unnecessary delays.”

In December, the federal government proposed several changes that would force health plans, including Medicaid, Medicare Advantage, and federal Affordable Care Act marketplace plans, to speed up prior authorization decisions and provide more information about the reasons for denials. Starting in 2026, it would require plans to respond to a standard prior authorization request within seven days, typically, instead of the current 14, and within 72 hours for urgent requests. The proposed rule was scheduled to be open for public comment through March 13.

Although groups like AHIP, an industry trade group formerly called America’s Health Insurance Plans, and the American Medical Association, which represents more than 250,000 physicians in the United States, have expressed support for the proposed changes, some doctors feel they don’t go far enough.

“Seven days is still way too long,” said Dr. Julie Kanter, a hematologist in Birmingham, Alabama, whose sickle cell patients can’t delay care when they arrive at the hospital showing signs of stroke. “We need to move very quickly. We have to make decisions.”

Meanwhile, some states have passed their own laws governing the process. In Oregon, for example, health insurers must respond to nonemergency prior authorization requests within two business days. In Michigan, insurers must report annual prior authorization data, including the number of requests denied and appeals received. Other states have adopted or are considering similar legislation, while in many places insurers regularly take four to six weeks for non-urgent appeals.

Waiting for health insurers to authorize care comes with consequences for patients, various studies show. It has led to delays in cancer care in Pennsylvania, meant sick children in Colorado were more likely to be hospitalized, and blocked low-income patients across the country from getting treatment for opioid addiction.

In some cases, care has been denied and never obtained. In others, prior authorization proved a potent but indirect deterrent, as few patients have the fortitude, time, or resources to navigate what can be a labyrinthine process of denials and appeals. They simply gave up, because fighting denials often requires patients to spend hours on the phone and computer to submit multiple forms.

Erin Conlisk, a social science researcher for the University of California-Riverside, estimated she spent dozens of hours last summer trying to obtain prior authorization for a 6-mile round-trip ambulance ride to get her mother to a clinic in San Diego.

Her 81-year-old mother has rheumatoid arthritis and has had trouble sitting up, walking, or standing without help after she damaged a tendon in her pelvis last year.

Conlisk thought her mom's case was clear-cut, especially since they had successfully scheduled an ambulance transport a few weeks earlier to the same clinic. But the ambulance didn't show on the day Conlisk was told it would. No one notified them the ride hadn't been pre-authorized.

The time it takes to juggle a prior authorization request can also perpetuate racial disparities and disproportionately affect those with lower-paying, hourly jobs, said Dr. Kathleen McManus, a physician-scientist at the University of Virginia.

"When people ask for an example of structural racism in medicine, this is one that I give them," McManus said. "It's baked into the system."

Research that McManus and her colleagues published in 2020 found that federal Affordable Care Act marketplace insurance plans in the South were 16 times more likely to require prior authorization for HIV prevention drugs than those in the Northeast. The reason for these regional disparities is unknown. But she said that because more than half the nation's Black population lives in the South, they'd be the patients more likely to face this barrier.

Many of the denied claims are reversed if a patient appeals, according to the federal government. New data specific to Medicare Advantage plans found 82% of appeals resulted in fully or partially overturning the initial prior authorization denial, according to KFF.

It's not just patients who are confused and frustrated by the process. Doctors said they find the system convoluted and time-consuming, and feel as if their expertise is being challenged.

"I lose hours of time that I really don't have to argue…with someone who doesn't even really know what I'm talking about," said Kanter, the hematologist in Birmingham. "The people who are making these decisions are rarely in your field of medicine."

Occasionally, she said, it's more efficient to send patients to the emergency room than it is to negotiate with their insurance plan to pre-authorize imaging or tests. But emergency care costs both the insurer and the patient more.

"It's a terrible system," she said.

A KFF analysis of 2021 claims data found that 9% of all in-network denials by Affordable Care Act plans on the federal exchange, healthcare.gov, were attributed to lack of prior authorization or referrals, but some companies are more likely to deny a claim for these reasons than others. In Texas, for example, the analysis found 22% of all denials made by Blue Cross and Blue Shield of Texas and 24% of all denials made by Celtic Insurance Co. were based on lack of prior

authorization.

Facing scrutiny, some insurers are revising their prior authorization policies. UnitedHealthcare has cut the number of prior authorizations in half in recent years by eliminating the need for patients to obtain permission for some diagnostic procedures, like MRIs and CT scans, said company spokesperson Heather Soules. Health insurers have also adopted artificial intelligence technology to speed up prior authorization decisions.

Meanwhile, most patients have no means of avoiding the burdensome process that has become a defining feature of American health care. But even those who have the time and energy to fight back may not get the outcome they hoped for.

When the ambulance never showed in July, Conlisk and her mother's caregiver decided to drive the patient to the clinic in the caregiver's car.

"She almost fell outside the office," said Conlisk, who needed the assistance of five bystanders to move her mother safely into the clinic.

When her mother needed an ambulance for another appointment in September, Conlisk vowed to spend only one hour a day, for two weeks leading up to the clinic visit, working to get prior authorization. Her efforts were unsuccessful. Once again, her mother's caregiver drove her to the clinic himself.

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