

Medical Care Delays for Approval Persist, Despite Insurers' Promises

Doctors and patients complain that the controversial practice of prior authorization for treatment and procedures is still widespread.



Candace Rond, center, with her daughters Gabby, left, and Sophia, who both have juvenile arthritis. Credit...Lindsay D'Addato for The New York Times

By [Reed Abelson](#) – The New York Times

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Nearly a year after the nation's health insurers [pledged](#) to overhaul their much-criticized practice of prior approval for medical care, patients and doctors say there is little evidence that delays and denials for necessary treatment have eased.

Just ask Candace Rond. She tried for weeks to get medication for her 15-year-old daughter, Gabby, who has two autoimmune diseases.

"The whole prior authorization experience is a nightmare," Ms. Rond said.

In January, Ms. Rond was told she could not refill her daughter's prescription until the insurer reviewed the request. Gabby was in pain, and Ms. Rond worried that her daughter's sophomore year of high school would suffer. "I just get so frustrated," Ms. Rond said.

About two months later, after repeatedly checking, Ms. Rond, who is a volunteer in Utah for the Arthritis Foundation, was finally able to refill the prescription. She is dreading this summer, when her insurance coverage begins a new year and a new approval cycle for her daughter's medication.

Insurers' use of prior authorization has generated significant public outrage, as has the budgetary stress caused by the rising costs of health care. In [a recent poll](#) conducted by KFF, a health research organization, one of three adults with insurance surveyed said prior authorization was a "major burden," with nearly 70 percent describing it as at least somewhat burdensome.

Last June, dozens of insurance companies voluntarily [promised](#) to reduce the number of tests and procedures requiring prior approval and to make sure patients could stay on the same treatment for 90 days even if they switched plans, according to a joint announcement by the industry's two major trade groups. They also vowed to speed up the reviews.

The trade organizations said in a recent statement that insurers were making headway by requiring authorization of fewer services and by responding sooner to doctors and patients.

But evidence of improvements remains spotty. Recent surveys of doctors found that prior authorization continued to be a major concern, that patients waiting for treatment could be harmed and that it contributed to significant administrative overload.

"It's a huge issue, and we're far from mission accomplished," said Anthony Wright, the executive director for Families USA, a health care advocacy group in Washington, D.C. "We shouldn't have insurers competing on how aggressively they deny needed care."

Chris Klomp, who oversees Medicare for the Trump administration and helped persuade insurers to commit to changes, acknowledged that far too many treatments still required authorization. The companies have made progress, he said, but need to do more. "I think that's an excellent first step," he said, "but hardly sufficient."

Mr. Klomp defended the voluntary pledge as essential to influencing industrywide response. "We needed to be able to do something across all lines of business," he said.

Broader legislation in Congress that would curtail the practice, at least for the private plans offered under Medicare, has stalled despite bipartisan support.

The Biden administration imposed some regulations, including shortening approval times for Medicare Advantage plans. In April, the Trump administration proposed [new rules](#) that would apply many of those regulations for medication reviews, a first attempt at oversight.

But states have limited authority to regulate plans offered by large employers and by private Medicare Advantage. Employers' plans are largely governed under the federal Employee Retirement Income Security Act, known as ERISA, partly to avoid a patchwork of state regulations.

Some states have passed [legislation](#) setting strict timetables for insurers' approval reviews, with Iowa being the most recent. A [Nebraska law](#) forces companies to authorize care if 72 hours had elapsed in cases involving urgent medical conditions. By 2028, Nebraska would shorten the decision window to 48 hours. Five years ago, the Illinois State Medical Society pushed state lawmakers to pass [legislation](#) that included requiring companies to keep approvals for patients with chronic conditions in place for a year. "I don't really know if I feel it," Dr. Richard C. Anderson, a surgeon and a former president of the medical society, said of any impact from insurers' promises.

Recent surveys reflect his observation. The Medical Group Management Association, which is made up of large physician groups, found that 90 percent of executives in the doctors' practices [reported](#) an increase in the last year of administrative work related to seeking approval for patient treatment.

This month, the American Medical Association released a [survey](#) in which more than a quarter of doctors said delays and denials had resulted in adverse patient conditions like hospitalization or a life-threatening incident.

“Physician trust in voluntary insurer pledges is deeply eroded after years of unfulfilled promises,” Dr. Bobby Mukkamala, the president of the association, said in a statement.

Data to measure the effect of regulatory and insurer changes has not been widely available to consumers. In March, for the first time, insurers were required by Medicare officials to publicly release information on the handling of medical requests, including the number of denials, for some of their plans. Dr. Archelle Georgiou, who was a senior executive at UnitedHealthcare until 2007, said it had been difficult to find reliable information, which is posted on the companies’ individual websites. A critic of prior authorization, Dr. Georgiou favors a centralized public database for people to navigate easily; Mr. Klomp said the government was considering one.

In a [recent analysis of some insurers’](#) available data, Dr. Georgiou found that many denials for care were ultimately overturned. But with about one in 10 claims denied, according to her data, only 7 percent were appealed and two-thirds of the rejections were reversed.

The statistics may be worse for medications, according to her [analysis](#) of limited state data. Dr. Anderson, for one, said he was frequently second-guessed by insurance companies. For example, he said, insurers insisted that some cancer patients get a CT scan before a PET scan, despite the PET scan’s ultimately being necessary to detail disease progression.

“They’re really not saving the system money, and they delay,” he said.

Prior approval is often required for imaging tests, and insurers do request reviews of surgeries outside of emergencies. Expensive medications, like GLP-1s for treating diabetes, are also subject to review. Insurers also differ in their requirements for the same treatment. The Trump administration has drawn criticism for a Medicare pilot program testing prior approval for a select group of conditions.

Insurance executives said it would take time for their efforts to affect the daily interactions among doctors, patients and insurers.

“This is not a matter of simply flipping a switch,” said Mike Tuffin, the president and chief executive of AHIP, a major insurance trade group that, along with the Blue Cross Blue Shield Association, collaborated on the industry pledge.

“The more transformative systematic reforms are going into effect next year,” Mr. Tuffin said. Those include the development of a standard package of information doctors can submit to every insurer. By 2028, the insurance companies hope to be able to assess 80 percent of electronic requests while patients are still in their doctor’s offices.

Medicare officials recently announced a new push that included an [initiative](#) by insurers and others, like suppliers of electronic health records, to improve the pace of approvals and reduce the administrative burden. Hospitals and doctors are also being encouraged to modernize their systems.

Last month, the trade associations said insurers had cut the overall number of treatments that needed a review by more than [six million](#), an 11 percent decline.

No insurer has been under more pressure to alter its practices than UnitedHealth Group, which owns the nation’s largest insurer, UnitedHealthcare. Reaction to the assassination in Manhattan of UnitedHealthcare’s chief executive, Brian Thompson, in late 2024 erupted into a [backlash](#) against insurers.

UnitedHealth has since publicized various changes in an effort to restore public confidence and repair its image.

The company announced that [it would reduce the number of treatments](#) requiring prior approval by 30 percent this year. UnitedHealth also plans to exempt [rural hospitals](#) from most approval restrictions. And OptumRx, its pharmacy benefit manager, said it was cutting the number of medications needing review.

Aetna, the big insurer owned by CVS Health, said it was approving [more than 80 percent](#) of requests in real time and requiring fewer reviews than many of its peers. The company, which also owns CVS Caremark, the pharmacy benefit manager, said it was trying to simplify the process by issuing a combined approval of medications and procedures for select groups of patients, like some with cancer, or bundling imaging reviews for those patients so they did not need separate authorizations for every scan.

Insurers have recognized that treatment delays drive up costs and evoke dissatisfaction among customers. “We’re in an all-out effort to increase trust,” said Steve Nelson, Aetna’s president.

Some industry executives say they are trying to address the complaints.

“We need to move away from a world where insurance companies are wedging themselves between the doctor and the patient,” said Dr. Sachin H. Jain, the chief executive of SCAN Health Plan, which offers Medicare Advantage plans.

“The hard part is we’ve created documentation wars,” Dr. Jain said. And while the insurers and doctors spend time arguing about what documents are needed to justify the care, “the person who is getting in the middle of that is the patient,” he said.

Reed Abelson covers the business of health care, focusing on how financial incentives are affecting the delivery of care, from the costs to consumers to the profits to providers.