

Doctors Push HHS to Show More Change on Prior Authorizations

Jun 11, 2026, 5:05 AM EDT

Ganny Belloni

Reporter

Summary by Bloomberg AI

- Physician groups are urging the Trump administration to give them more information on insurance companies' pledges to change their process for preapproving medical procedures.
- The Centers for Medicare & Medicaid Services secured assurances from insurers to adopt consistent documentation standards and reduce the number of procedures subject to pre-payment reviews, and announced that its partnership with health plans had eliminated 11% of prior authorizations.
- Physicians' groups are asking the Trump administration to set clear performance benchmarks to ensure insurers' pledges lead to tangible changes for doctors, and are seeking measurable reductions in administrative burdens and care delays.

Physician groups are urging the Trump administration to give them more information on insurance companies' pledges to change their process for preapproving medical procedures.

Since 2025, dozens of the nation's largest health insurance companies have pledged to change the prior authorization process, which requires doctors to submit detailed evidence to ensure that potentially costly services are medically necessary. Doctors regularly spend over **13 hours** per week working on these approvals, making the process one of their largest sources of clerical workload, according to the American Medical Association.

The Centers for Medicare & Medicaid Services in April secured assurances from insurers that they would adopt consistent documentation **standards** across companies, **reduce** the number of procedures subject to pre-payment reviews, and **set time limits** for prescription drug approvals.

In May, the agency **announced** that its partnership with health plans had eliminated 11% of prior authorizations across a range of their covered medical services, or about 6.5 million fewer pre-procedure reviews compared to the previous year.

Although physicians' groups such as the American Medical Association and the American College of Physicians lauded the reforms, both groups are asking the Trump administration to set clear performance benchmarks to ensure insurers' pledges lead to tangible changes for doctors.

"There is still significant work ahead," said Bobby Mukkamala, who until recently was president of the AMA. "Announced reductions in the number of services subject to prior authorization are a positive first step, but physicians and patients must experience a meaningful, real-world decrease in administrative burden and care delays."

Insurance company pledges

Standardize electronic prior authorization submissions
Reduce the volume of medical services subject to prior authorization
Honor existing authorizations during insurance transitions
Enhance transparency and communication around authorization decisions and appeals
Expand real-time responses and approvals
Ensure medical professionals review all clinical denials

Source: Centers for Medicare & Medicaid Services

Bloomberg Law

The sentiment is grounded in their real-life experiences with insurers. Nearly 4 out of 5 physicians **surveyed** by the AMA in 2025 reported patients abandoning treatment because of the prior authorization process, and over a quarter reported care delays that led to serious hospitalizations or even death.

Only about a third of doctors surveyed by the AMA believed that insurers' pledges would make a meaningful difference.

"We believe that prior authorization processes desperately need meaningful reform," said ACP President Jan Carney. "We recommend that the administration continue to have real collaborations with physicians, clinicians, and patient advocacy groups."

“We would like to see measurable benchmarks for improvement within the next year, and reductions in response times for these authorizations, measurable reductions in administrative burdens, and measurable reductions in inappropriate denials. And again, we still think that artificial intelligence should not be used to deny complex clinically complex requests without physician oversight and the accountability,” she added.

Chris Bond, a spokesman for America’s Health Insurance Plans, a trade group representing the interests of insurance companies, says the multi-year voluntary commitments “will streamline prior authorization while maintaining patient safeguards for safety, quality and affordability.”

“We encourage providers to do their part by doing away with error-prone manual processes and adopting electronic prior authorization to ensure health plans’ standardized approach will mean faster answers, a more consistent experience and less friction for everyone,” Bond said in a statement.

Ensuring Accountability

Insurers **surveyed** by the Georgetown Center on Health Insurance Reforms say prior authorization offers a way to keep costs in check after the Affordable Care Act required them to cover patients with pre-existing conditions.

The actuarial firm Milliman estimates that without it, yearly premiums for a family of four would rise by over **\$2,800**.

“It’s hard to imagine a world in which prior authorization completely disappears,” said Norton Rose Fulbright attorney Jeff Wurzburg, who was formerly with the US Department of Health and Human Services Office of the General Counsel.

“It would seem to me we’re heading towards a place of less friction and reducing burden, but managed care exists to control costs in an attempt to ensure that only medically necessary care is provided. And as long as that’s the case, there’s going to be friction,” he said.

Both the AMA and the ACP say, however, that the agency could take greater steps to ensure greater transparency and accountability from insurance companies. In a July 2025 **letter** to CMS Administrator Mehmet Oz, the ACP recommended the agency

foster genuine collaboration with physicians, clinicians, and patient advocacy groups who are directly impacted by the current prior authorization process.

“We need to see the proof in some form. We need to see the evidence, we need to see the metrics and the timelines,” Carney said.

“Transparency is essential to ensuring accountability and progress,” Mukkamala said.

Long-term Fix

“CMS absolutely has the authority via their regulations surrounding Medicare, Medicaid, and commercial insurance under the Affordable Care Act, to be able to implement regulations moving forward,” Wurzburg said.

In 2024, the agency put forth its [Interoperability and Prior Authorization Final Rule](#), which requires insurers to make decisions on urgent prior authorization requests within 72 hours and provide details behind their denials. The rule also requires payers to report their approval and denial rates, average response times, and top services requiring authorization.

Insurers contracting with the Medicare program could face enforcement actions ranging from warning letters to civil monetary penalties if they are found to not be in compliance with the rule.

“But requirements and regulations are only as good as the enforcement agency’s willingness to enforce them,” said Wurzburg. It’s too early to say how much of an appetite the agency will have to take on this issue, he added.

“If you think back to the last 15 years, you would see more news stories, more frustration, constituent complaints, complaints to Congress, and a slow change in requirements from CMS that ultimately led to Congress stepping in and passing the No Surprises Act.”

“I do wonder whether we are starting that same path where frustrations and frictions surrounding prior authorization now will lead to change through Congress,” said Wurzburg.

To contact the reporter on this story: **Ganny Belloni** at gbelloni@bloombergindustry.com