AMERICAN ECONOMIC LIBERTIES PROJECT

# BAN PRIOR AUTHORIZATION:

## Ending Big Medicine's Strategy to Boost Profits by Denying Medically Necessary Care

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# FOREWORD

By Hannah Garden-Monheit

*This brief is dedicated to my late father, Michael L. Monheit (1946-2026).*

When I called UnitedHealthcare to find out why they had denied prior authorization for my father to attend rehabilitation after the amputation of his leg, the call center worker was as perplexed and horrified as I was. "This is unreasonable, but I don't know how I can fix it," she told me. That sentence has haunted me. The people answering the phones knew how inhumane their employer's system was.

But for United, the system was working just as intended. After all, United's shareholders benefit when the Big Medicine insurance conglomerate's processes are so impenetrable that it prevents people from pursuing and receiving necessary care. And, in my dad's case, it worked.

The first denial cited dad's cancer diagnosis, apparently without registering that his leg had just been amputated — the reason his care team had prescribed a short-term intensive rehabilitation program specializing in amputees to begin with. When we appealed, the second denial stated that he did not need this rehab due to his progress. That progress was this: Through sheer grit and determination, my father had figured out how to hop on one leg from his hospital bed to a chair.

The bureaucratic maze was a dead end. At least twice I learned of a denial only after calling United to check on the status of the request. They hadn't even bothered with a letter. While the lines of communication felt frustratingly unpredictable, the answers always led to the same place: "no."

Dad's care team at Johns Hopkins was accustomed to this illogical system and fought alongside us. Together, we spent dozens of hours on these appeals, trying to find anyone with the power to make an informed, rational decision. We called United, their affiliate NaviHealth, hotlines at the Centers for Medicare and Medicaid Services, and the insurance administration in his home state. No one could help. Sometimes the call center representatives would say they could find no record of the appeals we knew the Hopkins team had filed. Other times, they'd say there was an expedited appeal in process, but "expedition" meant anything up to 72 hours — an eternity when you're trapped in a hospital watching a loved one suffer, fully dependent on a distant corporation's ruling to determine their fate.

My father spent more than a week stranded in the hospital, long past the point when his doctors were ready to discharge him. Eventually, we gave up — not because the denial was right, but because fighting it was consuming the time and energy my father needed to battle his cancer. He was ultimately discharged to a nursing home that had little experience with amputees.

"They kind of sapped my momentum," he said to me wistfully. He spent the rest of his life in a wheelchair and never received a prosthetic limb.

My father spent his life speaking truth to power. But when I asked whether I could share our story publicly while the battle was still ongoing, he said no. He was too scared that United would retaliate against him while he still needed their coverage for his cancer treatments. That fear is almost certainly shared by many people in similar positions. It is a completely understandable response to a system that holds the lives of people suffering from life-threatening illnesses in corporate hands.

Dad died in February 2026. May his memory be a blessing, and may sharing this story and paper now help prevent others from suffering as he did.

# I. INTRODUCTION

"Prior authorization" is the process by which health insurers require plan members to obtain their approval before a treatment occurs.[1] It began as a narrow cost-control tool but is now better understood as a "corporate care veto" strategy for boosting Big Medicine insurance conglomerates' profits. Today, these private insurers impose pervasive prior authorization requirements and then have their own corporate affiliates — including private equity-backed artificial intelligence (AI) companies — adjudicate requests for coverage. This poses a clear conflict of interest because the insurers profit when care is denied.

Big Medicine insurance conglomerates claim that prior authorization ensures care is "safe, effective, evidence-based[,] and affordable," while minimizing the risk of surprise bills.[2] In reality, the practice empowers distant corporate entities with a financial conflict of interest to override the professional judgment of physicians with firsthand knowledge of patients' medical needs.[3] There is generally little to no transparency or accountability for these decisions. Worse still, prior authorization does not actually guarantee coverage, with insurers sometimes denying claims for pre-approved services after the fact — leaving patients and clinicians exposed to unexpected costs.[4] And now, these conglomerates are racing to deploy AI tools that automate prior authorization processes, exacerbating the risk of wrongful delays and denials.[5]

For patients, prior authorization often results in delayed or denied treatment, worse outcomes, and, in some cases, avoidable hospitalizations or death.[6] For the physicians and other health care practitioners who care for them, it imposes a crushing administrative burden that distorts clinical decision-making, undermines the patient-clinician relationship, and contributes to burnout and moral injury.[7]

**Physicians and their teams now spend so much time on prior authorization that it consumes the equivalent of 99,290 full-time physician and advanced practice clinician workloads — more than the nation's current physician shortage — at a cost of as much as $32.7 billion annually.[8] In short, prior authorization diverts clinicians from patient care to paperwork, driving some to leave the profession entirely or to shift to concierge practice models accessible only to the wealthy.[9]**

There is growing bipartisan recognition that private insurers abuse prior authorization, yet the practice remains rampant and largely unregulated.[10] Both the Biden and Trump administrations adopted some incremental reforms, but those measures fail to address the structural conflict of interest that underpins the corporate care veto strategy. Meanwhile, the public overwhelmingly supports a much more robust solution. A recent poll found that 71% of U.S. voters — including a supermajority of both Democrats (76%) and Republicans (69%) — would support legislation prohibiting private insurers from using prior authorization at all.[11]

This policy brief first traces how prior authorization evolved into today's pervasive corporate care veto, explains the attendant harms, and describes the shortcomings of recent reform efforts. It then proposes a ban on prior authorization, prohibiting Big Medicine conglomerates with a financial conflict of interest from both imposing prior authorization requirements and adjudicating requests for coverage. Under our proposal, the practice of requiring pre-approval before treatment would be allowed only in rare, narrow circumstances where no conflict of interest is present and where strict safeguards are in place, including a prohibition on AI-based denials. By banning prior authorization and ending the corporate care veto, policymakers can start to address our health care crisis by improving patient outcomes, restoring clinician autonomy, reducing administrative waste, and freeing up workforce capacity to focus on care delivery.

# II. THE EVOLUTION OF PRIOR AUTHORIZATION FROM TARGETED COST-CONTROL TOOL TO PERVASIVE CORPORATE CARE VETO

Prior authorization is at least as old as Medicare, but its use has increased dramatically over the past six decades, as policymakers privatized federal health care programs and deregulated the broader industry.

Starting in the 1950s, hospitals and insurers began experimenting with post-service "utilization review" — scrutinizing hospital stays and related claims for potential abuse — as a means of cost containment. When Congress created Medicare in 1965, it required hospitals and extended-care facilities to conduct these reviews as a condition of participation in the program, despite early concerns about efficacy.[13] Private insurers and self-insured employers soon after began requiring providers to certify the medical necessity of certain procedures as a precondition of coverage.[14]

Beginning in the 1970s, both political parties adopted a new philosophy of deference to private market forces, upending federal antitrust and regulatory policy.[15] With regard to the health care sector, this philosophical shift enabled the rise of Big Medicine insurance conglomerates and the proliferation of their prior authorization requirements.

A core tenet of this shift was the purported "moral hazard" posed by insurance coverage. In 1968, economist Mark Pauly published an influential paper that argued insured patients would overuse health care relative to uninsured patients because they are not responsible for the full cost.[16] His hypothesis — based on economic theory, not empirical research — implicated physicians, who, as some later argued, would likewise overprescribe care, assuming insurers bore most of the expense.[17]

This view gave rise to the "managed care" revolution, in which policymakers from both parties moved health care away from a fee-for-service financing model to instead empower insurers to actively contain costs.[18] To do so, insurers imposed "utilization management" techniques — including prior authorization requirements — to prevent patients and clinicians from overusing health care benefits.[19]

From the late 1960s onward, policymakers embraced the managed care model, contracting with private insurers to administer public health care benefits. Between 1991 and 2024, the share of Medicaid beneficiaries enrolled in such privately managed plans increased from 9.5% to 78%.[20] Over that same period, the share of Medicare beneficiaries enrolled in what are now known as private Medicare Advantage plans increased from 3% to 54%.[21] In the wake of this privatization of our health care system, Big Medicine insurance conglomerates dramatically increased their use of prior authorization.[22]

**The expansion of prior authorization did not yield the promised cost-containment benefits. For instance, private Medicare Advantage insurers adjudicated nearly 53 million prior authorization requests in 2024 (1.7 requests per enrollee), compared with about 628,000 in traditional, fee-for-service Medicare (0.02 requests per enrollee), despite similar patient populations and coverage criteria across the two programs.[23] Although private Medicare Advantage plans imposed much more stringent prior authorization requirements, they still cost taxpayers 22% more per patient — or $83 billion — than traditional Medicare that year.[24]**

More recently, Big Medicine insurance conglomerates' corporate acquisition strategies have enabled them to increase their profits by using prior authorization to deny care. Beginning in the 2010s, insurers began vertically integrating with the previously separate vendors that adjudicated prior authorization requests. Such mergers enabled insurance conglomerates to internalize the profits that stem from coverage denials, increasingly aided by AI tools. In short, through vertical integration, insurance conglomerates can exploit a structural conflict of interest: When an insurer's corporate affiliate denies a prior authorization request, even for medically necessary care, the insurer saves money on coverage costs and thus increases their parent company's profits.

For example, in December 2018, the Cigna Group — which owns Cigna Healthcare, the nation's fourth-largest private insurer — acquired EviCore, a medical benefits management company that insurers contract with to adjudicate prior authorizations "using advanced predictive AI algorithms."[25]

In May 2020, UnitedHealth Group — which owns UnitedHealthcare, the nation's largest private insurer — purchased NaviHealth, which manages prior authorization requests for post-acute care services, for $1.1 billion.[26] A class-action lawsuit filed in November 2023 alleges that UnitedHealth Group illegally deployed NaviHealth's error-ridden predictive AI model to deny rehabilitation care for older Americans enrolled in UnitedHealthcare's Medicare Advantage plans.[27] According to the lawsuit, this "fraudulent scheme affords [UnitedHealthcare] a clear financial windfall in the form of policy premiums without having to pay for promised care, while the elderly are prematurely kicked out of care facilities nationwide or forced to deplete family savings to continue receiving necessary medical care, all because an AI model 'disagrees' with their real live doctors' determinations."[28] Faced with public scrutiny, UnitedHealth Group rebranded NaviHealth as "Home & Community Care."[29]

Other Big Medicine insurance conglomerates, including CVS Health and Elevance Health, have likewise purchased prior authorization vendors in recent years.[30] In October 2024, the U.S. Senate Permanent Subcommittee on Investigations released a report detailing "how Medicare Advantage insurers are intentionally using prior authorization to boost profits by targeting costly yet critical stays in post-acute care facilities," assisted by AI tools.[31]

# III. THE CORPORATE CARE VETO HARMS PATIENTS AND CLINICIANS

Big Medicine insurance conglomerates now routinely exercise the corporate care veto to override independent, patient-centered clinical judgment, worsening patient outcomes while driving up administrative costs for consumers and clinicians alike.

One in five U.S. working-age adults with private insurance report that they or a family member experienced coverage denials either before or after care delivery within the past year.[32] Of those who experienced a prior authorization denial, 41% said it led to a delay in care and 28% said a health problem worsened as a result.[33]

The vast majority of physicians report that prior authorization negatively impacts patient outcomes, including by delaying care (95%) and leading patients to abandon their recommended course of treatment (79%).[34]

**More than one in four physicians report that prior authorization has led to a serious adverse event for a patient in their care, including hospitalization, permanent impairment, birth defect, or death.[35]**

Nearly nine in 10 physicians report that prior authorization actually leads to *more* utilization of health care services — and thus increased spending.[36] This is because it forces patients to try ineffective treatments, schedule additional office visits, seek more expensive forms of care, or waste time and resources navigating administrative burdens. For instance, private insurers initially denied prior authorization requests for 70% of new brand-name prescriptions in 2025, up from 57% in 2021.[37] A year later, the denial rate fell to 24%, but only after patients and clinicians had wasted months on appeals and other administrative processes.[38] By one estimate, insurers' prescription drug utilization management techniques — including but not limited to prior authorization requirements — cost the U.S. health care system $93 billion annually, including increased administrative costs for insurers and physicians, increased costs to pharmaceutical manufacturers' patient access programs (which help un- and underinsured patients afford medications), and increased patient cost-sharing obligations.[39] Employers and other health plan sponsors are also impacted by absenteeism and loss of productivity when plan members struggle to access necessary care in a timely fashion.[40]

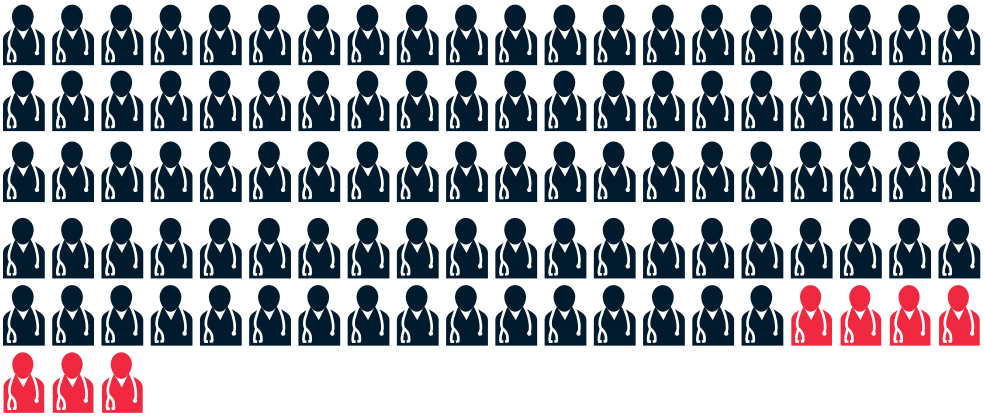
In addition to these financial costs, prior authorization imposes massive administrative burdens on health care practitioners in an already strained system. According to the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association, physicians and their staff spend, on average, 13 hours completing 40 prior authorization requests per provider per week, at a cost of $20-$50 *per hour*.[41] CMS estimates that "[f]or each provider, that's approximately $34,000 and 700 hours of administrative time each year that could otherwise be used to take care of patients."[42] Multiplied across the U.S. physician workforce, this amounts to over 650 million hours of administrative work per year, or the equivalent of 99,290 full-time physicians and advanced practice clinicians — more than the nation's current physician shortage — plus another 213,474 clinic staff, at a cost of as much as $32.7 billion annually.[43]

It's no surprise, then, that nearly nine in 10 doctors report that prior authorization increases burnout, which in turn worsens patient outcomes and increases physician attrition.[44] Prior authorization likewise burdens pharmacists, nurses, dentists, and therapists, among other clinicians.[45] And this burden is only growing, as AI tools enable Big Medicine insurance conglomerates to exercise the corporate care veto en masse, making it even harder for human clinicians to keep up with the associated administrative burden.[46]

# PRIOR AUTHORIZATION PAPERWORK BURDENS CONTRIBUTE TO PHYSICIAN SHORTAGE

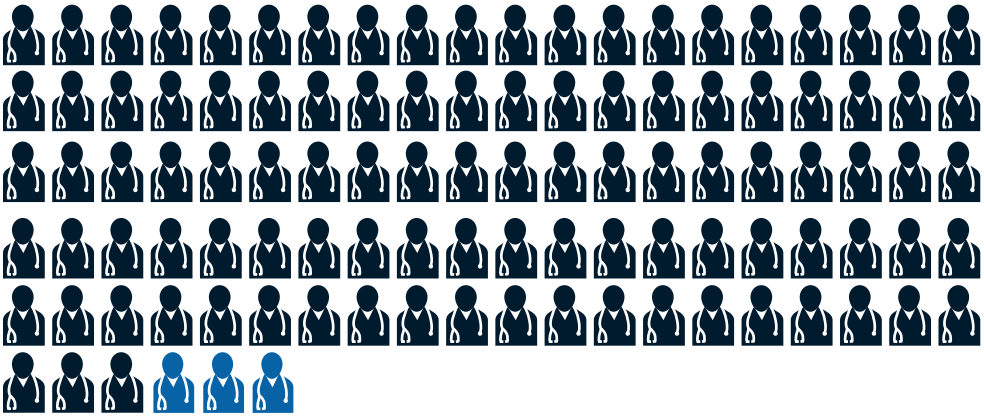
## U.S. Physician Workforce

Supply 962,350 Shortage 84,930 (-8%)



## U.S. Physician Workforce If Prior Authorization Were Banned

Supply 1,047,280 Surplus 14,360 (1%)



*Based on 2025 data. See endnote 43 for methodology and sourcing.*

This administrative burden weighs more heavily on independent medical practices and safety-net hospitals in rural and low-income metro areas, which typically have fewer administrative resources — including dedicated staff to handle prior authorization requests — than their large, corporatized counterparts.[47] As a result, prior authorization heightens these providers' risk of closure or acquisition and, therefore, patients' risk of being stranded in a care desert or shunted to a corporate-owned provider that charges more for lower-quality care.[48]

Widespread AI adoption is also exacerbating concerns about wrongful denials. Indeed, the aforementioned class-action lawsuit against UnitedHealth Group alleges that the company knew NaviHealth's predictive AI model had a 90% error rate and "bank[ed] on the patients' impaired conditions, lack of knowledge, and lack of resources to appeal the erroneous AI-powered decisions."[49]

Some experts argue that insurers use prior authorization to ration care "by inconvenience," indiscriminately denying requests because they know few patients and clinicians will bother with the appeals process despite the high rate of overturned denials.[50] Indeed, nearly 60% of physicians report that they do not believe appealing will be successful because of past experience.[51]

This dynamic benefits insurers. The former chief medical officer of UnitedHealthcare, Dr. Archelle Georgiou, analyzed 2025 prior authorization data from two major Medicare Advantage insurers — her former employer and Humana — and found:

> **"Using a conservative estimate of $100 per claim — applied to each denied case at the same overturn rate seen in actual appeals (58% for UnitedHealthcare; 65% for Humana) — the numbers are striking. Combined, across just two Medicare Advantage plans, wrongly denied and unappealed claims generated an estimated $100 million per year in avoided costs."[52]**

## In Their Words: Patients' and Health Care Professionals' Experiences with Prior Authorization[53]

"[Prior authorization requirements] made it harder for me to get medication I needed without having to restart medication I had failed in the past ..., postponed surgery for my daughter, [and] removed helpful services from my patients."
– Autumn, patient and health care professional

"My surgery was authorized after jumping through all the hoops. I had the surgery, my insurer paid for it. ... Seventeen months later, UnitedHealthcare sent a letter basically saying ... that they should have denied coverage, so they pulled the money back from my provider and charged me for the whole amount. It took several months of phone calls, sending copies, and generally running around in circles to convince them that any mistake was on their side. I was ultimately able to escape paying the $10,000 bill, but it was very time consuming and stressful, and I nearly lost my job for spending so much time dealing with them.

– Jeffrey, patient

"[Because of prior authorization,] I've lost access to critical medications I need to function normally."

– Erica, patient

"It was extremely difficult to obtain authorizations for substance abuse treatment when I covered the emergency department as a practicing psychologist. ... Other times, in my private practice, I would get authorizations and later experience 'claw backs' where Blue Cross, for example, would decide the treatment was not medically necessary and take back the money already paid. ... It is impossible at times to provide sound ethical treatment and extremely hard to make a living when reimbursement rates kept going down and the insurance companies could take back the money they had already paid for no obvious reason."

– Nancy, health care professional

"I handle prior authorizations for all providers at my workplace. Every single insurance company I have worked with has, at one point or another, denied a patient's medication or imaging order and caused days to months of delay [for] necessary patient care. ... Requiring prior authorizations ... has resulted in negative patient outcomes and is doing nothing but harm, for the profit of those who are too far removed to ever see the hurt they're causing real people."

– Milo, health care professional

"I have had two different migraine specialist offices with great doctors ... close because they had to do so much paperwork for each patient because of prior authorizations. ... I currently see a neurologist, and they moved my next appointment from six months out to nine months out because there aren't enough appointments available for all the patients now that the smaller clinics are all closed."

– Kelly, patient

"Denied continued hospitalization for patient who then died by suicide!"

– Julie, health care professional

# IV. THE CURRENT POLICY RESPONSE IS INADEQUATE

To date, state and federal prior authorization reforms have been incremental and largely ineffective at curbing Big Medicine insurance conglomerates' abuse or, worse, counterproductive, underscoring the need for a more robust solution.

In 2018, the hospital, insurer, physician, and pharmacist lobbies issued a consensus statement urging improvements to the prior authorization process.[54] In 2021, the Texas legislature passed a first-in-the-nation "gold card" law, which promised to exempt clinicians from insurers' prior authorization requirements if they had high approval rates on their requests.[55] However, just 3% of Texas clinicians qualify for a gold card because of insurers' onerous eligibility requirements, and similar laws in other states have faced the same problem.[56] Meanwhile, in many states, legislators from both parties have introduced bills to limit insurers' use of AI in coverage decisions, but they face opposition from the Trump administration, which issued an executive order that seeks to preempt state-level AI regulations.[57]

Federal reform efforts have likewise been insufficient. In 2024, the Biden administration finalized a rule that requires private Affordable Care Act (ACA), Medicaid managed care, and Medicare Advantage plans to adjudicate non-drug prior authorization requests more quickly and to provide more information to patients about the process.[58] In April 2026, the Trump administration proposed to extend these deadlines and reporting requirements to prescription drugs, but the rule has yet to be finalized.[59] Although these rules have made incremental progress, they do not address the structural conflicts of interests that give Big Medicine insurance conglomerates the ability and incentive to impose a corporate care veto.

In June 2025, the Trump administration announced a nonbinding "pledge" by Big Medicine conglomerates to voluntarily reduce their self-imposed prior authorization requirements.[60] Like the 2018 consensus statement, the 2025 pledge was joined by major insurers and America's Health Insurance Plans (AHIP), their lobbying group.[61] It includes voluntary commitments to standardize electronic prior authorization submissions, reduce the volume of services subject to prior authorization, enhance transparency around decisions and appeals, and speed response times. But these voluntary commitments are unenforceable and have not made a meaningful dent in the practice.

For instance, in December 2025, UnitedHealthcare announced it had voluntarily dropped prior authorization for 231 procedures — out of more than 11,000 billable services.[62] And even for those 231 procedures, the insurer failed to drop other problematic utilization management practices — such as post-service claims denials — and therefore effectively retained its corporate care veto power.[63] UnitedHealthcare later said it would eliminate 30% of remaining prior authorization requirements by the end of 2026, but the announcement lacked specifics or accountability measures.[64] That same month, AHIP and the Blue Cross Blue Shield Association released a survey of participating insurers that found they had reduced prior authorization by 11%, but they provided no data to back up their results.[65]

Groups representing hospitals and doctors report little change on the ground.[66] According to a recent consensus statement issued by the American Medical Association, "Physicians and patients have reason to be pessimistic that insurers will stay true to their word," including "that insurers have made little progress honoring their commitments as outlined in the [2018 consensus statement]."[67] And despite insurer pledges that denials based on medical necessity for clinical factors would be reviewed by a licensed and qualified clinician, only 16% of physicians participating in peer-to-peer reviews reported that the "peer" often or always was qualified to do so.[68]

Less than a week after announcing the voluntary pledge, the Trump administration issued a second announcement: It would enlist AI companies affiliated with some of those same insurers to expand prior authorization in traditional Medicare via the controversial Wasteful and Inappropriate Service Reduction (WISeR) pilot program.[69] Previously, traditional Medicare used prior authorization only in narrow circumstances and only when conducted by an independent third party. Now, under the Trump administration's WISeR model, traditional Medicare has enlisted for-profit contractors, most of whom have ties to private insurers, to conduct pilots in six states using AI tools to adjudicate prior authorization requests.[70] These contractors have incentives to deny care because they "may earn payment for non-affirmation of a prior authorization request for a WISeR item or service" — i.e., for denying prior authorization requests.[71] This expansion of AI-driven prior authorization in traditional Medicare has prompted bipartisan opposition, yet the pilots continue.[72]

Presumably, policymakers have shied away from banning prior authorization outright due to fears that doing so would cause health care costs to rise. However, that fear is not grounded in robust evidence, as analysis of the effects of eliminating prior authorization have been quite limited. A 2023 report commissioned by the Blue Cross Blue Shield Association — a national association of private insurance companies and therefore not an independent analysis — estimates that eliminating prior authorization could result in a 3.3% to 4.8% increase in premiums, totaling $43 billion to $63 billion annually, as well as a 1% to 2.6% increase in member cost-sharing.[73] Critically, however, the report notes significant limitations and caveats to its analysis, including that it does not account for either provider or insurer administrative cost savings and that it models savings based on denial rates without accounting for the fact that care is in fact often diverted to other treatments rather than forgone altogether.[75] Nor does the analysis account for other potential cost savings, such as patients receiving necessary treatments without delays that would otherwise make them even sicker.

A 2023 academic paper examined prior authorization in Medicare Part D and found that prior authorization limits on prescription drugs in those plans yielded net savings of $86 per beneficiary year. However, this analysis also suffers from significant limitations. For one, it uses $10 per beneficiary year as its estimate of administrative burdens on payers and providers, but that assumption is wildly out of step with CMS's estimate that providers spend an average of 13 hours per week on prior authorization at a cost of $20-$50 *per hour*.[75] For another, the authors acknowledge that they do not account for administrative burdens on patients, and that they were unable to reliably model effects on patient health — i.e., the analysis does not account for any cost increases associated with patients becoming sicker, and thus more costly, through delayed or denied care.[76]

Given the shortcomings of these studies, policymakers should not rely on them to conclude that banning prior authorization would increase costs. As explained above, administrative cost savings to providers from eliminating prior authorization would likely be significant, because prior authorization costs medical practices the equivalent of 99,290 full-time physicians and advanced practice clinicians, 213,474 full-time clinic staff, and as much as $32.7 billion annually.[77] Moreover, that $32.7 billion in potential annual savings accounts for provider administrative savings alone and does not account for other types of potential savings, such as administrative cost savings to insurers or patients, cost savings associated with the health effects of patients receiving timely care, or the savings to prescription drug manufacturers' payment assistance programs.[78] Although we are unaware of studies quantifying these additional potential savings, they are likely significant, particularly given that 95% of physicians report that prior authorization leads to delays in treatment and 92% report that it has a "somewhat or significant negative impact" on clinical outcomes.[79] Finally, we note that the solution we propose in the next section bans prior authorization as we know it today — ending the corporate care veto forever — while allowing pre-approval to be used as a narrow cost-control tool in the rare circumstance where there is documented evidence of overprescribing of medically unnecessary care, with strict limits and safeguards.

# V. THE SOLUTION: BAN PRIOR AUTHORIZATION

Instead of relying on piecemeal, incremental reforms, policymakers should ban prior authorization as it exists today, ending Big Medicine insurance conglomerates' ability and incentive to exercise the corporate care veto.

**To do so, Congress and state legislatures should ban Big Medicine insurance conglomerates — including those that administer public health care benefits — from owning or being affiliated with an entity that adjudicates prior authorization requests.** This structural rule will eliminate the financial conflict of interest that arises when a private insurer (or its corporate affiliate) both imposes a prior authorization requirement and adjudicates requests for coverage.

In rare circumstances, there may be a legitimate, evidenced-based reason to believe prior authorization would curb wasteful spending on medically unnecessary procedures.[81] In such contexts, Congress and state legislatures should establish additional safeguards to ensure that clinicians' professional judgment about their patients' health care needs cannot simply be overridden or cast aside by distant bureaucrats or AI algorithms. **Specifically, Congress and state legislatures should provide that prior approval requirements cannot be imposed unless *all of the following conditions are simultaneously met:***

## Protections Against Proliferation

- **Documented, evidenced-based need:** Before a prior authorization requirement can be imposed, the Department of Health and Human Services (HHS) — or, in the case of state regulation, the relevant state agency — must make written, evidence-based, factual findings that the particular clinician or the particular item or service has been subject to a pattern of fraud, overprescribed relative to its clinical efficacy, or is a new or experimental or high-risk indication, such that a peer-to-peer confirmation of medical necessity prior to care delivery is warranted. This will raise the evidentiary bar for when prior authorization requirements can be imposed in the first place, so that insurers aren't playing by their own made-up rules.
- **Non-emergency indication:** The particular item or service subject to prior authorization must be for a non-emergency indication. Federal law already prohibits public health care programs and private insurers from requiring prior authorization for emergency services.[82] This important limitation should remain.

## Protections to Ensure Independent, Qualified Human Review

- **No conflict of interest:** Instead of Big Medicine affiliates adjudicating prior authorization, any utilization management practices that require pre-approval of treatment must be adjudicated by an independent third party, such as existing Medicare administrative contractors (MACs).[83] Additionally, compensation of the third party must not be tied to the outcomes of prior authorization adjudications or to the volume of denials.
- **No AI denials:** Independent third-party adjudicators may use AI to approve prior authorization requests, but AI-based denials must be prohibited. This will protect against wrongful and arbitrary automated denials.
- **Peer-to-peer review by an actual peer:** Independent third-party adjudicators must be required to engage in a true peer-to-peer dialogue with the prescribing physician or other health care practitioner *before* issuing a denial. The "peer" must be a board-certified physician in the same specialty and subspecialty, where applicable, as the prescribing physician to ensure an accurate review. The peer must also disclose their name, title, clinical

credentials, and direct contact information to both the prescribing physician and the patient to ensure accountability. If the clinician does not respond to a peer-to-peer dialogue request within a reasonable time, the adjudicator must notify both the prescribing physician and the patient in writing, and it must give both of them the opportunity to respond or reopen the request. This will ensure requests aren't rejected for logistical reasons or based on the adjudicator's misunderstanding of the patient's medical needs.

## Procedural Protections

- **24-hour shot clock for a written decision:** There are currently time limits on decisions and appeals promulgated by HHS and applicable to all plans to ensure care isn't delayed, but they are too lengthy and frequently delay access to necessary care.[84] Specifically, CMS requires private insurers — including ACA and most employer-sponsored plans — to respond to urgent prior authorization requests within 72 hours and non-urgent requests within 15 days.[85] Instead, the time limits proposed in the bipartisan Improving Seniors' Timely Access to Care Act — 24 hours for urgent requests and seven days for non-urgent ones — should be adopted across the board, for all types of insurers.[86] (The bill currently applies only to private Medicare Advantage insurers.) If a written decision is not issued by the deadline, the request must be automatically approved.
- **Standardized process:** The prior authorization process — including the submission of the request, review, adjudication, and any appeals — must conform to a uniform standard promulgated by HHS (or, in the case of state regulation, the relevant state agency). For instance, the aforementioned 2024 CMS rule requires ACA, Children's Health Insurance Program, Medicaid, and Medicare Advantage health plans to build electronic systems that allow clinicians to submit prior authorization requests and receive decisions through existing electronic health record software.[87] The rule also requires these plans to give patients electronic access to their own prior authorization and claims information. Adopting these standards across all plans, without exception, will cut down on the administrative burden on clinicians, who currently must navigate fragmented and outdated prior authorization requirements — like the use of fax machines — that vary widely across insurers.[87] It will also ensure accountability, unlike voluntary industry pledges.
- **Coverage guarantee:** Any approval of a prior authorization request must confer a guarantee of coverage. This will protect against insurers retroactively denying a claim for an item or service that it had previously approved. Crucially, Congress and state legislatures should also prohibit post-service claims denials except when all of the above criteria are met. Otherwise, private insurers will likely shift the corporate care veto to slightly later in the claims review process, preserving its harms to patients, clinicians, employers, and taxpayers.

By providing that prior authorization is prohibited unless all of the above conditions are met, policymakers can end insurers' ability and incentive to abuse the practice for their own financial gain. Doing so would not only improve patient outcomes but also significantly curb costly administrative burdens that force clinicians to focus on paperwork instead of patient care.

The corporate care veto is an inappropriate and cruel method of health care cost containment. It is especially indefensible given that Big Medicine insurance conglomerates are making tens of billions of dollars in annual profits and spending billions more on things that don't improve care, like stock buybacks, advertising, and executive pay.[88]

# MYTH VS. FACT: DEBUNKING INDUSTRY CLAIMS ABOUT PRIOR AUTHORIZATION

**Myth:** ***Prior authorization promotes patient safety and prevents inappropriate care.***

**Fact:** Prior authorization puts patients' health at risk by preventing necessary care. Ninety-five percent of physicians report that prior authorization delays care, and nearly three in 10 physicians report that prior authorization has led to a serious adverse event for a patient in their care, including hospitalization, permanent impairment, or death.[90]

**Myth:** ***Banning prior authorization would result in higher premiums and out-of-pocket costs.***

**Fact:** Big Medicine insurance conglomerates make this claim without robust evidence to back it up. For example, a 2023 report commissioned by the insurance industry estimates that eliminating prior authorization would increase premiums, but the study does not account for significant potential savings, such as patients receiving necessary treatments without delays that would otherwise make them even sicker and costlier to care for or administrative savings.[91] Moreover, our proposal would ban prior authorization except in the rare and narrow circumstances in which there is a legitimate, evidence-based reason to believe it would curb wasteful spending on unnecessary procedures. Traditional Medicare has long used prior authorization much more sparingly than other insurers, and yet it costs significantly less than otherwise comparable plans.[92]

**Myth:** ***Prior authorization prevents surprise billing.***

**Fact:** Insurers sometimes include fine print providing that prior authorization approval does not guarantee coverage or protection from surprise bills. Such insurers sometimes authorize care in advance, only to then still deny the resulting claim after services are rendered, leaving clinicians and patients to navigate unexpected costs.[93]

**Myth:** ***There are already appropriate safeguards to protect against unfair prior authorization denials.***

**Fact:** Insurers can get away with improper prior authorization denials because they know that few patients and clinicians will pursue an appeal — which generally entails navigating obscure and cumbersome processes.[94] That said, the vast majority of appeals are successful, which further undermines insurers' claim that the practice is necessary to lower costs associated with unnecessary care.[95]

**Myth:** ***Private insurers and policymakers have already solved the prior authorization problem.***

**Fact:** Narrow state-level reforms, incremental federal rules, and voluntary pledges by the private insurers have so far failed to meaningfully address the prior authorization problem. As a result, robust structural reforms to eliminate insurers' financial ability and incentive to abuse prior authorization to boost their own profits are still needed. In the absence of robust oversight and accountability, widespread AI adoption risks exacerbating the problem by allowing insurers to automate denials at scale.

# VI. CONCLUSION

Prior authorization began as a narrow cost-control tool but has since devolved into a pervasive corporate care veto in which Big Medicine insurance conglomerates override clinical judgment in ways that too often serve their own financial interests at the expense of everyone else. Reform efforts have repeatedly fallen short because they have not addressed the underlying incentive: Insurers profit when they deny care.

Support for bold, structural reform is broad and bipartisan because it is painfully obvious to patients, caregivers, and clinicians alike that prior authorization, as currently practiced, imposes both financial and human costs that far exceed its benefits. Policymakers should adopt legislation that meets the moment by permanently and enforceably banning prior authorization as we know it today and restoring clinical decision-making to health care professionals.

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90 “Fortune 500,” *Fortune*, June 3, 2026, https://fortune.com/ranking/fortune500/2026/; “Form 10-K,” UnitedHealth Group, March 2, 2026, https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2025/UNH-Q4-2025-Form-10-K.pdf; “Form 10-K,” CVS Health, Feb. 10, 2026, http://d18rn0p25nwr6d.cloudfront.net/CIK-0000064803/fbe8d854-5705-4843-bf0a-c4cafc17fcd4.pdf; “Form 10-K,” McKesson, May 8, 2026, https://s24.q4cdn.com/128197368/files/doc_financials/2025/ar/f228364d-7e15-414a-a2e2-177651014ef5.pdf; “Form 10-K,” Cencora, Sept. 30, 2025, https://d18rn0p25nwr6d.cloudfront.net/CIK-0001140859/76d55a73-04ea-4af4-be6b-10270ebef61e.pdf; “Form 10-K,” The Cigna Group, Feb. 26, 2026, https://investors.thecignagroup.com/financials/sec-filings/sec-filings-details/default.aspx?FilingId=19188102; “Form 10-K,” Cardinal Health, Aug. 12, 2025, https://d18rn0p25nwr6d.cloudfront.net/CIK-0000721371/af4f5ef3-12df-4c7e-a350-e1d952402ed5.pdf.

91 See “2025 AMA prior authorization survey” at 3.

92 See 74.

93 See 24-32 and accompanying text.

94 See “Patients Stuck With Bills After Insurers Don’t Pay As Promised” at 4.

95 See “‘Rationing by inconvenience’: Health insurers count on customers not appealing denials” and “Prior Authorization: I Killed It Once. They Brought It Back. Now the Data Shows Why.” at 51.

96 See “Medicare Advantage Insurers Made Nearly 53 Million Prior Authorization Determinations in 2024” at 24.

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