NEWS BRIEF

HHS Announces Support From Insurers for Changes to Prior Authorization

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U.S. Health and Human Services (HHS) Secretary Robert F. Kennedy Jr. announced that the country's largest health insurers have voluntarily pledged to standardize and reform the prior authorization process. The insurers pledged commitments to streamline, simplify and reduce prior authorization.

Prior authorization, also known as preauthorization, is when a physician must get approval from an insurer for medication or treatment before administering it. While prior authorization is often used as a cost-cutting tool by insurers, patients and health care providers argue that it creates too many roadblocks, delaying or denying access to care.

A KFF survey revealed that about 1 in 6 insured adults say they've had prior authorization problems.

U.S. Centers for Medicare and Medicaid Services (CMS) Administrator Mehmet Oz noted that out of the about 6,000 procedures subject each year to prior authorization, only about 2,000-3,000 should require the process.

According to Kennedy, almost 50 health insurers pledged to streamline the prior authorization process, including Blue Cross Blue Shield Association, Cigna, Elevance Health, Humana and UnitedHealthcare. The HHS shared that there are six key parts of this pledge:

1. Standardize electronic prior authorization submissions.
2. Reduce the number of medical services that require prior authorization.
3. Honor existing authorizations when patients change insurance plans in the middle of ongoing treatment.
4. Enhance transparency and communication about authorization decisions and appeals.
5. Minimize delays with real-time approvals for most requests.
6. Ensure medical professionals review all clinical denials.

According to the pledge, these changes would be implemented across insurance markets, including private, Medicare Advantage and Medicaid.

What's Next?

This voluntary pledge aims to cut red tape, accelerate care decisions and enhance transparency for patients and providers. As such, health insurers are working to develop standardized data and submission requirements for electronic prior authorization by Jan. 1, 2027. They will also work on reducing the scope of claims that require prior authorization by Jan. 1, 2026, and ensure authorizations are valid for a 90-day period if the patient changes insurance companies during treatment. Keep in mind that this is simply a commitment and not a finalized rule. Employers will have to wait and see what happens.

Furthermore, Oz noted that pledge participants cover three-quarters of U.S. patients, and the CMS will publish a full list of participating plans later this summer.

Employers should continue to monitor prior authorization changes. Contact us for more health care resources.
