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A Decisionmaker's Guide to Competing Health Evidence

Prior Authorization Reform: The Evidence Behind the Debate, the Reforms Now Moving, and What No One Is Measuring

Medicare Advantage insurers made nearly 53 million prior authorization decisions in 2024 — roughly 145,000 every day. Reform is now moving on four tracks at once: federal rules, a voluntary insurer pledge, bipartisan legislation, and state laws. Nearly all of it targets how prior authorization works. The evidence on whether it works deserves more attention than it is getting. Here is what the research shows, where it runs out, and what to watch.

AT A GLANCE

- **What it does**: Prior authorization requires an insurer's advance approval before it will cover certain services, items, or drugs.
- **How big it is**: Medicare Advantage insurers made nearly 53 million prior authorization decisions in 2024, roughly 145,000 every day and nearly two for every enrollee. Traditional Medicare made about one for every 50 beneficiaries.
- **What's at stake**: Whether prior authorization's documented costs in delays, denied appropriate care, and paperwork, are justified by the spending reductions it produces, and whether the reforms now moving would change that calculus.
- **What the evidence shows**: Prior authorization reliably reduces use and spending on the services it targets, but evidence on total costs, patient outcomes, and the effects of specific reforms is much thinner.

Who's Saying What

This map describes public positions of major stakeholders. It does not endorse or evaluate them.

Physician and provider groups (pushing for restrictions on prior authorization)

- **The American Medical Association** campaigns against prior authorization as practiced. Its **2024 survey** found 29 percent of physicians reporting a serious adverse event tied to it.
- **The American Hospital Association** **supports the federal legislation**, arguing that high overturn rates show plans deny large volumes of appropriate care up front.
- **Specialty societies** emphasize fields where delay is most costly. **ASCO's provider survey** reports widespread treatment delays in cancer care.

Insurers (defending prior authorization while committing to streamline it)

- **AHIP** calls prior authorization **"a vital patient safeguard"** and, with the **Blue Cross Blue Shield Association**, organized the June 2025 pledge. Their **April 2026 progress report** describes 6.5 million fewer prior authorizations and real-time electronic decisions by 2027, though eight signatories declined the technology commitment.

Government voices (documenting problems and setting rules)

- **CMS** issued both waves of the federal rules and, through its Innovation Center, launched the **WISeR model** testing prior authorization in traditional Medicare.
- **The HHS Office of Inspector General** **found in 2022** that 13 percent of denied requests met Medicare coverage rules. Its June 2026 reports document far higher denial rates for care after a hospital stay (details in Section 3).
- **Congress** has moved with unusual bipartisanship. The House bill cleared committee 42-0 with nearly 300 co-sponsors.

1. Why This Matters Right Now

Your doctor orders a scan, a new medication, or a few weeks of rehabilitation after surgery. Then everything stops because the insurer must review the request before agreeing to pay. That review is prior authorization: the insurer must approve a service, item, or drug before it will pay. Insurers use it to screen out care that's unnecessary, inappropriate, or needlessly expensive. Physicians describe it as a bureaucratic obstacle that delays care and consumes enormous amounts of clinical time. Both descriptions are accurate, which is why the policy question is harder than either side admits. Medicare Advantage insurers alone made **nearly 53 million prior authorization determinations in 2024**, denying about 7.7 percent of requests overall, with much higher rates for some services. When patients or providers appealed those denials, 80.7 percent were overturned. The question underlying the whole reform debate is whether the screening saves more than it costs, once you count delayed care, denials of appropriate treatment, and the paperwork burden on everyone involved. For patients, the question is more immediate. Why is someone who has never examined me deciding whether I get the treatment my doctor ordered?

Reform is now advancing on four tracks: federal regulation, a voluntary insurer pledge, federal legislation, and state laws. The regulation came in two waves, the first setting what plans must cover and the second setting how quickly they must decide. A **2023 rule** requires Medicare Advantage plans to use traditional Medicare's coverage rules rather than their own stricter ones and to keep an approval in place for a patient's full course of treatment. **Rules effective January 1, 2026**, require Medicare Advantage, Medicaid managed care, and Affordable Care Act marketplace plans to decide urgent requests within 72 hours and standard ones within seven days. CMS has **proposed extending these requirements to drugs**. In June 2025, more than 50 insurers pledged voluntary reforms, and their **first progress report** this spring claimed an 11 percent reduction in services subject to prior authorization. In July 2026, the House Ways and Means Committee **unanimously advanced** the Improving Seniors' Timely Access to Care Act, which would write the requirements into law for Medicare Advantage. Unfortunately, nearly all of this activity targets how prior authorization works, not whether it works. The evidence on that second question deserves more attention than it's getting.

2. Why Do Smart People Disagree?

Some health care is low-value, and almost no one argues that insurers should approve everything automatically. Nearly everyone agrees the current process is broken: too manual, too slow, too opaque, and still running partly on fax machines. The insurers' own pledge concedes this; you don't promise to fix something that's working. And the appeal numbers bother everyone. When 80.7 percent of appealed denials are overturned, either the initial reviews are wrong at a remarkable rate or the appeals are, and neither possibility flatters the system.

Where's the disagreement? It's mostly about which question people are asking. Prior authorization produces savings and costs, but they land on different parties and are measured with different tools. An economist studying drug spending, a physician filling out the week's 39th request, and an inspector general auditing denials are all looking at the same program and seeing different things. Unfortunately, they're all seeing it accurately.

THE QUESTIONS BEHIND THE DEBATE

The question being asked	What It Measures	Who Tends to Ask It
Does prior authorization reduce spending on the services it targets?	Use and spending on specific drugs, tests, or procedures subject to review	Health economists, insurers, actuaries
Does it reduce total health care spending?	Total cost of care, including substitute services, downstream hospitalizations, and administrative costs on all sides	Skeptical researchers, budget analysts
Does it block care that patients should have received?	Denial rates, appeal overturn rates, denials that met coverage rules	OIG, GAO, journalists
Does it harm patients clinically?	Delays in treatment, therapy abandonment, adverse events	Physicians, specialty societies, patient groups
What does compliance cost the delivery system?	Staff hours, practice spending, physician time diverted from care	Provider groups, practice researchers
Can technology fix the process without changing the policy?	Decision speed, electronic submission rates, real-time approval shares	CMS, insurers, health IT vendors

Two features make the debate worse than it needs to be. The first is simpler than it sounds. The savings from prior authorization flow to the insurer that imposes it. The costs, staff hours, paperwork, and delayed care fall on the physicians who navigate it and the patients who wait. Each side's accounting is internally correct, and that's why they rarely convince each other. They're not looking at the same ledger. Second, reporting requirements give us data on Medicare Advantage and Medicaid, but commercial plans, where much of prior authorization happens, report almost nothing.

The real disagreement isn't about whether prior authorization saves money on the services it targets. It usually does. It's about whether those savings justify the costs that fall mostly on people other than those who capture the savings. The honest answer is that we've measured the savings much better than the costs.

3. What Does the Evidence Show?

The answer hinges on which costs you count and whose. On the narrow question of whether prior authorization reduces use and spending on the services it targets, the evidence is strong, and the answer is "yes." On the broader questions of whether it reduces total spending, whether the care it deters is care patients needed, and whether the reforms now moving will fix any of the documented problems, the evidence grows progressively thinner. That gradient matters more than any single finding.

What any study has to measure

Before weighing the studies, know what they're trying to capture. Prior authorization works through three channels. First, the plan can simply deny the request. Second, the patient and physician can switch to a covered alternative, usually a cheaper one. Third, the request never gets submitted because the physician expects denial or the practice can't absorb the paperwork. The third channel is the largest, and it leaves no denial statistic and no appeal, so most public debate focuses on the smallest, most measurable piece of the program.

Evidence that it saves money

The strongest causal study in this literature is a **Medicare Part D analysis** by Brot-Goldberg and colleagues, which took advantage of the fact that low-income beneficiaries are randomly assigned to default drug plans, some of which restrict a given drug while others don't. That random assignment makes the comparison as clean as a lottery. Beneficiaries facing a restriction were 26.8 percent less likely to fill the restricted drug. The restrictions cut net drug spending by about $96 per beneficiary per year while generating only about $10 in paperwork costs. For drugs in this population, prior authorization saves much more than it costs to administer.

The most comprehensive evaluation of services is a **study of Medicare's program** for repetitive, scheduled, nonemergency ambulance rides, a service with well-documented improper use. Across 1.7 million beneficiaries, the study compared states that received the requirement with similar states that didn't. Spending on the targeted transports fell 77 percent, total Medicare spending fell 2.4 percent per beneficiary per year, and the study detected no worsening in the access and health measures it tracked.

Beyond these two, the literature quickly weakens. **MACPAC's review** of Medicaid studies found savings for targeted drugs in some state programs and none in others, with consistent difficulty in generalizing. Notice what the two strong studies share: narrow targets, documented overuse, and inexpensive substitutes. The evidence supports prior authorization as a scalpel. Nothing in it justifies using it as a club, which is roughly what applying it to thousands of distinct services amounts to. And plans don't reserve it for services with documented overuse. Applying **one large insurer's rules** to traditional Medicare would have put a quarter of Part B spending under review and touched more than 40 percent of beneficiaries each year.

Evidence on whether it blocks appropriate care

The government's own auditors offer the clearest evidence. The HHS Office of Inspector General **found in 2022** that 13 percent of prior authorization denials it reviewed in Medicare Advantage were for services that met Medicare coverage rules. Those patients would have received the care under traditional Medicare. Its June 2026 reports on care after a hospital stay found denial rates of **54 percent for inpatient rehabilitation facilities and 65 percent for long-term care hospitals**, with denials concentrated among the largest insurers. **Of appealed skilled nursing facility denials, 95 percent were overturned**. To be fair to the plans, the overturn data can't fully separate incorrect initial reviews from appeals that simply arrived with more complete documentation. Either explanation means appropriate care was delayed.

The appeal data reveals a quieter finding. Only **11.5 percent of denials are appealed**, even though 80.7 percent of appeals succeed. Appealing takes time, paperwork, and awareness of the option, and a denial usually arrives when the patient is least equipped to fight one. Patients who appeal tend to have stronger cases, so the overturn rate can't simply be applied to denials that nobody contested, which makes OIG's random-sample 13 percent the more telling estimate. Some share of unappealed denials were wrong, and that's appropriate care no statistic captures as harm.

Clinical evidence on the consequences is strongest in oncology, where delay is most dangerous. A **claims-based study** by Kyle and Keating followed Medicare patients already stable on oral cancer drugs when their plan imposed a new prior authorization requirement, comparing them with similar patients whose plans didn't. The requirement delayed the next refill by about 10 days on average and increased the odds that patients stopped filling the prescription within four months sevenfold. That's an analysis of what patients actually did, not what physicians recall, which matters. Much of the harm literature rests on surveys, and physicians asked about a policy they oppose are not a neutral measurement instrument. That doesn't make the harms fabricated. It makes them hard to count. The burden also lands directly on patients. In **ASCO's patient survey**, three-quarters of people in cancer treatment faced a recent prior authorization, and in half of those cases patients or families had to get personally involved to push it through. Inappropriate denials and delays happen at scale. The evidence quantifying how much health they cost is weaker.

Evidence on administrative burden

Every available estimate is large; none is precise. A **Health Affairs Scholar survey** estimated that providers spend time on prior authorization equivalent to more than 100,000 full-time registered nurses per year. The **AMA survey reports** 39 requests per physician per week, taking 13 hours of physician and staff time. The asymmetry is the point. The Part D study found the insurer's paperwork cost was about $10 per beneficiary against $96 in savings, but that accounting doesn't include the physician's side of the transaction, where the ledger looks much worse.

What we know:

- Prior authorization reduces use and spending on the services it targets. The best causal evidence shows net savings even after the insurer's administrative costs.
- A meaningful share of denials are wrong by the system's own standards. OIG's random-sample audit found 13 percent met Medicare coverage rules, and 80.7 percent of appealed denials are overturned.
- Only about one denial in nine is appealed, so overturn rates understate how much appropriate care is ultimately foregone.
- Compliance costs on providers are large by every available measure, though most measures are surveys.

What we don't know:

- Whether prior authorization reduces total health care spending once substitute care, downstream care, and everyone's administrative costs are counted. The ambulance program passed that test, but it was built to.
- What happened to the roughly half of Part D patients who, diverted from a restricted drug, took no drug at all. Deterred care is the program's largest effect and its least measured.
- Almost anything about commercial insurance, where most prior authorization happens and almost nothing is reported.
- Whether the current reforms improve outcomes or reduce burden. Timelines, electronic submission, gold carding, and pledges have no rigorous published evaluations, and studies of outright removal are mixed.

The evidence on the reforms themselves

This is the shortest subsection because there's the least to report, and that is itself the finding. The federal timeline requirements took effect in January 2026. No evaluation of their effects exists yet, and faster decisions are not necessarily better. Gold carding, the most popular state reform, exempts physicians with high approval rates from review. The theory is sound, but only **3 percent of Texas providers** had qualified after three years. The exemptions are earned service by service and insurer by insurer, one for brain MRIs with one plan at a time, which helps explain why so few clear the bar. The Texas Medical Association calls its impact "underwhelming," and no study has measured its effects on spending or outcomes. The insurers' pledge reports an **11 percent reduction** in prior authorization volume, a self-reported figure, and the AMA's **December 2025 survey** found physicians reporting 40 requests per week, no better than before. It's also not the industry's first pledge. Plans and physician groups signed a **similar consensus statement in 2018**, and the AMA spent years documenting how little changed. The closest thing to real reform evidence comes from studies of removing prior authorization entirely for a drug. When state Medicaid programs dropped their requirements for buprenorphine, the medication that treats opioid addiction, **one study** found prescriptions rose, while **a larger 23-state analysis** found no substantial overall change. Even the deregulation evidence resists confident claims. The strongest case for some review is what happened without it. Traditional Medicare spending on skin substitutes, bandage-like wound care products, grew from about **$250 million in 2019 to more than $10 billion in 2024**, while Medicare Advantage plans, whose review programs restricted the products, **spent about 93 percent less** on clinically similar patients. A separate scheme **billed traditional Medicare $10.6 billion in fraudulent catheter claims**, caught by Justice Department data analytics rather than by any insurer's review, but incubated by a system that pays first and checks later. Both help explain why CMS's Innovation Center went the opposite direction, launching the WISeR model in January 2026 to test AI-assisted review, with denial decisions made by licensed clinicians, for selected services in traditional Medicare across six states. Skin substitutes are on its target list. Whatever one thinks of that experiment, it comes with comparison states and a six-year evaluation, which is more than any reform on this list can say.

4. Risks and Unknowns

If the timeline rules work exactly as intended, expect more denials, not fewer. The new deadlines regulate speed, not accuracy. A plan can comply fully by denying in 72 hours what it used to deny in two weeks. Faster answers have real value, but nothing in the rules addresses OIG's finding that a meaningful share of denials are wrong. A wrong answer delivered quickly is still wrong.

If plans continue to cut prior authorization volume, watch where the review activity shifts. Prior authorization is one tool in a set that includes denying claims after care is delivered, step therapy (requiring patients to fail on a cheaper drug first), and narrower networks. The pledge covers the first tool, not the set, and early analyses of hospital billing data already report **rising claims denials** as prior authorization volume falls. Shifting review from before care to after changes who bears the financial risk, not necessarily how much care gets paid for.

If artificial intelligence takes over review, watch appeal and overturn rates, not processing times. AI makes review faster and cheaper to run, and things that get cheaper tend to be used more. OIG has already found that **plans using outside review contractors denied at higher rates** than plans reviewing internally, and most surveyed physicians expect AI to further raise denial rates. Note the direction of travel. The same administration that is streamlining prior authorization in Medicare Advantage is piloting its expansion into traditional Medicare, so the end state may be more prior authorization overall, executed faster and electronically. Whether that's good depends entirely on targeting.

If reforms meaningfully cut savings, watch premiums and benefits. The savings don't vanish when the program shrinks; they move. In Medicare Advantage, there's a paradox worth naming. Plans are marketed for extra benefits, and the business model that funds those extras is the same one that drives prior authorization volume. Congress has already run this experiment once. The 2022 version of the current House bill passed the House unanimously, then **died in the Senate** after the Congressional Budget Office scored it at roughly $16 billion over ten years. The bill was revived only after the CMS rules absorbed its costly provisions and the score fell to roughly zero. Reform advocates rarely name who should absorb those costs, and the honest answer is enrollees or taxpayers.

5. How to Read the Evidence Yourself

Prior authorization claims arrive daily from every side of this debate. Five questions will sort most of them.

1. **What would have happened to these patients without the requirement?** This counterfactual question cuts both ways. When an insurer says prior authorization "avoided" a billion dollars in unnecessary care, the claim assumes the care that was deterred was unnecessary. When a physician group says a denial harmed a patient, the claim assumes the service would have helped. The Part D study found that half of diverted patients took no medication at all, and the whole debate turns on whether that's waste avoided or treatment lost. No one has measured it. Be suspicious of anyone on either side who talks as if they have.
2. **Does the study capture deterrence, or only denials?** The largest effect of prior authorization is requests never submitted, which appear as no denials and no appeals. The strongest studies compare populations facing a requirement with those that don't, which captures deterrence. Studies comparing approved requests with denied requests can't.
3. **Whose costs are in the accounting?** A study can honestly report that prior authorization saves money while counting only the insurer's spending and paperwork. The physician's staff time, the patient's delay, and any downstream care from foregone treatment fall outside that ledger. When a savings estimate doesn't specify whose costs it includes, assume the narrowest possible answer.
4. **Is this a claims analysis or a survey, and who was surveyed?** Much of the harm literature asks physicians to recall harms, and much of the benefit literature asks plans whether their programs work. Both are testimony from interested parties. Surveys establish that a problem exists and how it feels; they can't establish rates. Claims-based studies, in which someone counts what actually happened, are much more valuable, though they can miss clinical nuance.
5. **Which corner of the system was studied, and does the claim hold up there?** Nearly all rigorous evidence comes from Medicare Part D drugs, a Medicare services program, and scattered Medicaid drug classes. Nearly all prior authorization occurs elsewhere. The narrower the study and the broader the claim resting on it, the more skepticism the claim deserves.

6. The Bottom Line

The evidence falls between what either side claims and what the stalemate suggests. Prior authorization works in a narrow sense. It reduces use and spending on the services it targets, and the best-designed studies show that the savings exceed the insurer's cost of running the program. The evidence also shows that the program, as practiced, is error-prone in ways its defenders should find uncomfortable. Thirteen percent of audited denials met Medicare's own coverage rules; four in five appealed denials are overturned; and eight in nine denials are never appealed at all. Both findings are true at once. The program saves money and wrongly denies care, and the studies documenting each rarely acknowledge the other.

The irreducible tradeoff is this: any system that screens care before delivering it will stop some care patients need, and any system that doesn't will pay for some care patients don't. Reform can change the error rate, the speed, and who bears the burden of the process; it can't eliminate the choice between the two errors. The current debate is largely a fight over which error to prefer, conducted by parties who each face only one of them. Insurers capture the savings and never see the patient who gave up; physicians see the patient and never see the premium. A reform that pretends the tradeoff away, in either direction, is advertising, not policy.

Unfortunately, the evidence on the reforms now moving is much weaker than the evidence on the program they would change. We have credible causal estimates of what prior authorization does; we have essentially none for what timeline mandates, electronic submission, gold carding, or voluntary volume pledges do. That asymmetry should temper how confidently anyone predicts a reform's effects. Decisionmakers should be more skeptical of confident claims about what these reforms will accomplish than of the underlying evidence about what prior authorization does, and should ask, of every proposal, the question this whole literature keeps failing to answer. What happens to the patients whose care is deterred, and would they have needed it? The reforms most worth supporting are those designed to find out.

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