

Families Scramble To Pay Five-Figure Bills as Clock Ticks on Promised Preauthorization Reforms

Millions of patients face denials through the prior authorization process, which requires preapproval before proceeding with medical care.

March 25, 2026 By Lauren Sausser and KFF Health News

Sheldon Ekirch is used to being disappointed by her health insurance company.

That's why Ekirch, 31, of Henrico, Virginia, was stunned when she learned Anthem would finally have to pay for life-changing medical treatment.

For two years, she had battled the company to cover blood plasma infusions called intravenous immunoglobulin, or IVIG. The treatment has been shown, in some cases, to improve symptoms associated with small-fiber neuropathy, a condition that makes Ekirch's limbs feel like they're on fire.

But Anthem had repeatedly denied coverage for IVIG, which costs about \$10,000 per infusion. Then, in February, an external review of her case conducted for the Virginia Bureau of Insurance overturned Anthem's denial. It meant her parents would no longer need to withdraw money from her father's retirement savings to pay out-of-pocket. Already, they'd spent about \$90,000.

"My mom was sobbing. My dad was on his knees, sobbing. I don't think I've ever seen him cry like that," said Ekirch, describing her parents' reaction to the reversal.

"I think I'm in shock from it all," she said.

In a prepared statement, Stephanie DuBois, a spokesperson for Anthem Blue Cross and Blue Shield, said IVIG did not "align with our evidence-based standards." But she said the company respects "the external reviewer's decision" to overturn the denial.

Meanwhile, each year millions of patients like Ekirch continue to face denials through the prior authorization process, which requires many patients or their doctors to seek preapproval from health insurers before proceeding with medical care. And despite promises of reform from insurance companies, denials remain a frustrating hallmark of the American health care system.

Last June, Trump administration officials announced in a press conference that health insurance leaders had pledged to simplify prior authorization by taking steps such as “[reducing the scope of claims](#)” subject to preapproval. The insurers also promised faster turnaround times and “clear, easy-to-understand explanations” of their decisions.

Yet in February, when KFF Health News contacted more than a dozen major insurers that signed the pledge, half of them failed to provide specifics about health care services for which they no longer require prior authorization.

A [January press release](#) said the industry remains committed to the effort. But physicians, consumers, and patient advocates are pessimistic about the insurers’ willingness to follow through with these voluntary changes.

“They have no desire to do what’s in the best interest of the patient if it’s going to hurt their pockets,” said Matt Toresco, CEO of Archo Advocacy, a patient advocacy and consulting company.

“In the insurance world, the fiduciary responsibility is not to the patient,” he said. “It’s to the Street,” he said, referring to Wall Street.

Meaningful Change?

The Department of Health and Human Services did not respond to questions for this article. The few updates the federal government has issued since June on prior authorization reform include a [September announcement](#) about ensuring clinicians can submit requests electronically.

AHIP, the health insurer trade group that issued the January press release, did not provide information about specific treatments, codes, medications, or procedures that its members have released from prior authorization since signing the pledge.

“We will have additional progress updates coming out later this spring,” said Kelly Parsons, a spokesperson for the Blue Cross Blue Shield Association, which represents 33 independent Blue Cross and Blue Shield companies. She also offered no specifics.

Blue Cross and Blue Shield companies that cover patients in Alabama, Arkansas, Iowa, Michigan, Pennsylvania, South Carolina, South Dakota, and Tennessee either did not respond to questions for this article or deferred to the Blue Cross Blue Shield Association.

By contrast, other insurers cited specific examples of change.

Aetna CVS Health began “bundling” prior authorizations for musculoskeletal procedures, as well as for lung, breast, and prostate cancer patients, spokesperson Phil Blando said. This practice allows providers to file one authorization request for a patient’s treatment instead of several.

And Humana removed prior authorization requirements for “diagnostic services across

colonoscopies,” among other changes, spokesperson Mark Taylor said.

UnitedHealthcare, which came under intense scrutiny for its use of prior authorization following the [fatal shooting](#) of one of its executives in late 2024, removed prior authorization requirements on January 1 for “certain nuclear imaging, obstetrical ultrasound and echocardiogram procedures,” among other changes, spokesperson Matthew Rodriguez said.

Yet some health care insiders doubt these changes will amount to much.

“Insurers have made similar promises before and failed to deliver meaningful change,” said Bobby Mukkamala, president of the American Medical Association, which represents U.S. physicians and medical students.

In 2018, [various health industry groups](#), including AHIP and the Blue Cross Blue Shield Association, announced a partnership “to identify opportunities to improve the prior authorization process.” Yet, [Mukkamala wrote](#) in response to the June pledge, the process remains “costly, inefficient, opaque, and too often hazardous for patients.”

“Transparency is essential so everyone can see whether real reforms are happening,” he told KFF Health News.

Curbed Enthusiasm

Prior authorization may be getting more political attention, but data shows patients — particularly those with chronic conditions that require ongoing medical treatment — continue to face barriers to doctor-recommended care.

Among patients in that group, 39% said prior authorization is “the single biggest burden” in receiving care, according to a [recent poll](#) by KFF, a health information nonprofit that includes KFF Health News.

That’s true for Payton Herres, 25, of Dayton, Ohio, who in 2012 received a heart transplant, which requires her to take an antirejection prescription medication for the rest of her life.

But last year, she said, Anthem denied coverage for the expensive drug. She’d been taking it for more than 10 years.

“I’ve been with Anthem my entire life, and then, all of a sudden — I don’t know what happened — they just started denying me over and over,” she said. “I almost ran out of medication.”

DuBois, the Anthem spokesperson, confirmed the company has approved the medication. It had not taken Herres’ treatment history into account when it denied coverage for the drug, DuBois said.

But Herres said the company will require her to obtain a new authorization for the medication in

September.

“Are they going to deny other things, too?” she asked. “I hope I don’t have to keep fighting like this for the rest of my life.”

Anna Hocum, 25, is preparing for a similar fight. In 2024 and 2025, her insurer repeatedly denied coverage for expensive treatment used to slow the progression of a rare genetic condition that destroys her lung function.

“I just thought I was going to die,” said Hocum, of Milwaukee. “I was fighting to survive, and then I was fighting to convince someone that I deserved to survive.”

Like with Ekirch, Hocum’s parents paid while they waited for her insurance company to overturn the initial denials. Friends and family donated more than \$30,000 through a GoFundMe campaign to help defray the costs.

Then last spring, Hocum said, her insurer reversed the denial without an apparent explanation. But the approval is valid for only 12 months, so she will need another prior authorization approval this year.

“It is scary,” she said. “It’s not guaranteed that it’ll be accepted.”

Even though it’s a “huge relief” that Anthem is now obligated to cover Ekirch’s treatment, her mother doesn’t know if or how the family will recoup the money it has already paid.

In a letter to Ekirch confirming the external reviewer’s decision, Anthem explained that the authorization would be valid for a year beginning on Sept. 25, 2025. “We are pleased we can provide a favorable response in this case,” a grievance and appeals analyst for Anthem wrote.

Ekirch said the letter highlighted the company’s hypocrisy.

“They act as though they are a benevolent organization doing me a favor.” In reality, she said, “they fought me tooth and nail every step of the way, to the point that they made my life a living hell.”

Now, Ekirch’s access to IVIG may be in jeopardy again. Her COBRA coverage through Anthem expires in late March. In April, she will need to transition to a new insurance plan — and she’s bracing herself for another round of prior authorization.

“I just am so afraid that I don’t have the strength to go through and do what it takes,” Ekirch said, “to fight this battle again.”

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