January 20, 2026

The Honorable Morgan Griffith
Chairman
Committee on Energy and Commerce, Subcommittee on Health
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Committee on Energy and Commerce, Subcommittee on Health
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Re: Statement for the Record- Committee on Energy and Commerce Subcommittee on Health Hearing on Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability

Dear Chairman Griffith and Ranking Member DeGette,

The Medical Group Management Association (MGMA) thanks you for holding the hearing, *Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability* on January 22, 2026, and inviting the CEOs from UnitedHealth Group, CVS Health, Elevance Health, the Cigna Group, and Ascendiun to testify. With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA members are responsible for delivering care to hundreds of millions of patients annually, spanning primary care, specialty services, and rural health. They are at the forefront of improving access, efficiency, and quality of care in the U.S. healthcare system. MGMA's diverse membership uniquely situates us to offer the following insights on factors that are driving up health insurance costs and policy recommendations to solve them.

As the Subcommittee on Health holds productive discussions with health insurance companies on the core drivers working against health care affordability—namely, onerous government interference, administrative burdens, waste, fraud, and abuse, and lack of competition and patient choice- it is of the utmost importance to draw attention to insurers' overuse of prior authorization. Prior authorization is a process that requires clinicians, physician practices, and hospitals to obtain advance approval from health plans before patients can receive certain tests, treatments, or medications. Prior authorization often leads to delays in care, worsening conditions, and costlier interventions, ultimately driving higher downstream healthcare spending. A 2023 survey of MGMA members found that 97 percent of medical group practices surveyed report their patients experienced delays or denials for medically necessary care (e.g., prescription medicine, diagnostic tests, or medical services) due to prior authorization requirements. An investigation from the Department of Health and Human Services (HHS) Office of the Inspector General

(OIG) found that 75 percent of denied prior authorization requests were overturned upon appeal[1], suggesting systemic issues with the accuracy and appropriateness of initial determinations. Not only do these unnecessary denials lead to delays in critical patient care, but they create costly inefficiencies in our health care system by creating administrative burden. 89 percent of medical group practices report that prior authorization requirements are extremely problematic or burdensome, and 92 percent have had to hire or reassign staff solely to handle the growing volume of prior authorization requests—resources that could otherwise go toward patient care, such as hiring a nurse or expanding service hours. 60 percent of practices indicated that at least three employees are typically involved in completing a single prior authorization request, while 35 percent reported spending upwards of 35 minutes on average per request.[2]

Medical group practices cite Medicare Advantage as the most burdensome as it pertains to obtaining prior authorization when compared to commercial plans, traditional Medicare, and Medicaid.[3] This concern is reinforced by HHS OIG findings that Medicare Advantage plans often delay or deny care even when requests meet Medicare coverage rules.[4] As Medicare Advantage enrollment continues its significant two-decade expansion, these burdens are intensifying, reinforcing the need for focused attention on prior authorization reform in Medicare Advantage. The widely supported bipartisan and bicameral bill, Improving Seniors' Timely Access to Care Act (H.R. 3514; S. 1816) (Seniors' Act)— which has 65 cosponsors in the Senate and 244 in the House of Representatives —would make long needed changes to prior authorization and allow practices to focus resources on clinical care instead of administrative tasks that too often drive up health care costs and undermine affordability for patients. This legislation has the support of hundreds of healthcare organizations, as well as insurers in the Better Medicare Alliance, including UnitedHealth Group. It would implement commonsense changes to improve transparency around prior authorization utilization and expedite an often laborious process. In June 2025, insurers including, UnitedHealth Group, CVS Health, Elevance Health, and the Cigna Group pledged the Trump Administration to implement key prior authorization reforms—including standardized FHIR-based electronic submissions, reduced prior authorization volume by 2026, continuity of existing authorizations, improved transparency, expanded real-time- decisions by 2027, and clinician review of all denials—all of which are reflected in the Seniors' Act.[5] While MGMA appreciates this pledge, prior experience has demonstrated the importance of pairing industry commitments with congressional oversight and statutory action to ensure meaningful, enforceable accountability. MGMA joined a Consensus Statement on

---

[1]Office of Inspector General, U.S. Department of Health and Human Services. *Medicare Advantage appeal outcomes and audit findings raise concerns about service and payment denials.* OEI 09-16-00410, 2018. https://oig.hhs.gov/reports/all/2018/medicare-advantage-appeal-outcomes-and-audit-findings-raise-concerns-about-service-and-payment-denials/.

[2] Medical Group Management Association. *Prior authorization in Medicare Advantage.* May 3, 2023. https://www.mgma.com/getkaiasset/fa2103f5-a2f6-47a1-b467-4748b5007c7e/05.03.2023_PA-in-MA_FINAL.pdf.

[3]Medical Group Management Association, *Prior authorization in Medicare Advantage*.

[4]Office of Inspector General, U.S. Department of Health and Human Services. *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care*. OEI 09-18-00260, 2022. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

[5]Centers for Medicare & Medicaid Services. *HHS Secretary Kennedy, CMS Administrator Oz secure industry pledge to fix broken prior authorization system*. June 23, 2025. Accessed Jan. 15, 2026. https://www.cms.gov/newsroom/press-releases/hhs-secretary-kennedy-cms-administrator-oz-secure-industry-pledge-fix-broken-prior-authorization.

Improving the Prior Authorization Process in 2018[6] with provider groups and health plans that outlined similar commitments, yet in the years that followed, prior authorization remained the top regulatory burden for medical group practices.

MGMA looks forward to working with the Subcommittee to support legislation and policies that will improve the affordability of health care for senior citizens and all Americans. If you have any questions, please contact Hannah Grow, Associate Director of Government Affairs, at hgrow@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

[6]Medical Group Management Association. *Consensus statement on improving the prior authorization process*. 2018.https://www.mgma.com/getkaiasset/87f683d9-401c-4137-946b-761abe36c2f7/01.01.2018_PA-consensus-statement.pdf.