cohere HEALTH

The hidden cost of prior authorization:

Findings from a survey of 200 U.S. providers

National provider survey fielded for Cohere Health, Inc. by

WAKEFIELD

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Overview

Across the United States, **patients face significant delays in receiving recommended care**, and the cause is often administrative, rather than clinical. Lagging responses to prior authorization (PA) requests can lead patients to abandon recommended treatments and even result in avoidable hospitalizations or emergency room visits. The prior authorization process, put in place to ensure appropriate use of medical services, remains a significant hurdle in delivering timely quality care.

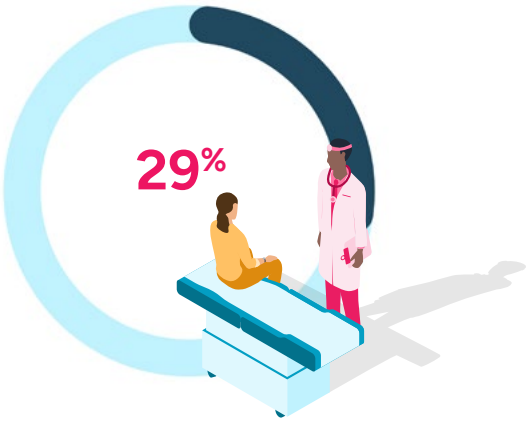
While it's patients' health that's at risk, it's **medical professionals who carry the burden.** Clinicians and administrators must navigate a prior authorization process that **increases their stress, disrupts their workflows, and causes burnout.**

This is what **Cohere Health®** and **Wakefield Research** found when they surveyed **200 U.S. hospital or medical system workers,** including both clinicians and office professionals, with 100 people in each group. The findings highlight the pervasive obstacles faced by clinicians and office administrators, including **unclear prior authorization requirements, rigid processes, and outdated technology.** Roughly a **quarter of prior authorization requests still take place via phone or fax,** according to medical clinicians and office administrators. For a sizable share—29% of clinicians and 47% of office administrators —the health plans they work with don't consistently accept electronic submissions.

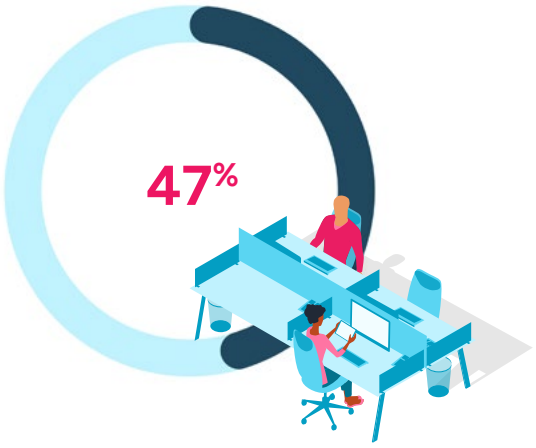
Q. What, if anything, prevents you or your team from using online portals or electronic systems to submit prior authorization requests? (Asked among those who do at least some prior authorization requests via fax or phone.)

A. Health plans we work with don't consistently accept electronic submissions.

Clinicians



Office administrators

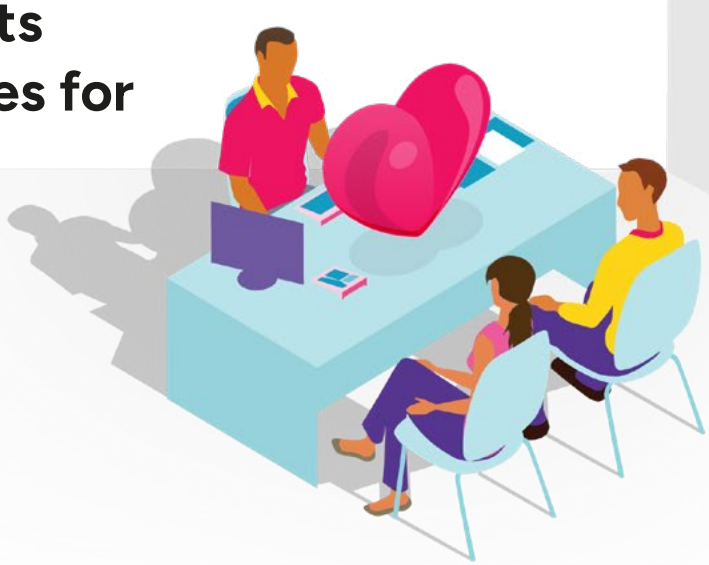


Improving these systems cannot wait: new federal mandates for faster turnaround times are set to take effect on January 1, 2026.

Alongside these mandates, **industry leaders like AHIP and federal agencies including HHS** have outlined ongoing goals to further streamline prior authorization requirements and increase transparency, signaling that additional reform and expectations are on the horizon. With this looming deadline and broader regulatory momentum, **there is collective optimism among healthcare workers about the potential of digital platforms, automated processes, and artificial intelligence (AI) to transform and improve the prior authorization landscape.**

By analyzing the sentiments expressed by clinicians and the office professionals most involved in the prior authorization process, we can identify pain points and highlight strategies for improvement. When put into action, these findings can help **enhance efficiency** in the prior authorization process and **improve patient care.**

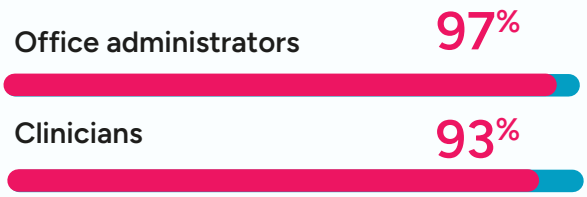
By analyzing the sentiments expressed by clinicians and the office professionals most involved in the prior authorization process, we can identify pain points and highlight strategies for improvement.



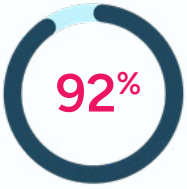
Key Findings

Impactful

97% of office administrators and 93% of clinicians have observed that **prior authorization delays can lead to avoidable hospitalization or emergency care.**



55% of clinicians & office administrators have seen **patients abandon treatment due to prior authorization delays,** often, or even all the time.



Clinicians

Office administrators

92% of clinicians and 89% of office administrators are **frequently unclear about whether a specific treatment requires prior authorization.**

Clinicians

Office administrators

Only 16% of office administrators and 24% of clinicians **use electronic prior authorization platforms for more than 40% of their submissions.**

Opportunities

99% of clinicians and 96% of office administrators **trust the use of AI in making prior authorization approvals.**

67%
Clinicians

65%
Office administrators

67% of clinicians and 65% of office administrators express a strong interest in **a fully digital prior authorization experience.**

About a quarter of prior authorization requests are still submitted by phone or fax, with clinicians reporting an average of 26% and office administrators 20%.

100% of clinicians and 99% of office administrators also **strongly encourage real-time tracking.**

The unacceptable wait before care

Timely access to care is essential for good health outcomes—but for many patients, **care is delayed** not for clinical reasons, but because of administrative bottlenecks. Prior authorization, meant to ensure appropriate care, too often stands in the way. According to **nearly all providers surveyed, these delays have real clinical consequences.**

Q. Have you seen prior authorization delays lead to avoidable hospitalizations or emergency care?

97%
of office administrators said yes

93%
of clinicians said yes

Even when delayed care doesn't cause an emergency, the consequences are still severe. Both groups report that **prior authorization delays regularly lead to treatment abandonment.** More than half of both clinicians and office administrators (55%) have seen **patients walking away from care often, or even all the time.**

Good news is on the horizon. 59% of health plans have committed to adopting FHIR® APIs and delivering real-time decisions for at least 80% of electronic prior authorizations—with all required documentation—by 2027.

Spotlight

New standards are coming

Beginning January 1, 2026, new federal regulations will require health plans to respond to prior authorization requests within:

- **72 hours for urgent cases**
- **7 calendar days for standard requests**

But right now, **most providers say those targets are rarely met.** Just 12% of clinicians and 7% of administrators report that they consistently receive decisions within those timelines.

These numbers send a clear message: the status quo isn't sustainable. **Delays are the rule, not the exception—and patients are paying the price.**

For both clinicians and office administrators, **the #1 challenge in the prior authorization process is clear**: the time it takes to receive a decision from the health plan. 34% of clinicians and 37% of office administrators cite this as their top frustration.

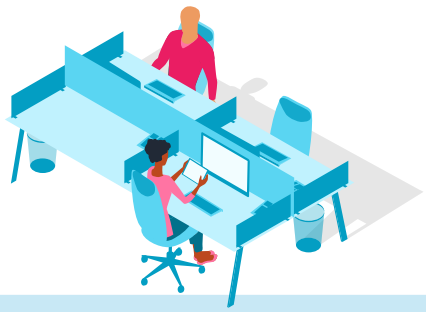
Another major factor? A lack of clarity.

92% of clinicians and 89% of office administrators say they're frequently unsure whether a treatment even requires prior authorization. For some, the confusion is constant—13% of clinicians and 12% of office administrators say they're always unclear.

And when a request is denied, the delays don't end. Providers often wait even longer just to find out why. Is it a coding issue? A coverage problem? Until that's clear, next steps—whether it's appealing the decision or exploring alternatives—are stalled.

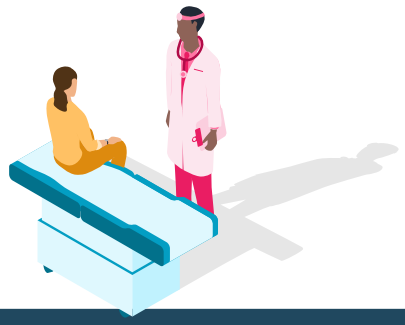
Q. Which of the following are the biggest challenges you experience in the prior authorization process? (Top 3 selected shown):

Office administrators



- **37%** Delays in receiving a decision from the health plan
- **34%** High rate of denials leading to resubmissions or appeals
- **32%** Difficulty gathering required clinical documentation and patient information

Clinicians



- **34%** Delays in receiving a decision from the health plan
- **31%** Lack of transparency into the status of requests
- **31%** Inconsistent rules and requirements across health plans

This lack of transparency and consistency doesn't just frustrate providers—it puts patients at risk.

Burden on providers

While patients wait for care, it's medical professionals who carry the weight of navigating a complex and outdated prior authorization process. **For many, it's more than an inconvenience—it's a daily operational strain and a growing threat to morale.**

For 92% of clinicians and 95% of office administrators, the prior authorization process is a burden. **For the largest share of clinicians, the biggest impact is on their daily workflow,** with 36% reporting disruptions and 10% citing burnout as a result. Office administrators feel the weight even more acutely: 46% experience workflow disruptions, and, like clinicians, 10% say the burden contributes to burnout.

These challenges aren't just caused by volume—they're worsened by unnecessary complexity, inconsistent requirements, and rigid systems that fail to adapt to real-world clinical and administrative needs.

Technology could help—but isn't always used

Despite widespread frustration, providers see a path forward—but outdated systems and inconsistent adoption are holding them back. Only 24% of clinicians and 16% of office administrators use electronic platforms for more than 40% of their submissions.

A key barrier? **Health plans don't consistently accept digital submissions**—a top concern for 47% of office administrators. Another 31% say their own organizations still require phone or fax. Even today, about a quarter of prior authorization requests are submitted by phone or fax—methods widely seen as inefficient and error-prone.

Spotlight

A one-size-fits-all system doesn't work

Clinicians and office administrators express deep frustration with rigid rules and workflows that don't reflect the nuances of real care delivery.

- 65% of clinicians and 55% of office administrators **say the current process doesn't account for the unique needs of different specialties, providers, or patients.**
- Among them, 30% of clinicians and 23% of office administrators **strongly agree that the system lacks flexibility.**

Peer review is another pain point:

95% of clinicians believe that peer reviewers should share the same specialty as the requesting provider—an alignment that could reduce unnecessary denials and improve clinical accuracy.

In a system built to evaluate medical necessity, a lack of clinical nuance puts both care quality and provider trust at risk.

And the issue goes deeper. Most organizations haven't integrated prior authorization into their EHR systems, leaving providers to track requests manually and outside of clinical workflows.

Only 8% of clinicians, and 0% of office administrators, report seeing prior authorization integrated into EHRs most of the time.

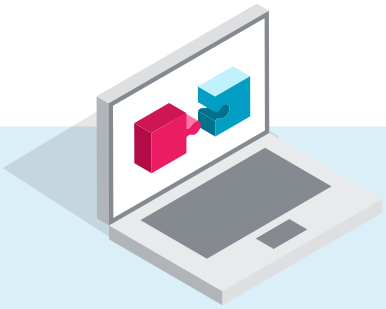
Q. What percentage of your prior authorization requests are submitted via fax or phone? (Average percentage shown):

Office administrators

20% still use a telephone or fax machine for submitting PA requests

Clinicians

26% still use a telephone or fax machine for submitting PA requests



Spotlight

The transparency gap

Even with digital tools emerging, a lack of transparency continues to frustrate providers and delay care.

100% of clinicians and 99% of office administrators **want real-time tracking for prior authorization**—visibility into what's needed, where a request stands, and when to expect a decision.

Transparency challenges start even earlier in the process. 92% of clinicians and 89% of office administrators say they're **frequently unsure whether a treatment requires prior authorization,** and for more than 1 in 10, this confusion is constant.

With new federal regulations taking effect in 2026, and recent alignment between CMS and AHIP on modernizing prior authorization—including real-time decision-making, electronic submission, and improved data transparency—the industry is moving toward meaningful reform. HHS has also signaled that additional requirements may be on the horizon.

The message is clear: now is the time for transparent, digital-first solutions.

What providers want from digital innovation

Medical professionals aren't resisting change—they're asking for it. **Clinicians and office administrators are ready for digital transformation, and they have a clear vision of what would make the prior authorization process work better.** But among the array of underutilized tools and sporadically applied solutions, what would help medical professionals and ultimately their patients the most?

Providers are ready for a fully digital experience

The **desire for modernization is overwhelming:** When asked what would significantly improve their workflow, both clinicians and office administrators said **a fully digital prior authorization experience.**

When asked what would make the biggest impact, both groups emphasize consistency, integration, and smarter automation:

- Clinicians prioritize consistent requirements across health plans (35%), followed by EHR integration (34%), and better provider-payer communication (30%).
- Office administrators want automated prompts for plan-specific requirements (36%), improved communication (33%), and more consistency (30%).

Providers aren't asking for futuristic solutions—they're asking for existing tools to be implemented thoughtfully, integrated into clinical workflows, and designed to reduce unnecessary effort. They're ready for a prior authorization system that's consistent, intelligent, and aligned with the realities of care.

Q. Which of the following would have the biggest impact on improving your experience with prior authorization requests?

65% of office administrators believe a fully digital experience would significantly improve their workflow

67% of clinicians believe a fully digital experience would significantly improve their workflow

Spotlight

AI wish list: clinical insight

Having AI tools isn't enough—**providers want AI that meaningfully supports care decisions.**

42% of clinicians say the most valuable use of AI is pinpointing the right clinical documentation for submission or resubmission.

There's also strong support for AI's broader role in the process:

- 65% of clinicians and 43% of office administrators believe **AI should play a substantial role** in prior authorization.
- 25% of both groups go even further, saying **AI should be essential,** as long as the right safeguards are in place.

Crucially, trust is already high. 99% of clinicians and 96% of office administrators are comfortable with AI assisting in prior authorization decisions.

Conclusion

Our findings confirm what many in the healthcare system have long suspected: **prior authorization isn't just an administrative hurdle;** it poses real clinical and operational risks. It can delay care, discourage patients from following through with their treatment, and undermine the well-being of providers. The onerous administration of this system wears down medical professionals, eroding morale and exposing practices to reputational risk.

Inconsistent requirements, outdated technology, and a lack of transparency force providers and administrators to waste valuable time navigating phone trees, chasing paperwork, and submitting duplicate information—time better spent caring for patients.

Despite these risks and operational burdens, there is a reason for optimism.

Clinicians and office administrators share a common goal in their desire for change: they trust digital tools. They believe in AI's ability to improve efficiency, and they are ready to embrace a modern, consistent, and intelligent prior authorization system.

With new federal standards for prior authorization turnaround times on the horizon, health plans have both a mandate and an opportunity to lead the way. **By investing in tools to automate specific processes, supporting full digital adoption, integrating prior authorization into electronic workflows,** and ensuring that all these efforts align with clinical best practices, health plans can create a system that benefits everyone.

The path forward is clear: embrace innovation, prioritize clinical needs, and modernize prior authorization.

Patients can't afford to wait.

METHODOLOGICAL NOTES

The Cohere Health Survey was conducted by Wakefield Research among 200 respondents who work in hospitals or with medical systems and are either clinicians or back-office professionals, with 100 respondents in each audience, across the US, between April 9th and April 23rd, 2025, using an email invitation and an online survey.

Results of any sample are subject to sampling variation. The magnitude of the variation is measurable and is affected by the number of interviews and the level of the percentages expressing the results. For the interviews conducted in this particular study, the chances are 95 in 100 that a survey result does not vary, plus or minus, by more than 6.93 percentage points from the result that would be obtained if interviews had been conducted with all persons in the universe represented by the sample.

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About Cohere Health

Cohere Health's clinical intelligence platform delivers AI-powered solutions that streamline access to quality care by improving collaboration between physicians and health plans. Cohere works with 660,000 providers and processes millions of prior authorization requests annually. Its AI auto-approves up to 90% of requests for millions of health plan members. Cohere has been recognized in the Gartner® Hype Cycle™ for U.S. Healthcare Payers in 2024 and 2025, named a Top 5 LinkedIn™ Startup in 2023 and 2024, and is a three-time KLAS Points of Light award recipient.