



June 15, 2026

Re: CMS-0062-P, Interoperability Standards and Prior Authorization for Drugs Proposed Rule

Dear Secretary Kennedy, Administrator Oz and Assistant Secretary Keane:

Thank you for the opportunity to provide feedback on updated interoperability and prior authorization standards. Consumers for Quality Care (CQC) is a coalition of advocates and former policy makers partnering with health advocacy organizations to provide a voice for patients in the health care debate as they demand better care.

Our organization is dedicated to advancing the interests and well-being of patients. Today, health care remains a top concern for Americans. According to a recent [Pew Research](#) poll, 73% of Americans say that health care affordability is a “very big problem.” Rising costs, growing insurance premiums, and unfair hospital practices limit consumers’ access to care and grow the medical debt crisis.

Insurers further add to patient pain through complicated prior authorization requirements, step-therapy and fail-first policies that delay patients’ access to necessary medications, treatments, surgeries, and other care, often forcing them to wait weeks or months for approval, or denying the treatment altogether. Furthermore, these policies often go against doctor’s recommendations, requiring patients to fail first on one or more medications before the plan will cover the cost of the originally prescribed treatment.

CQC is strongly supportive of the overall approach of this proposed rule and its aim to ensure that prior authorization is evidence-based, transparent, and immediate. Specifically, expedited timelines for prior authorization decisions and reporting, including the requirement that decisions be made for all drugs within 24 hours, will go far in alleviating the burden that insurer’s prior authorization process has put on patients. CMS’s proposed rule will improve the prior authorization process by alleviating the administrative burden for providers, expediting the approval process for drugs, and creating a more intuitive health care information ecosystem.

Delayed care, either through waiting on prior authorization requests or due to step-therapy requirements, can lead to hospital stays, increased costs, and drastic worsening of patient conditions. [Joel Hechler](#) was diagnosed with Crohn’s disease and ulcerative colitis, two autoimmune diseases that impact the lining of patients’ digestive tracts. Neither is curable but the symptoms can be controlled by medication. For many patients, finding the right medication can be difficult. Hechler’s doctor felt that a drug called Remicade would be the best course of treatment. Unfortunately, Hechler’s insurer required step therapy, forcing him to try other



medications first. In the six weeks Hechler spent fighting Premera Blue Cross to approve Remicade, he became so ill he was admitted to the hospital.

Countless stories like Hechler's exist across the country. CQC supports requirements for expedited decision making by insurers, including 24-hour decisions for all drugs, and ensuring that the expedited requirements do not lead to unnecessary denials. Furthermore, patients deserve a detailed justification for all denials, as well as a robust appeals process.

Prior authorization requirements also take time and resources away from physicians, meaning that more patients go untreated. [The average physician completes 31 prior authorization requests each week](#), which takes about two days of physician and staff time that would be better spent on patient care. An [American Medical Association \(AMA\) survey](#) of 1,000 physicians found that 9 in 10 reported prior authorizations delayed access to necessary care and more than 25% said the delays had led to a serious adverse event.

Doctors, not insurance companies, know what the best course of treatment is for their patients, and receiving treatment in a timely manner is vital. Therefore, we support implementation of electronic prior authorization to allow doctors to request and track prior authorization status in a more timely and efficient manner.

Regarding the Step Therapy Request for Information, CQC urges CMS to introduce more transparency into that process as well. First, insurers should be required to disclose when step therapy is required, and to build exceptions and a strong appeals process into their system. Furthermore, a patient who has undergone step therapy with one insurer should not be required to undergo step therapy again just because they move to a different insurance provider; instead, insurers should honor step therapy across plans.

CQC urges CMS to continue efforts to reform prior authorization so that Americans can receive fast and effective quality health care. Streamlining health information sharing between insurers, providers, and patients, and expediting the process for prior authorization approval, are each positive steps in reforming the American health care system to ensure all Americans can access high-quality health care.

Sincerely,
Consumers for Quality Care