The use of prior authorization in Medicare Advantage, 2021–2023

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BACKGROUND

Prior authorization (PA) is a tool designed to help health plans manage utilization and minimize unnecessary services, thereby helping to contain costs and protect patients from receiving potentially inappropriate care. Nearly all Medicare Advantage (MA) enrollees are in plans that require PA for some categories of services, and those requirements can vary across MA plans. Two types of plans predominate in MA: health maintenance organizations (HMOs) and preferred provider organizations (PPOs). MA HMO networks tend to include a smaller share of physicians than PPOs, but they also tend to have lower beneficiary cost sharing.

RESEARCH OBJECTIVE

The aim of this study was to examine the volume and outcomes of prior authorization requests in MA, and how those vary by MA contract characteristics, such as plan type.

METHODS

Study design

Longitudinal descriptive analysis

Population studied

MA enrollees from 2021 through 2023 (n = 28.5 million and 33 million, respectively). We limited our analysis only to enrollees in conventional HMO and local PPO contracts, in the 50 states and Washington, DC. HMOs represented a higher enrollment share, with 59.1 percent of enrollment in 2023.

Analysis

We analyzed 2021–2023 Part C Reporting Requirements data, which MA plans report annually to CMS, to characterize MA organization determinations (initial requests) and reconsiderations (first-level appeals), and their outcomes (fully favorable, partially favorable, adverse). We analyzed raw and enrollment-weighted prior authorization decisions in aggregate and per enrollee. We also compared the volume of requests and outcomes between HMOs and local PPOs.

PRINCIPAL FINDINGS

PA requests from enrollees and providers to MA plans have been increasing steadily over time, from approximately 37.8 million requests in 2021, to over 50 million requests in 2023. However, this largely reflects the increase in MA enrollment over the same period; per capita prior authorizations have held steady at between 1.3 and 1.5 PAs per enrollee per year.

MA prior authorization requests increased, but decisions remained largely favorable

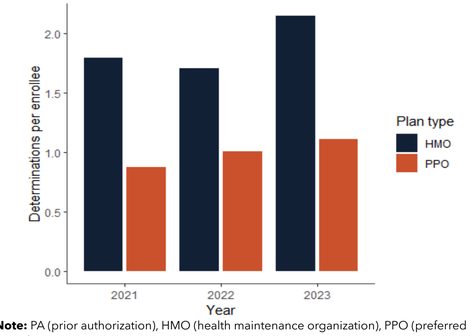
	Determinations		Reconsiderations	
	Volume (in millions)	Share approved	Volume (in millions)	Share approved
2021	37.8	94.5%	0.23	80.4%
2022	45.7	92.6	0.33	82.3
2023	50.1	93.6	0.37	80.6

Note: MA (Medicare Advantage). "Share approved" refers to the percentage of organization decisions that yielded a fully-favorable outcome. Shares are weighted by contract-level enrollment. "Determination" refers to the MA organization's initial response to a prior authorization request. "Reconsideration" refers to the MA organization's response to a first-level appeal.
Source: MedPAC analysis of CMS Part C Reporting Requirements and MA enrollment data.

There was sizeable variation in the use of prior authorization across parent organizations, ranging from 0.3 requests per capita in one organization, to nearly 3 per enrollee in another. PAs are overwhelmingly likely to be approved, with between 90 and 95 percent of initial requests being fully approved each year. Reconsiderations—the first level of PA appeal—were approved over 80 percent of the time.

The PA determinations per HMO enrollee and PPO enrollee have both increased over time. In 2023, there were 2.1 PA determinations per HMO enrollee, which was nearly twice as many as the 1.1 PA determinations per PPO enrollee.

Nearly twice as many PA requests per enrollee in HMOs compared to PPOs



Note: PA (prior authorization), HMO (health maintenance organization), PPO (preferred provider organization).
Source: MedPAC analysis of CMS Part C Reporting Requirements and MA enrollment data.

HMOs appear to be more likely to approve PAs than PPOs; initial requests to HMOs were approved roughly 95 percent of the time, compared to about 90 percent of requests to PPOs.

HMO PAs more likely to be approved; PPO enrollees more likely to appeal

	Share approved			Share appealed		
	HMO	PPO	*p*	HMO	PPO	*p*
2021	95.7%	91.8%	<0.000	0.9%	2.4%	<0.000
2022	94.4	89.2	<0.000	1.1	2.6	<0.000
2023	95.1	91.7	<0.000	1.4	2.5	<0.000

Note: PA (prior authorization), HMO (health maintenance organization), PPO (preferred provider organization). "Share approved" refers to the percentage of organization decisions that yielded a fully favorable outcome. "Share appealed" refers to the percentage of initial determinations that were reconsidered. Shares are weighted by contract-level enrollment.
Source: MedPAC analysis of CMS Part C Reporting Requirements and MA enrollment data.

CONCLUSIONS

In 2021 to 2023, MA plans fully approved the vast majority of PA requests they reviewed. When a provider or enrollee asked the MA plan to reconsider an unfavorable decision, MA plans approved the majority of those reconsiderations. Despite increases in MA enrollment and consequent increases in the volume of determinations and reconsiderations, the proportion of PA outcomes that were favorable remained stable over time.

IMPLICATIONS FOR POLICY AND PRACTICE

MA plans rely on PA to manage utilization. PA has been identified as a major source of administrative burden for providers and can become a health risk for MA enrollees if policies cause needed care to be delayed, abandoned, or denied. The high volume of approvals—both initially and on appeal—may raise questions about how judiciously prior authorization is being used in MA.

Beginning in 2027, CMS will require MA plans to automate the process for providers to facilitate PA requests and decisions, which has the potential to reduce the burden of PA on beneficiaries and providers. Future research can include tracking the effects of these requirements on PA use and outcomes.

LIMITATIONS

There are several gaps in the PA data that CMS currently collects from MA insurers. Because MA contracts are required to report aggregate data, we are unable to report prior authorization requests or outcomes by service type, specialty, or beneficiary characteristics, and we cannot assess the clinical appropriateness of these decisions.

REFERENCES

Medicare Payment Advisory Commission. 2024. Chapter 2: Provider networks and prior authorization in Medicare Advantage. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

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