

Prior Authorization in Medicare Advantage

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Prepared for the Permanent Subcommittee on Investigations of the Committee on Homeland Security &
Governmental Affairs

United States Senate

Hearing on

Examining Health Care Denials and Delays in Medicare Advantage

May 17, 2023

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Introduction

Good afternoon, Chairman Blumenthal, Ranking Member Johnson, and Members of the Subcommittee. Thank you for inviting me to testify about Medicare Advantage, including the prior authorization, payment, and appeals process.

I am Jeannie Fuglesten Biniek, an associate director in KFF's Program on Medicare Policy. KFF is a non-profit organization providing non-partisan health policy analysis, polling, and journalism (KFF Health News) for policymakers, the media, the health policy community and the public. We are not associated with Kaiser Permanente.

In recent years, enrollment in Medicare Advantage has grown rapidly, with just over half of all eligible Medicare beneficiaries enrolled in Medicare Advantage this year. Virtually all Medicare Advantage enrollees are enrolled in a plan that requires prior authorization before the insurance company will cover some services. While prior authorization plays a role in helping Medicare Advantage plans reduce costs and prevent people from receiving unnecessary or low-value services, there are some concerns that current prior authorization requirements and processes may create barriers and delays to receiving necessary care, as well as exacerbate complexity for patients and providers.

My testimony will describe what the Medicare Advantage market looks like today, the use of prior authorization by Medicare Advantage insurers, and gaps in data that limit oversight and the ability to understand and assess how the use of prior authorization impacts Medicare Advantage enrollees.

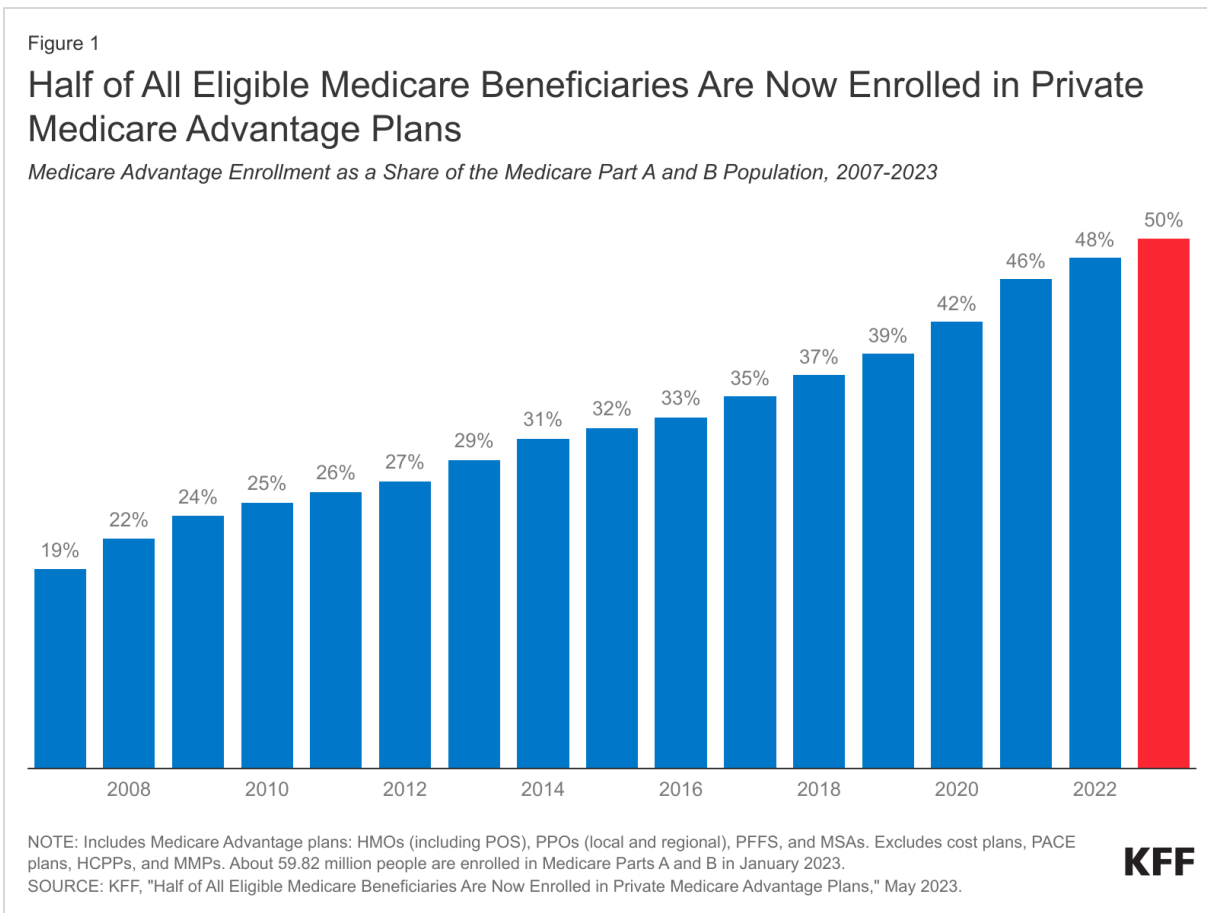
Medicare Advantage Today

Medicare Advantage, the private plan alternative to traditional Medicare, covers Medicare Part A and Part B benefits, and often also includes Part D prescription drug coverage. As of January 2023, [half](#) of eligible Medicare beneficiaries are enrolled in a private Medicare Advantage plan. That reflects a dramatic increase in enrollment in recent years. In 2007, just 19% of eligible Medicare beneficiaries were enrolled in a private plan (Figure 1).

The increase in enrollment is due to a number of factors, including the attraction of [extra benefits offered by most plans](#), such as coverage of vision, hearing, and dental services, and the potential for lower out-of-pocket spending, particularly compared to traditional Medicare without supplemental coverage. Often, Medicare Advantage plans offer these benefits for no additional premium, other than the part B premium. In 2022, [more than two-thirds \(69%\)](#) of Medicare Advantage enrollees in plans that included Part D prescription drug coverage available for individual purchase paid no additional premium. Medicare Advantage plans also offer the simplicity of one-stop shopping, in that enrollees do not need a separate Part D prescription drug plan or supplemental coverage.

This year, the average Medicare beneficiary can choose from [43 Medicare Advantage plans](#), more than double the average number available in 2018. A majority of Medicare beneficiaries can choose from plans

offered by [at least 9](#) different firms. Despite most beneficiaries having access to plans operated by several different insurers, [nearly half](#) of all Medicare Advantage enrollees are in a plan operated by UnitedHealthcare or Humana.



One reason Medicare Advantage insurers can offer plans with extra benefits and the potential for lower out-of-pocket spending is because they are supported by a generous payment system. The Medicare Payment Advisory Commission reports that while it costs Medicare Advantage insurers [83%](#) of what it costs traditional Medicare to pay for Medicare-covered services, they receive payments from CMS that are [106%](#) of spending for similar beneficiaries in traditional Medicare, on average (including the estimated effects of higher coding intensity in Medicare Advantage). Thus plans retain [more than \\$2,300](#) per person above the costs of paying for Medicare-covered services, which they use to lower cost sharing, pay for extra benefits, and reduce premiums, as well as add to their profits.

Consistent with the generous payments to Medicare Advantage insurers, gross margins, or the amount by which total premium income exceeds total claims costs, are [consistently higher](#) in the Medicare Advantage market than in other health insurance markets on a dollars per enrollee basis. In 2021, gross

margins for Medicare Advantage plans averaged \$1,730 compared to \$768 for Medicaid managed care plans, \$745 for individual market plans, and \$689 for group plans.

Medicare Advantage Plans Have Several Tools to Manage Utilization and Costs

Medicare Advantage plans have lower costs for Medicare-covered services than traditional Medicare, in part, because they use tools to manage utilization and costs. These include requiring prior authorization for certain services, requiring referrals for certain types of providers (such as [mental health providers](#)), denying payment for services not deemed medically necessary, establishing networks (including for [hospitals](#), post-acute care facilities, [physicians](#) and other providers), entering into risk-based contracts that hold providers responsible for cost and quality, and the use of care coordination and care management programs for enrollees with particular conditions.

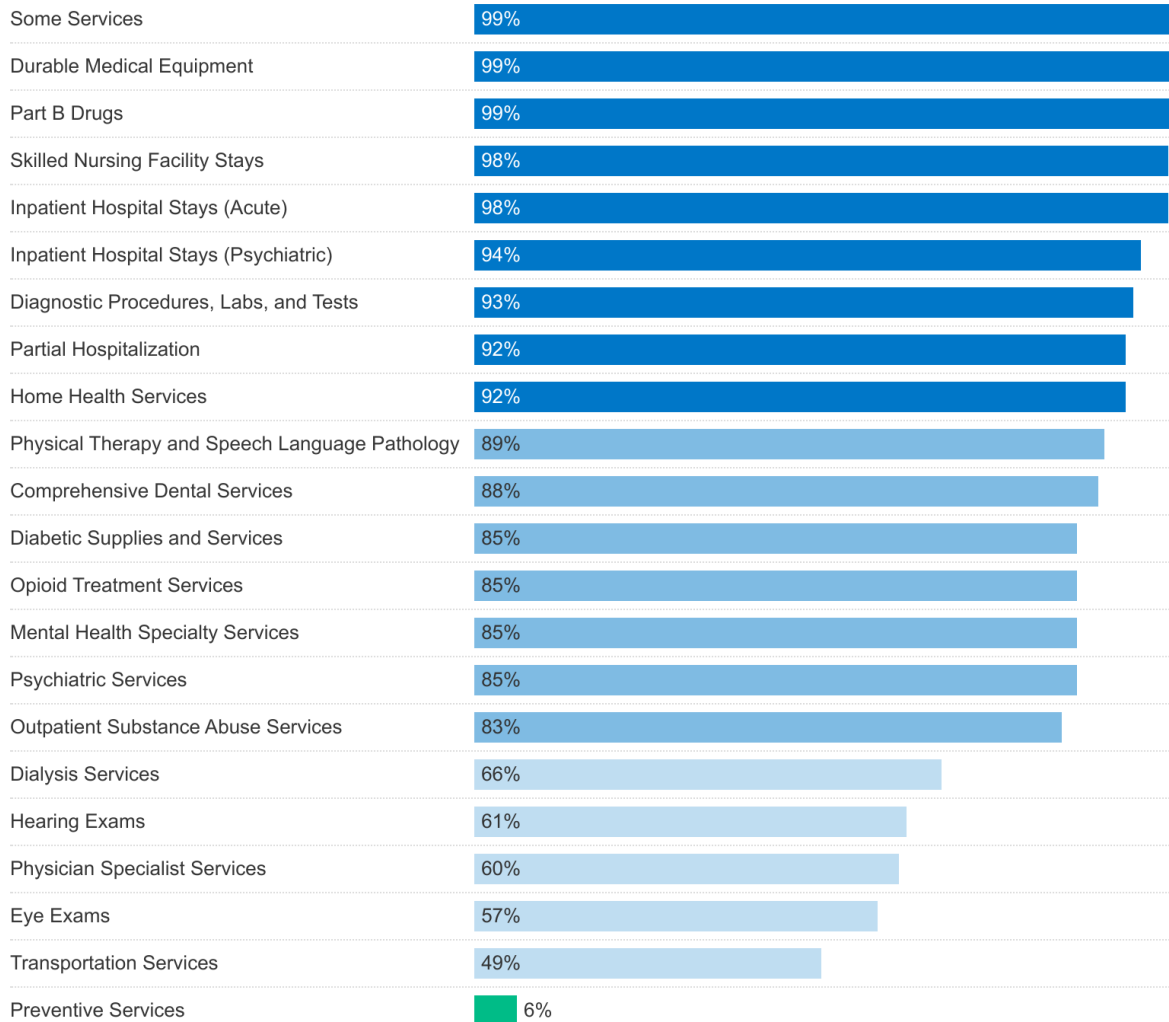
Prior authorization is intended to ensure that health care services are medically necessary and has long been used as a tool to contain spending and prevent people from receiving unnecessary or low-value services. Recently, the use of prior authorization has gained attention, prompted in part by findings from the U.S. Department of Health and Human Services Office of Inspector General that raise concerns that the requirements and processes for obtaining approval may create [barriers](#) and [delays](#) to receiving care.

Prior authorization requirements are common in Medicare Advantage, with [99%](#) of Medicare Advantage enrollees in a plan that requires prior authorization for at least some services. Higher-cost services require prior authorization more often than lower-cost services. For example, in 2022, prior authorization was required for Part B drugs (including chemotherapy), skilled nursing facility stays, inpatient hospital stays, and home health services for more than 90% of Medicare Advantage enrollees, while just 6% of Medicare Advantage enrollees were in a plan that required prior authorization for preventive services (Figure 2).

Figure 2

Share of Medicare Advantage Enrollees Required to Receive Prior Authorization, by Service, 2022

Most enrollees are required to receive prior authorization for the **highest cost services** and fewer enrollees need to receive it for **preventive services**



NOTE: Excludes employer group health plans. Preventive services are Medicare-covered zero-dollar cost-sharing preventive services. For supplemental benefits, including dental, hearing, vision, and transportation, the share of enrollees required to receive prior authorization are based on the enrollees in plans that offer those benefits.

SOURCE: KFF, "Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings," August 2022.

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Use of Prior Authorization in Medicare Advantage

As part of its oversight of Medicare Advantage plans, CMS requires Medicare Advantage insurers to submit data for each Medicare Advantage contract (which usually includes multiple plans) that includes the number of prior authorization determinations made during a year, and whether the request was approved. Insurers are additionally required to indicate the number of initial prior authorization decisions that were reconsidered, and whether the appeal was successful. We used these data to examine the [use of prior authorization](#) in Medicare Advantage during the 2021 calendar year (the most recent year for which data are available). Note, the data we analyzed do not include prior authorization requests for prescription drugs covered under Medicare Part D.

We found that in 2021, Medicare Advantage plans made over 35 million prior authorization determinations. On average, that translates into 1.5 requests for prior authorization per Medicare Advantage enrollee. Across Medicare Advantage insurers, the number of prior authorization requests ranged from a low of 0.3 requests per enrollee for Kaiser Permanente to a high of 2.9 for Anthem (Figure 3).



Differences across Medicare Advantage insurers in the volume of prior authorization requests likely reflects some combination of differences in the range of services that are subject to prior authorization requirements and the frequency with which contracted providers are exempted from those requirements, such as through "gold carding" programs. Gold carding programs exempt providers with a history of

complying with the insurer's prior authorization policies. Differences across Medicare Advantage insurers may also reflect the relationship between insurers and providers. Kaiser Permanente is atypical among insurers in that it generally operates its own hospitals and contracts with an affiliated medical group.

Of the over 35 million prior authorization requests, 6% (2 million) were denied in full or in part. The denial rate ranged from 3% for Anthem and Humana to 12% for CVS (Aetna) and Kaiser Permanente (Figure 4). In general, insurers that had more prior authorization requests denied a lower share of those requests.

Medicare Advantage enrollees have the right to appeal a denial, but just 11% of denied prior authorization requests were appealed. As with other measures we examined, the share of denials that were appealed also varied across insurers. For example, the share of denials that were appealed was almost twice as high for CVS (20%) and Cigna (19%) than the average across all insurers (11%) (Figure 5).

Among the small share of prior authorization denials that were appealed, 82% were overturned either fully or partially. The relatively high rate of appeals that were overturned was consistent across insurers. Only Kaiser Permanente overturned less than half (30%) of the prior authorization determinations that were appealed. Two insurers – Centene and CVS – overturned at least 9 in 10 denials with UnitedHealthcare not far behind (Figure 6).

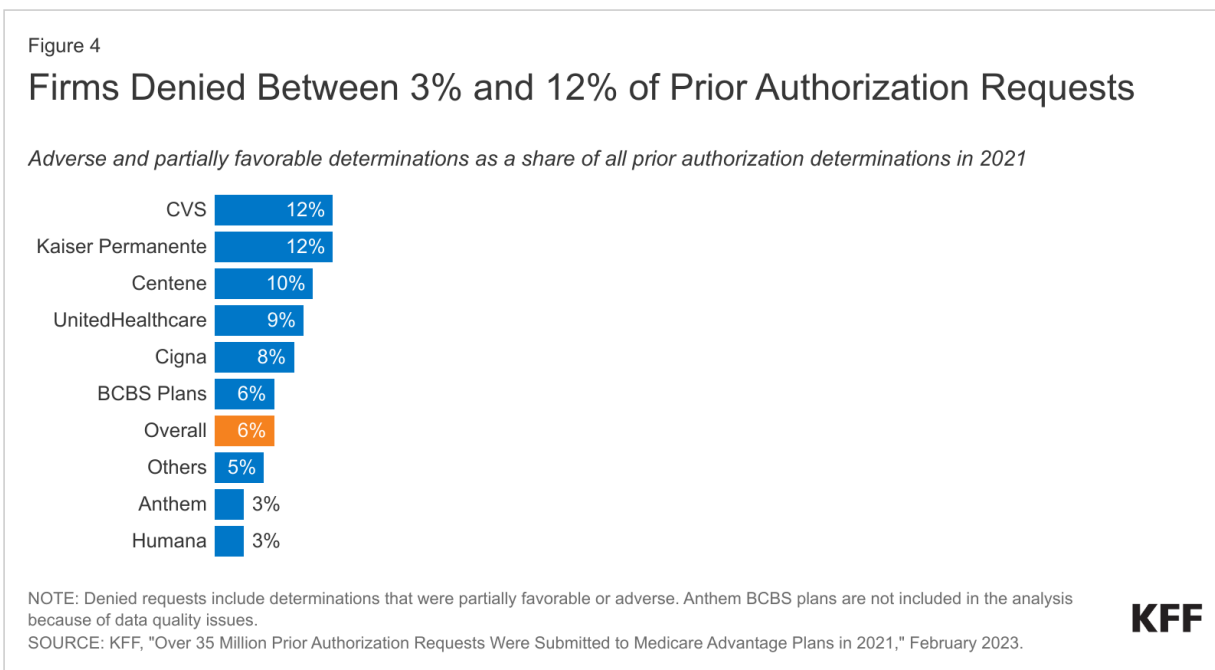
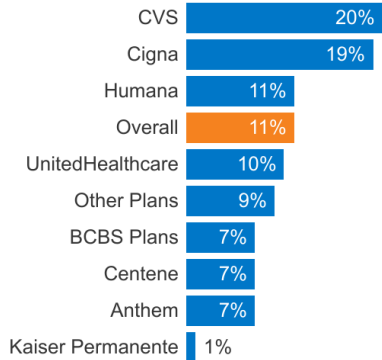


Figure 5

About 1 in 10 (11%) Prior Authorization Request Denials Were Appealed

Share of adverse and partially favorable prior authorization determinations that were reconsidered in 2021



NOTE: Anthem BCBS plans are not included in the analysis because of data quality issues.

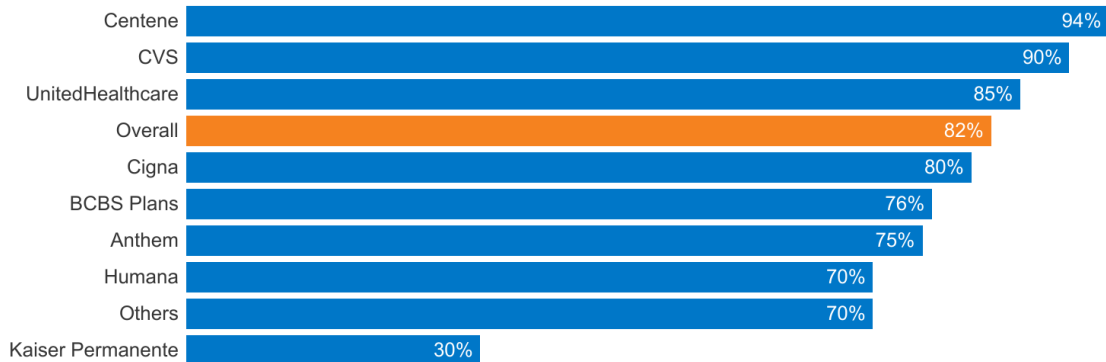
SOURCE: KFF, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021", February 2023.



Figure 6

Across Most Firms, the Vast Majority of Prior Authorization Request Denials that Were Appealed Were Overturned

Share of reconsiderations that were fully or partially favorable in 2021



NOTE: Includes reconsiderations that were fully or partially favorable. Anthem BCBS plans are not included due to data quality issues.

SOURCE: KFF, "Over 35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021", February 2023.



Gaps in Prior Authorization Data

The publicly available data on the use of prior authorization in Medicare Advantage has several notable limitations, primarily due to gaps in what CMS currently requires Medicare Advantage insurers to report. For example, we could not answer the following questions:

- **Do prior authorization requests, denials and appeals vary by type of service?** CMS requires plans to report the aggregate number of prior authorization determinations (approved and denied requests) and reconsiderations (appeals) and their outcome (approved in full, approved in part, denied). However, plans are not required to report the number of prior authorization requests, denials or appeals by specific service or service category. For example, it is not possible to assess whether insurers deny use of post-acute skilled nursing facility care more frequently than home health services?
- **Why are prior authorization requests denied?** Medicare Advantage insurers are not required to indicate the reason a denial was issued in the reporting to CMS, such as whether the service was not deemed medically necessary, whether the provider seeking approval provided insufficient documentation, or whether other requirements for coverage (such as trying a more basic service first) were not met.
- **Do prior authorization requests, denials and appeals vary across subgroups of enrollees?** No information about the characteristics of enrollees for whom prior authorization requests are submitted is included in the data, such as race/ethnicity, sex, age, or diagnosed health condition.
- **Do denial rates vary by type of plan?** The data are reported at the contract level. Medicare Advantage contracts include plans of different types (i.e., HMO and PPO), as well as plans that are offered to different groups of beneficiaries, including plans that are generally available for individual purchase, special needs plans, and plans sponsored by employers/unions.
- **How timely were initial prior authorization determinations and appeal decisions?** Medicare Advantage insurers are not required to provide any information about the time between the prior authorization request or appeal and when a determination was made. Whether prior authorization requirements create barriers to care depend in part on how timely determinations are made.
- **What share of providers are exempt from prior authorization requirements?** Insurers can waive prior authorization requirements for certain providers, for example as part of “gold carding” programs.

In addition to the gaps in data on prior authorization, several [other key pieces](#) of information that would be useful in conducting oversight and assessing the performance of Medicare Advantage plans are not publicly available. For example, Medicare Advantage insurers do not report the use of extra benefits and associated spending or the share of Medicare Advantage claims for which payment is denied after a service has been provided. Additionally, CMS does not publish out-of-pocket spending or other payment information for Medicare-covered services, nor reasons why people disenroll from Medicare Advantage by beneficiary characteristics.

Conclusion

Private plans now provide Medicare coverage to just over half of all eligible Medicare beneficiaries. These plans typically require prior authorization for at least some services. In 2021, insurers made more than 35 million decisions in response to requests for prior authorization on behalf of enrollees in Medicare Advantage plans, of which 2 million, or 6%, were denied. Among the small share (11%) of denials that was appealed, insurers overturned more than 80% of their initial decisions when they were reconsidered.

The relatively low rate of denied prior authorization requests may mean that the prior authorization process is not well targeted. Nevertheless, each prior authorization request requires providers to allocate time and staff resources that could instead be used for patient care. These requirements can also be a burden on beneficiaries who are already navigating a complex health care system, and lead to delays in care even if the prior authorization request is ultimately approved.

Additionally, though we do not know the reason prior authorization requests were initially denied, the high frequency of favorable outcomes upon appeal raises questions about whether a larger share of the initial requests should have been approved. Each initial denial that was subsequently approved represents medical care that was ordered by a doctor or other health care provider and ultimately deemed necessary by the plan. The potential delay that results from a prior authorization request, and the additional step of appealing a denial, may have negative effects on beneficiaries' health.

Prior authorization is one of many ways insurers manage utilization of health care services by their enrollees and our analysis finds that Medicare Advantage insurers vary in their use of prior authorization. Recently, several Medicare Advantage insurers have announced they are revising their prior authorization policies in an effort to simplify the process. Those changes could potentially reduce the burden on both providers and enrollees, depending on how the specific changes are implemented. CMS has also recently [finalized several policies](#) aimed at streamlining the prior authorization process in Medicare Advantage by clarifying the criteria that may be used to establish prior authorization policies and the duration for which a prior authorization is valid.

It is difficult to assess the impact on Medicare Advantage enrollees of both current policies and processes and planned changes to prior authorization because the necessary data are not available. For example, information about which services are most likely to be denied, how frequently different insurers issue denials for particular services, and whether certain enrollees are subject to more denials than others are not reported to CMS by Medicare Advantage insurers. As the number of Medicare beneficiaries enrolled in Medicare Advantage continues to grow, a better understanding of the use of prior authorization and other tools to contain spending and manage utilization will be important in evaluating the implications of these policies on utilization and quality, including variation across Medicare Advantage plans and compared to traditional Medicare.