Examining Prior Authorization in Health Insurance

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Long used as a tool to control spending and to promote cost-effective care, prior authorization in health insurance is in the spotlight as advocates and policymakers call for closer scrutiny about its use across all forms of health coverage.

What is Prior Authorization?

Prior authorization (also called "preauthorization" and "precertification") refers to a requirement by health plans for patients to obtain approval of a health care service or medication before the care is provided. This allows the plan to evaluate whether care is medically necessary and otherwise covered. Standards for this review are often developed by the plans themselves, based on medical guidelines, cost, utilization, and other information.

The process for obtaining prior authorization also varies by insurer but involves submission of administrative and clinical information by the treating physician, and sometimes the patient. In a 2021 American Medical Association Survey, most physicians (88%) characterized administrative burdens from this process as high or extremely high. Doctors also indicated that prior authorization often delays care patients receive and results in negative clinical outcomes. Another independent 2019 study concluded that research to date has not provided enough evidence to make any conclusions about the health impacts nor the net economic impact of prior authorization generally.

How Often is Prior Authorization Used and What is its Impact?

There is little information about how often prior authorization is used and for what treatments, how often authorization is denied, or how reviews affect patient care and costs.

A 2021 KFF Issue Brief found that most (99%) Medicare Advantage enrollees are in plans that require prior authorization for some services. In addition, 84% of Medicare Advantage enrollees are in plans that apply prior authorization to a mental health service.

A recent report from the U.S. Department of Health and Human Services' (HHS) Office of the Inspector General (OIG) found 13% of prior authorization denials by Medicare Advantage plans were for benefits that should otherwise have been covered under Medicare. The OIG cited use of clinical guidelines not contained in Medicare coverage rules as one reason for the improper

denials, as well as managed care plans requesting additional unnecessary documentation. The OIG recommended and HHS agreed that the Centers for Medicare and Medicaid Services (CMS) should take a closer look at the appropriateness of clinical criteria used by Medicare Advantage plans in making coverage determinations.

What's Happening Now?

Concern about the use and impact of prior authorization by health plans has prompted consideration of various measures to regulate the practice or make it more transparent.

Clinical coverage criteria. The use of health plans' own "home grown" clinical criteria to make coverage decisions has come under scrutiny. California, for example, now prohibits plans from using their own clinical criteria for medical necessity decisions, requiring commercial insurers to instead use criteria that are consistent with generally accepted standards of care and are developed by a nonprofit association for the relevant clinical specialty. Of note, state laws like this would not apply to self-insured employer-sponsored plans.

Use in behavioral health. The Mental Health Parity and Addiction Equity Act (MHPAEA) requires commercial insurers, employer-sponsored plans, and certain Medicaid plans to document the use of prior authorization for both medical and behavioral health care covered services. Plans must provide a comparative analysis that includes the rationale and evidence for applying prior authorization, as well as all other nonquantitative coverage limits. While compliance with this requirement has been slow according to a recent federal agency report to Congress, enforcement at the federal and state level has increasingly required plans to eliminate prior authorization for specific behavioral health treatment due to alleged parity violations.

Transparency. Increasing transparency about how the prior authorization process works is also gaining some momentum. H.R. 3173, with 306 cosponsors, would require Medicare Advantage insurers to report to HHS on the types of treatment that requires prior authorization, the percentage of prior authorization claims approved, denied, and appealed. Similarly, some states have required this type of data reporting as part of their mental health parity implementation, while some regulators urge more reliance on data reporting for MHPAEA compliance. Such transparency data proposals are similar to current law requirements under the Affordable Care Act for private plans to report to data on claims payment practices and denials. While this federal law applies to all commercial insurers and employer-sponsored plans, to date it is largely un-implemented, with only limited reporting required of non-group plans sold through HealthCare.gov.

Setting standards for prior authorization. Other current law standards regulating prior authorization are limited.

- The Affordable Care act prohibits use of prior authorization related to emergency care.

- Some states have moved to ban prior authorization for certain behavioral health care. For example, New York prohibits use of prior authorization during the first days of an inpatient admission for a mental health condition for children.
- Michigan recently passed a law requiring use of standardized prior authorization methods and new transparency reporting.
- Several states have adopted or are considering "gold card" laws that would require health plans to waive prior authorization for services ordered by providers with a track record of prior authorization approval.

Administrative reforms. Last year CMS finalized a regulation to streamline the prior authorization process for Medicaid and for private health plans offered on HealthCare.gov through new electronic standards and other changes. While the rule was later withdrawn, similar changes may still be forthcoming from HHS. H.R. 3173 would require CMS to implement an electronic prior authorization program for Medicare Advantage plans with capacity to make real-time decisions. The insurance industry generally has supported electronic prior authorization reforms to expedite review times.

Debate over further standards to limit the use or regulate prior authorization may well involve tradeoffs between claims spending versus access to care for patients and administrative burden for providers. Promoting transparency of this process and how it works in practice could help inform what those tradeoffs might involve.