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Fact Sheet: Prior Authorization in Medicare Advantage

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"Prior authorization" is a utilization management tool employed by health insurers requiring that the enrollee (and/or their provider) receive approval from the health plan before a treatment, procedure, or service will be covered. While there is widespread recognition that the use of prior authorization can be effective in reducing unnecessary, duplicate or even harmful "low-value" care; it can also result in denials of or delays in necessary and sometimes even critical care, as well as costly out-of-pocket (OOP) medical expenses when a patient receives care that is denied by their health plan after the fact.

In 2024, over half of all eligible beneficiaries, or about 34 million people, enrolled in private Medicare Advantage (MA) plans. This increased from only one third a decade earlier. Unlike TM, nearly all MA plans require prior authorization for some care; most frequently for durable medical equipment and expensive care such as skilled nursing facility stays, Part B (provider-administered) drugs, inpatient hospital stays, and behavioral health services. Over time, the breadth in use of prior authorization has expanded. One study found that between 2009 and 2019, while the share of MA enrollees exposed to any prior authorization requirements remained fairly stable, it was applied to more service categories with fastest growth for diagnostic procedures, labs, and tests, psychiatric services, and diabetic supplies and services.

In recent years, some MA plans have been charged with inappropriate use of prior authorization and denials of care. Government auditors and other stakeholders warn that this practice can result in MA enrollees not receiving basic Medicare benefits to which they are entitled. Recently, the Centers for Medicare & Medicaid Services (CMS) have put in various new requirements and guardrails, and a bipartisan group of legislators supported steps to protect consumers and increase transparency around coverage denials. Finding a sustainable balance between timely access to appropriate care and containing health care costs has been a persistent struggle for our health care system, including within the MA program. This fact sheet addresses the issue of prior authorization and denials of care in MA plans and summarizes recent efforts to protect beneficiaries from inappropriate denials and delays in care.

What are the trade offs for beneficiaries who choose Medicare Advantage?

Medicare Advantage (MA) plans are attractive to beneficiaries because they offer lower out-of-pocket costs and extra benefits that traditional Medicare does not cover such as limited dental, vision, and hearing coverage. However, many beneficiaries are not aware that choosing MA comes with trade offs that could affect their access to care. **First**, MA enrollees often need to obtain prior authorization for certain care and services that may have been automatically covered in TM. This can be a lengthy process for both the patient and provider. **Second**, while beneficiaries in TM can seek care from any provider that accepts Medicare payment rates, MA enrollees are often limited to specific provider networks, and face higher costs (or no coverage) if care is sought from out-of-network providers. This can be particularly limiting for enrollees in rural areas or in areas with provider shortages.

In this fact sheet:

Why do Medicare Advantage plans use prior authorization?

MA plans have a financial incentive to reduce utilization and promote lower cost care. Unlike TM in which Medicare pays providers on a fee-for-service basis (providing no incentive for providers to choose less expensive treatments), MA plans are paid a fixed-dollar "capitated" amount per enrollee each month—an amount that is adjusted to reflect each enrollees diagnoses and expected costliness. Thus, plan sponsors must manage the cost of paying for all care that meet the Medicare coverage criteria, plan administrative costs, and their expectations for profit within this fixed amount of revenue. Requiring prior authorization for certain services is a way that MA plans prioritize lower cost care, deny what they deem to be unnecessary or duplicative care, ensure that they are only covering care that meet Medicare coverage criteria, and ultimately reduce their spending.

Utilization management can also limit "low-value" and duplicative care.

Low-value care is defined as care for which the harms or costs outweigh the benefit. Examples include: Emergency Department visits for non-emergencies, surgery when physical therapy would be equally or more effective, or inappropriately prescribed antibiotics. One study found that up to 40 percent of Medicare beneficiaries receive a low-value health care service each year. One recent study found that on average, MA plans provide significantly less low-value care than TM, but this also varied by plan sponsor, indicating some plans are better at this than others.

Evidence does not support the idea that MA reduces overall Medicare program costs.

Recent analysis by MedPAC and other researchers has shown that the federal government spends more for beneficiaries in MA than for similar individuals in TM. For 2025, MedPAC estimates that Medicare pays 20 percent more for MA enrollees, resulting in a projected additional cost of $84 billion.

Prior authorization, appeals, and denials in Medicare Advantage

CMS requires MA plan sponsors to have formal procedures for evaluating prior authorization requests, including reviews by clinical staff for whether the care is medically necessary for the patient and whether a coverage decision complies with Medicare coverage rules. Once the prior authorization request is sent to the plan, currently it must provide its decision in the form of a "notice of coverage determination" no more than 14 days after a standard request, or within 72 hours for an expedited request. There are three types of potential outcomes: fully favorable (the service is approved for coverage and payment), partially favorable (coverage is approved but at a reduced level of service), or adverse (denial of coverage). The plan must send a written notice within 60 days of the initial decision to inform the enrollee of their right to appeal to the health plan (requesting a "redetermination"). Beneficiary advocates say some plans often do not send notices or make decisions within the specified time frame. If an MA plan denies a prior authorization request and then upholds its original denial, the case is automatically forwarded to an independent review entity. If the enrollee is not satisfied with the outcome of that decision, they may seek higher levels of appeal.

Fewer than one in ten MA prior authorization requests are denied.

In 2023, over 50 million prior authorization requests were submitted to MA plan sponsors, or 1.8 requests per MA enrollee (a slight increase from 1.7 in 2022). Between 2019 and 2023, that rate of request remained fairly stable but the absolute number of requests increased with MA enrollment. In 2023, MA plan sponsors denied (full or partial) 6.4 percent of prior authorization requests—a decrease from 7.4 percent in 2022 but an increase from about 5.7 percent between 2019 and 2021. Rates of request for prior authorization varied across major MA plan sponsors in 2023, from a low of 0.5 per enrollee for Kaiser Permanente, to a high of 3.1 per enrollee for Humana and Anthem.

Few MA enrollees appeal denials, despite high odds of a favorable outcome.

In 2023, 11.7 percent of care denials were appealed by MA enrollees. However, in that same year, nearly 82 percent of appeals resulted in a decision that was favorable to the enrollee. Experts believe that few enrollees file appeals because the process is too complicated, especially for beneficiaries during a time of illness, and have called on CMS to simplify the process.

Problems with prior authorization in Medicare Advantage

Prior authorization can lead to delays or denials of medically appropriate care.

Policymakers, federal oversight agencies, beneficiary advocates, and researchers have raised concerns that some MA plans have used prior authorization to delay or deny medically appropriate care.

Throughout the U.S. health care system, in 2023, 94 percent of practicing physicians reported that health plans' use of prior authorization resulted in delays in access to necessary care for their patients. Nearly one in four reported that this led to a serious adverse health event for one or more of their patients. In addition, denials or delays by MA plans can force patients to seek out-of-network care, pay out of pocket, go without care, or engage in a lengthy appeals process.

There is a lack of transparency in MA reporting on prior authorization and denials of care.

Currently, MA plan sponsors only report aggregate data to CMS on prior authorization requests and denials, so details such as the most commonly denied services and the characteristics of beneficiaries who are being denied care are not available. This has made it impossible for beneficiaries who are choosing an MA plan to compare prior authorization practices by plan. While a 2024 CMS rule requires that by 2026, MA plan sponsors must report additional information, this information will not be reported for each plan and will not be differentiated by specific items or services.

Some MA plans are denying care that should be covered because it meets the Medicare coverage rules.

The Office of Inspector General examined a selection of MA plans and found that services such as advanced imaging (including MRI and CT scans), post-acute care in skilled nursing and inpatient rehabilitation facilities, and injections were the most commonly denied despite the fact that they met Medicare coverage rules. Another investigation found that inpatient post-acute care was denied more than any other care.

Use of Artificial Intelligence (AI) in coverage determinations can be problematic.

MA plans and benefits management vendors that administer prior authorization on their behalf increasingly use proprietary AI models to predict the level of post-acute care a beneficiary may need. Plan sponsors argue that AI models are used as an aid in clinical decision making. Beneficiary advocates, however, contend that MA prior authorization decisions have been made solely by the AI tools themselves and decry a lack of transparency behind plans' decision making. Plan enrollees have launched class-action complaints against major MA plan sponsors over the influence of AI tools in denials of post-acute care. A further concern is that AI algorithms can be discriminatory because the underlying data on which they are based are missing data on historically underserved populations. In February 2024 CMS issued guidance clarifying that it is the responsibility of the MA organization to ensure that the AI complies with all applicable rules for how coverage determinations by MA organizations are made. A bicameral, bipartisan group of congress members wrote to CMS to express their concerns that this guidance did not go far enough to solve the problem (see below).

Providers are increasingly exiting MA networks due (in part) to administrative burden.

Studies by provider associations and MedPAC focus groups of physicians show that prior authorization and the need to support appeals make the administrative burdens in MA far higher than in TM. In one study, 90 percent of medical group practices reported that prior authorization was very or extremely burdensome and that they had to hire or redistribute staff to handle increases in prior authorization requests. As a result, providers and health systems are increasingly exiting MA contracts, citing difficulties getting paid, paperwork burdens, and high denial rates. They report that these administrative burdens along with low payment rates are the reason they no longer participate in certain MA plan networks.

Steps and proposals to address prior authorization in MA

In recent years, CMS made several regulatory changes aimed at ensuring that people with MA could access the same medically necessary care they would receive in TM and to prevent disruptions in care.

- **One set of actions focused on streamlining the prior authorization process** by setting standards for how plans exchange electronic health information with providers. Wider use of electronic prior authorization could speed up the coverage determination process and reduce administrative burden. Beginning in 2026, plans are also required to make regular prior authorization decisions within 7 calendar days (down from 14 days), provide a specific reason for denying care in notices to beneficiaries, and report more information to CMS about denials.
- **Another set of measures focused on MA plans' responsibility to cover the same benefits as in TM and set guardrails on their clinical decision making.** For example, CMS clarified that when evaluating medical necessity, plans may only use prior authorization to confirm the presence of diagnoses or other medical criteria. The agency also specified that MA plans must follow TM's national and local coverage determinations and may not create their own internal coverage criteria when coverage criteria are fully established under TM.
- **To avoid disruptions in care,** CMS required MA plans to keep approved prior authorizations valid for as long as medically reasonable and necessary. CMS's rule also established a 90-day transition period that prohibits prior authorizations for new MA enrollees undergoing active treatment.

Additionally, there are several proposals that aim to further improve MA prior authorization practices and ensure that MA enrollees are being approved for services that are covered by Medicare.

- **In 2024 CMS published a proposed rule which,** if finalized by the Trump administration, would require MA plans to be more transparent about their denials, appeals, and reasons for denying care, as well as their internal coverage policies, and ensuring that enrollees understand their right to appeal.
- **A bipartisan, bicameral bill in Congress: Improving Seniors' Timely Access to Care Act of 2024** would, if passed, codify steps to standardize electronic exchange of health information, require more reporting on prior authorization requests and denials (and response time), protect new enrollees from prior authorization, and direct federal agencies to examine and use data about prior authorization appeals and denials to set future policy.
- **In June 2024, a bicameral and bipartisan group of Senators and Members of Congress sent a letter to CMS** reinforcing their support for more transparency around denials and appeals and for giving beneficiaries more information in denial notices specifying the criteria they used to deny care. They also requested more limitations on how MA plans can use AI to deny care.
- **Provider associations have also indicated their support for more detailed, transparent reporting on prior authorization requests, appeals and denials.** And some have advocated for reducing provider burden by implementing a "gold card" approach, which would waive the prior authorization requirement for contracted providers with a track record of high approval rates on certain services. A bipartisan bill to this effect was introduced into Congress in 2023.
- **Other policy proposals to change prior authorization are also available in the Medicare Policy Initiative's Compendium of Medicare Advantage and Part D Proposals.**

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This fact sheet is a product of the Medicare Policy Initiative, part of the Center for Health Insurance Reform at Georgetown University.

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