Weekly Checkup

Prior Authorization Is Not the Whole Ballgame

MICHAEL BAKER | JUNE 27, 2025

This week's pledge by the health care industry and the Department of Health and Human Services (HHS) regarding prior authorization (PA) was a positive-sounding public relations message masked as a sweeping declaration of game-changing policy commitments. To recap, a group of insurers led by AHIP and the Blue Cross Blue Shield Association agreed to address several topics:

- Standardizing Electronic Prior Authorization
- Reducing the Scope of Claims Subject to Prior Authorization
- Ensuring Continuity of Care When Patients Change Plans
- Enhancing Communication and Transparency on Determinations
- Expanding Real-Time Responses
- Ensuring Medical Review of Non-Approved Requests

There are critics of the PA process across the health care industry. Doctors, hospitals, patients, and care givers have all taken issue with navigating PA. Individually and together, they claim it is opaque, unfair, reductive, and burdensome. They allege that insurance companies have colluded to limit access to care in pursuit of profit by setting overly strict standards when deciding whether to cover care.

In an effort to settle this bitter debate, the commitments listed above allow both sides to claim they are addressing concerns with PA. But is there really substance to this agreement? Let's drill down a little more to see if this agreement represents a major change.

First, the commitment to a standardization of electronic PA – meant to be implemented by

January 1, 2027 – will use Fast Healthcare Interoperability Resources (FHIR®) application programming interfaces and be based on common data and submission requirements. This industry standard is an easy and reasonable path to some level of interoperability but will require clearer adherence to a long-opposed policy. Next, let's consider reducing the scope of claims subject to prior authorization, as well as inter-plan continuity of care. These may in fact lead to an increase in services received, but these policy changes may also lead to greater claim denials for future care that isn't authorized and is also not subject to *new* plan coverage – meaning patients would be on the hook for that care. Finally, while standardizing electronic PA may somewhat improve communication and transparency in determinations, including real-time responses, and could alleviate some of the waiting game providers and patients play, it wouldn't reduce PA denials or increase the coverage of services. People will just get a "yes" or "no" faster. And while that isn't nothing, it hardly addresses the fundamental disagreements between health care stakeholders on the essential role of PA.

And this is really the essential problem with the pledge between HHS and industry stakeholders: **The list of actions provide no commitment to do anything about the following: reducing the number of denials patients receive, preventing the future denial of prior authorization requests outside of the agreed-upon transition period, lowering the cost of the procedures that are being authorized, or increasing the number of covered services.**

The second point worth making is that the agreement sounds a lot like the 2018 PA consensus statement put out by roughly the same group of people (at least on the payer side), and since we're talking about the same issue again in 2025, it's clear that it didn't move the needle. And that stands to reason: **Simply committing to communicate more rapidly about denials – but not expanding coverage of those procedures no longer subject to PA – is not a panacea to the problems facing the health care insurance industry.**

But there is another claim worth investigating. Are PA denials in the United States particularly excessive? PA denials in Medicare Advantage (MA), the most oft-cited example of PA problems, tell a story that doesn't exactly show a system crying out for help. Based on data analysis from KFF of 2023 contract year MA claim denials, appeals, and outcomes, the overall claim denial rate was 6.4 percent. **These denials are not sorted by any type of service or validity of denial, but at face value this rate – among the 49.8 million total MA PA submissions – is lower than one might expect for a program of that size. Moreover, of these PA denials, 81.7 percent are overturned if they are appealed.** Traditional Medicare PA reviews had a 27.6-percent denial rate, and only 28.7 percent of those appealed denials were overturned. While not a complete apples-to-apples

comparison, the much-maligned PA process does not seem to be quite the problem certain industry segments make it out to be.

What can we learn from these data? The PA appeals process appears very effective at reversing claims denials, and improving that process may be the avenue to make further improvements in PA, to remediate any incorrect or excessive denials. But more generally, **for all the talk about prior authorization, there are other, more pressing issues in health care coverage.** Premium levels, deductibles, out-of-pocket costs, price and coverage transparency, medical workforce availability, network adequacy, and claims denials (which could become a larger problem with a reduction in PA) are all independent – and arguably more drastic – health insurance problems that need reform.

As a procedural point of order, this entire move was a voluntary agreement – announced via press release – that isn't accompanied by any rulemaking, legislation, or enforcement mechanism. While there may be some rules that have been promulgated or come into effect that assist these PA goals, those rules existed *before* this announcement, and PA was still considered a problem that necessitated this industry agreement.

Prior authorization is a highly visible, deeply frustrating bottleneck – especially because it's perceived as standing between a patient and medically necessary care. PA is often a boogeyman for problems facing health care, with patients, providers, and payers all being able to point fingers at one another while not claiming responsibility. This debate papers over real issues in health care, such as availability and affordability of services, the effectiveness of health interventions, and over (or under) regulation of various pieces of the health care finance chain. **Instead of resting on the weak laurels of this announcement, the health care industry and policymakers should focus on real, actionable, and impactful reforms to the health insurance industry.**

CHART REVIEW: NATIONAL HEALTH SPENDING EXPECTED TO OUTPACE ECONOMIC GROWTH OVER NEXT DECADE

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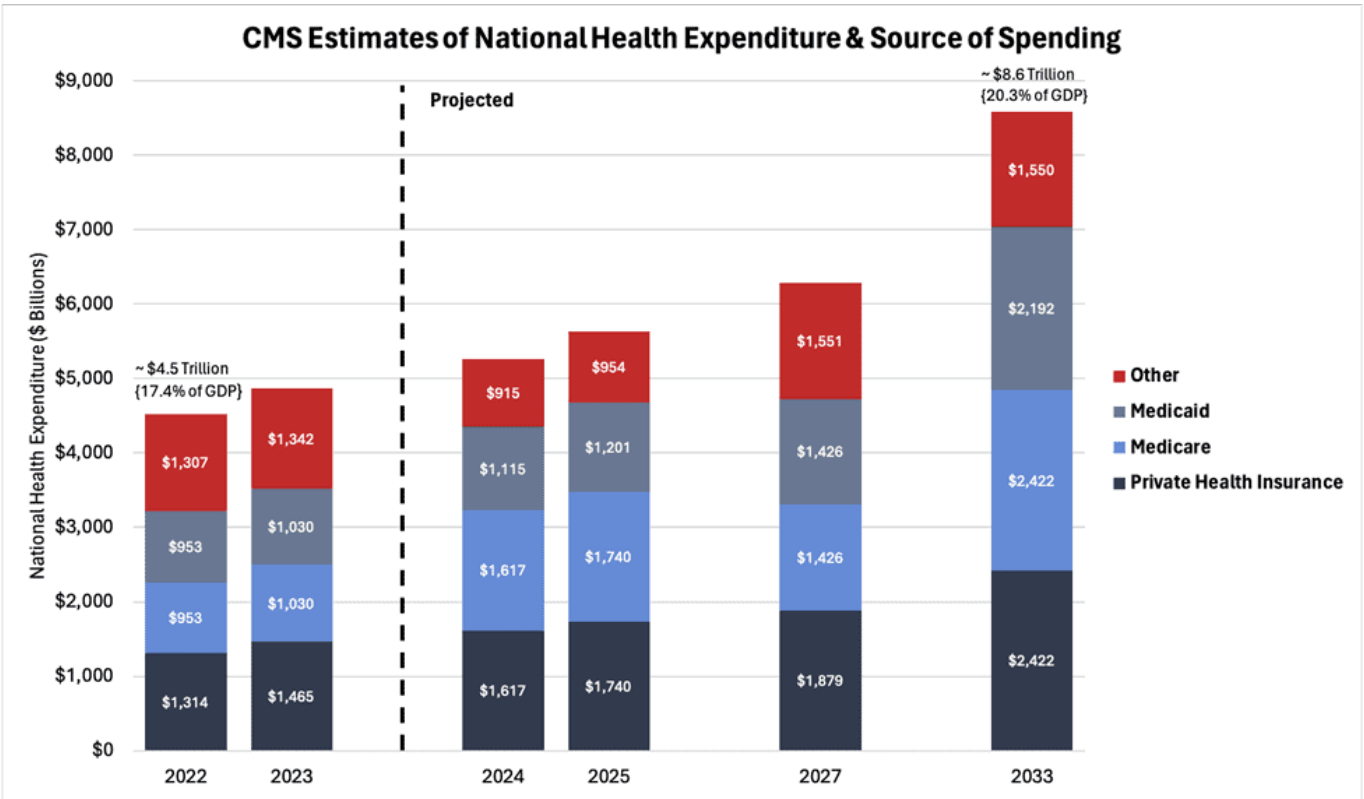
On June 25, the Centers for Medicare and Medicaid Services (CMS) published its national health spending projections for 2024–2033. The findings may surprise many, as the projections show an even-worse trend of CMS' previous estimates – which predicted that health care spending would continue to outpace economic growth over the next decade. This trend reflects a growing demand for health care services, an aging population, an

increase in the cost of health care, and a changing regulatory environment.

While aggregate health care spending has increased considerably since the COVID-19 pandemic, the rate of annual growth is expected to continue slowing as various legislative provisions (which expanded health care coverage and enrollment) expire. In 2025 health care spending is expected to increase by 7.1 percent, which is a noticeable decrease from the estimated 8.2 percent growth in 2024. Moreover, annual growth in national health expenditures is projected to average 5.8 percent over the next decade – which is far below spending levels in the immediate aftermath of the COVID-19 pandemic. Simply put, the sunset of COVID-19 pandemic-related funding may show some decline in the rate of health care spending, but the overarching trend still demonstrates tremendous future growth in national health expenditures.

As mentioned previously, this growth is expected to exceed the average annual growth in gross domestic product (GDP), with the national health expenditure share of GDP increasing from 17.4 percent in 2022 to over 20 percent in 2033. CMS notes that this trend is largely attributable to an influx of Americans enrolling in Medicare, which has the highest per-enrollee spending due to the demand for health care services. The chart below demonstrates the enormous growth in Medicare spending over the next decade, increasing by 154 percent from 2022–2033 – followed by Medicaid at 130 percent, private insurance at 84 percent, and other health care spending (i.e., the 340B Program and other health programs) at 19 percent.

It is notable that CMS' estimates are not just contingent on enrollment patterns and the demand for health care services. Regulatory measures under consideration, including the budget reconciliation bill and other health care-related rules and legislation, may contribute to any acceleration or deceleration of national health care spending in the future. Furthermore, health care spending behaviors may be affected by macroeconomic conditions – including inflation and wage growth – which will provide further uncertainty.


CMS Estimates of National Health Expenditure & Source of Spending
National Health Expenditure ($ Billions)
$9,000
$8,000
$7,000
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
Projected
~$4.5 Trillion
{17.4% of GDP}
~$8.6 Trillion
{20.3% of GDP}
$1,307
$953
$953
$1,314
$1,342
$1,030
$1,030
$1,465
$915
$1,115
$1,617
$1,617
$954
$1,201
$1,740
$1,740
$1,551
$1,426
$1,426
$1,879
$1,550
$2,192
$2,422
$2,422
2022
2023
2024
2025
2027
2033
Other
Medicaid
Medicare
Private Health Insurance