EXPLAINER

Utilization Management: An Overview

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California Health Benefits Review Program (CHBRP)
University of California

There are a variety of ways legislation can impact the health benefits of patients. One way is by mandating or rescinding coverage for a specific test, treatment, or service. Another way is by changing the terms and conditions of health insurance coverage. An example of the latter is by proposing new rules to utilization management techniques. This document provides an overview of utilization management and how different practices are used in clinical and financial decision-making. Understanding the mechanisms, rationale, and implications of utilization management is essential for navigating the contemporary healthcare landscape.

What is Utilization Management?

Utilization management is a term used to describe the various tools used by health plans and insurers to maintain compliance with these laws and ensure medication compatibility, monitor utilization, control costs, and manage safety. The goal is to provide a structured approach to medication management that balances patient care needs with the financial constraints of payers and patients.

Examples of utilization management include benefit coverage requirements related to prior authorization, step therapy, quantity limits, and limits related to the age or sex of the enrollee (such as prescription-only infant formula or prostate cancer screening for men). A brief description of some utilization management techniques follows in the remaining subsections.

Both federal and state laws include provisions to help protect patients in two primary ways when they use health care services. The first is to ensure patient safety and limit low-value or unnecessary care. Federal law requires all states to develop a drug utilization review program for their Medicaid programs to ensure that prescription drugs are appropriate, medically necessary, and not likely to result in adverse medical results.[1] The law also focuses on reducing overutilization and underutilization of prescription drugs, fraud, clinical abuse and misuse, and appropriate clinical use of medications. California law requires any entities that exercise utilization management techniques to have written policies and procedures governing the process.[2]

[1] Section 1927(g) of the federal Social Security Act.
[2] Health and Safety Code Section 1367.01(b); Insurance Code Section 10123.135(b).

Prior Authorization

Prior authorization[3]– also known as precertification, prior approval, or prospective review – is a utilization management technique commonly used by health plans and insurers to ensure that a given medical intervention meets the health plan or policy's criteria for coverage (Newcomer et al., 2017). Prior authorization was also developed as a tool to assess the appropriateness of treatment that would result in a hospital admission or a high-cost procedure (Resneck, 2020).

The process typically requires providers to establish eligibility and submit documentation demonstrating medical need to the plan or insurer for approval of coverage before either medical services are provided or a prescription is filled in order to qualify for payment. Health plans and insurers may also impose prior authorization requirements on nonpreferred medications in an effort to promote the use of preferred medications that can be procured at lower prices.

Purposes of prior authorization:

- **Coverage evaluation:** Allows evaluation of whether a test, treatment, or service is medically necessary and otherwise covered.
- **Safety:** Acts as a safeguard to confirm that a patient's medications are compatible and provides an opportunity to check that proper diagnostic testing has been completed to ensure patient safety prior to use of a requested treatment. Prior authorization also reduces inappropriate patient care by stopping unsafe or low-value care that is inconsistent with the most recent clinical evidence.
- **Cost control:** Imposition of prior authorization for nonpreferred medications can encourage the use of preferred medications that can be procured at a lower price.

Step Therapy

Step therapy, or "fail-first" protocols, is an insurance protocol applied to prescription drugs to ensure medication compatibility, control costs, and ensure patient safety. Health plans and insurers may use step therapy protocols to apply clinical guidelines established by professional societies and other recognized organizations to treatment plans. They require an enrollee to try and fail one or more medications prior to receiving coverage for the initially prescribed medication. Step therapy protocols usually recommend starting with a less expensive outpatient medication and/or one that has more "post-marketing safety experience" (PBMI, 2015). In addition, they sometimes require starting with a less potent medication or dosage, perhaps with fewer side effects, and graduating to more potent medications as necessary (e.g., from prescription ibuprofen to oxycodone to treat pain). Generally, more expensive or more potent medications are covered when the patient fails to respond to the step therapy–required medication (PBMI, 2018).

Quantity Limits

Quantity limits may be applied to prescription drugs by health plans and insurers to promote safe use and manage costs (CMS, 2025). Quantity management rules often set caps on the amount of medication a patient can receive at one time or over a specified period, including limits based on duration of therapy, total quantity dispensed, or maximum daily dose (AMCP, 2025). Such restrictions are often applied to medications with high potential for abuse or dependence (e.g., opioids) or are costly and require monitoring for safe use (AMCP, 2025). Health plans insurers use quantity limits to align with clinical guidelines from professional organizations and drug safety data reviewed by the U.S. Food and Drug Administration (FDA). These limits are placed regardless of the prescription written by the provider. For example, a health plan may only cover 30 pills of a medication per month, even if a physician prescribes 60, requiring patients to seek an exception or pay out-of-pocket for the additional supply.

[3] More information about prior authorization is available in CHBRP's 2023 analysis, Prior Authorization in California.

Concurrent and Retrospective Review

Concurrent reviews are conducted during an active course of treatment to determine if ongoing care is medically necessary and if the patient is in the most appropriate setting. Because this process requires monitoring a patient's progress over time, it is almost exclusively conducted in inpatient or facility-based settings, though it can apply to intensive ongoing outpatient care. This process helps reduce misuse of hospital services and facilitates smoother transitions to the next appropriate level of care, whether that be home or a lower-acuity setting (Giardino and Wadhwa, 2023).

Retrospective review, in contrast, takes place after care has already been delivered and billed. Its purpose is to confirm that the care provided was medically appropriate and accurately coded according to established standards (e.g., to International Classification of Diseases, Tenth Revision (ICD-10) standards) (Giardino and Wadhwa, 2023). Beyond financial validation, this process serves a quality control function. It generates data on treatment outcomes and care quality, which is shared with providers and health systems to drive performance improvements (Giardino and Wadhwa, 2023).

Formularies

Formularies are curated lists of medications and technologies that are regularly updated based on evidence-based medicine, expert judgment, and cost consideration (Hydery and Reddy, 2024). They are also dynamic management tools that are updated regularly by health plans and pharmacy benefit managers. Formularies are often tiered, meaning certain drugs are preferred by the health plan and are accompanied by lower copayments. By determining which drugs are covered and under what conditions, formularies can help ensure appropriate and cost-effective use of medications (Hydery and Reddy, 2024). Formulary designs often incorporate utilization management tools like prior authorization and step therapy to promote affordable care while guiding patients towards high-value therapies (Hydery and Reddy, 2024).

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About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource Academic Rigor on a Legislature's Timeline.

To read any of the bill analyses CHBRP has completed, see the Completed Analysis page on CHBRP's website. In addition to analysis of introduced legislation, CHBRP produces other publications including several annually updated resources, as well as issue briefs and explainers.

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