ISSUE BRIEF:

Fix medication prior authorization now

MMA POSITION:

Medication prior authorization (PA) delays, disrupts and, in some cases, harms patient care. PA is inconsistent from insurer to insurer, and is complex and inefficient. The MMA supports legislation to simplify medication PA and to fundamentally transform it from an advance approval requirement to a focused quality improvement activity. We support HF 1060, authored by Rep. Tony Albright, and SF 934, authored by Sen. Melisa Franzen.

BACKGROUND:

Medication therapy is critically important to patient care, as are insurance policies that ensure appropriate medication coverage. Most patients looking to purchase health insurance are faced with coverage information that is complex, difficult to compare and lacking in sufficient detail. Once coverage is purchased, insurers and/or pharmacy benefit managers (PBMs) can change which medications they cover and how much patients must pay out-of-pocket for them at any time.

Access to appropriate medications is complicated by PA and other approval requirements imposed by insurers/PBMs, including step therapy and quantity limits. PA requires physicians and other prescribers to obtain approval in advance from the insurer/PBM before a pharmacist can dispense a medication to a patient.

On the surface, PA appears to be a tool that could support evidence-based prescribing practices and ensure cost-effective treatment for patients. The evidence supporting its use, however, is limited. Untended outcomes of PA have been well-documented and include reduced use of essential therapies; declines in patient health; substitution of less-effective, more toxic or more expensive medications; and increased use of more costly physician or institutional care.

Medication PA is also inefficient. In Minnesota, approximately 76 to 86 percent of initial authorizations are approved. A more targeted process that focuses on those prescriptions for which an alternative drug may be more appropriate or that request a drug outside the norm would be far more effective and efficient.

The variation in the use and application of PA in Minnesota is dramatic. The MMA analyzed the drug formularies from five Minnesota insurers (Blue Cross and Blue Shield, HealthPartners, Medica, PreferredOne and UCare) and Medical Assistance. The analysis found approximately 1,036 medications with PA or other authorization requirements. Of those, only six drugs were common across all of the payers, and none of those drugs had the same type of authorization requirement. Such variation suggests that PA is not being used to ensure medically appropriate prescribing practices (the science does not vary from insurer to insurer), but instead is being used to steer prescribers and patients to the drugs for which the individual insurer has secured the best discount or rebate; that medication may or may not be the best one for the patient.

Using the most effective and affordable medications is a goal that patients, insurers and physicians all share. Insurers can support that goal by designing coverage and benefit policies that align evidence with affordability. But medication PA is an inefficient and potentially dangerous strategy that delays care, interferes with the physician-patient relationship, and is extremely costly in terms of the time physicians spend on it—approaching $68,274 per physician per year, on average. It is time to fix PA now.

TALKING POINTS:

The MMA favors:

- Improving patient understanding of the medication coverage included in their health plan (similar to current Medicare Part D requirement)
- Limiting formulary and medication coverage changes during the enrollment year (similar to current Medicare Part D requirement)
- Creating a 60-day transition period for patients who change insurance plans or other policies to prevent gaps in their ongoing medication needs (similar to current Medicare Part D requirement)
- Transforming medication prior authorization to a retrospective quality improvement activity
- Creating a pharmaceutical coverage oversight task force to monitor trends in medication coverage and formulary design
- Simplifying administrative processes by using a single PA form, requiring communication to prescribers of covered alternatives when initial prescriptions are denied, and providing faster turnaround times for initial authorization requests and appeals (similar to changes made by many other states)

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1 See, for example: Soumerai S. Benefits and Risks of Increasing Restrictions on Access to Costly Drugs in Medicaid. Health Affairs, 23, no.1 (2004):135-146.
2 Aggregate data provided by the Minnesota Council of Health Plans, September 2014.