Minnesota Medical Association

ISSUE BRIEF

ISSUE

Reduce Third-Party Interference in Patient Care

MMA Position

Health plans must not be allowed to force a patient to change a drug that is working for them during their contract year. The MMA supports SF1006/HF 1257 that prohibits that practice. We also support requiring health plans to adopt real-time benefit notification that tells the prescriber what drug is on the preferred drug list.

Background

Patients who choose their health plan based upon a plan's coverage of the medications that work for them have no guarantee that the plan will continue that coverage. For patients with chronic conditions such as MS, arthritis, epilepsy or mental illness, forcing a patient to change a drug therapy because an insurer or pharmacy benefit manager (PBM) has a better financial deal can cause direct harm to the patient and add to the overall cost of treatment.

Patients are bound by the terms of the health plan they've selected and cannot change coverage until the next open enrollment period. Yet, nothing currently stops PBMs or health plans from changing their drug formularies mid-year and requiring patients to switch drugs. These changes to a drug's coverage or benefit class do not benefit the patient and can lead to compromised care by requiring patients to switch from medications with demonstrated effectiveness to ones that may not provide the same therapeutic benefit.

Legislation is needed to prohibit health plans and PBMs from forcing a patient who is currently receiving a drug therapy from changing drugs until the end of the patient's contract year. The MMA acknowledges the role that formularies and preferred drug lists can play in reducing costs. The proposed legislation would only apply to a patient who is currently receiving a drug therapy. Nothing in the bill would prohibit PBMs and health plans from changing formularies for all other enrollees.

Legislation is also needed to require the use of a tool by which a prescriber can receive real-time responses from a health plan regarding coverage of a prescription to a patient. A tool is being developed by the National Council of Prescription Drug Programs (NCPDP), the standard setting organization for the pharmacy industry. Physicians are often open to prescribing a drug that is covered by the patient's insurance, though it is often difficult to know which drugs are covered until after a denial. The NCPDP standards will soon be required for Medicare Part D and should be required for all health plans in Minnesota.

Talking Points

- Patients deserve to have access to their needed medications in a timely manner.
- Patients are bound to the terms of the contract with a health insurer; and yet nothing in state law stops the insurer or PBM from changing the patient's drug coverage for drugs they are already on, even in the middle of a contract year.
- Drugs that were covered one month suddenly are no longer covered without the patient or physician receiving notification prior to a denial of a prescription.
- Physicians should be informed in real-time, at the time of ordering the medication, whether it is fully covered or not. They are open to writing prescriptions for drugs that are on the preferred drug list, but it's difficult to know which drugs are covered until a prescription is denied by the insurer or PBM.
- Legislation is needed to mandate the use of the NCPDP standards that are being developed for a real-time benefit notification tool.