We need to fix PA now

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edicine has become more complex and costly given advances in imaging technology, development of implantable devices and the advent of new drugs. Prior authorization (PA) is a technique used by health plans and payers to help control some of the costs of these innovations. Controlling costs is a laudable goal. However, the processes for obtaining medication PA are widely variable and complex, and decisions often are not based on medical evidence.

In fact, a task force convened by the MMA to study the issue found that of the approximately 1,036 medications requiring advance approval by six Minnesota health plans, only six were on all of the lists. This suggests something other than science is determining which drugs health plans will pay for.

Prior authorization adds considerable burden and cost for physicians and pharmacists, as well as administrative expense for health plans and payers. More troublesome is the fact that PA creates needless worry and, in some cases, harm for patients.

The MMA initially attempted to work with the health plan community to address the wide variation in PA practices, but we faced significant resistance. In January, the Board of Trustees voted to seek a legislative solution to the problems related to PA and health plan prescription drug coverage. In particular, the MMA is looking to shift from PA to a quality-improvement activity that retrospectively identifies and reviews prescribing practices that fall outside the norm.

According to data from the Minnesota Council of Health Plans, between 76 and 86 percent of initial PA requests are approved. Wouldn’t it be a better use of time and resources to focus on the outliers rather than needlessly forcing the overwhelming majority of prescribers to jump through complex hoops?

The MMA is also looking to apply some commonsense requirements in Minnesota such as requiring payers to disclose in advance which drugs they cover and what the patients’ share of the cost for those drugs will be; limiting the frequency of formulary changes; and providing patients with a 60-day supply of a drug to accommodate changes to a formulary or transition to a new health plan.

Physicians have the enormous responsibility to prescribe the most clinically and cost-effective medications for their patients. Yet most payers make it extremely difficult for them to know which medications are covered and to what extent patients must share in the cost. And because of the differing rebates and discounts that an individual payer might negotiate with drug manufacturers, the least-expensive drug for a patient covered by one payer is likely to be different from the least-expensive drug covered by another.

I am optimistic that we can find a solution to the PA problem that will benefit everyone—one that will result in a process that is less onerous for physicians, less disruptive to patient care and more cost-effective for insurers. Patients deserve to have clear and accurate information about the medications that will be covered under their insurance policy; they deserve to have those medications covered for the term of their policy; and they deserve to have their medications uninterrupted if their condition is well-managed. And physicians deserve to have their medical expertise and clinical knowledge recognized.

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