ZVMS Policy Brief

PRIOR AUTHORIZATIONS

SUMMARY

Prior Authorizations are measures implemented to reduce short-term cost by delaying or denying medically necessary care. These measures result in increased direct and indirect costs for clinicians and patients. The resulting delay or denial in medically necessary care is a barrier to providing patient-centric care as illnesses go untreated for longer and often can lead to serious adverse events. Moreover, a recent physician survey conducted by the American Medical Association (AMA) has revealed that physicians complete an average of 40 prior authorizations per week, creating tremendous administrative waste [1].

BACKGROUND

Prior authorization is the process required by payors (typically health insurance companies) to determine medical necessity and/or medical appropriateness of otherwise covered healthcare services (including medications) before agreeing to pay for such services using their respective unique criteria. The criteria are usually unclear and rarely available at the point-of-care to clinicians, adding to the complexity of patient care, placing patients at risk of serious adverse outcomes secondary to delay and denial of care and a marked increase in the administrative burden. The Minnesota Legislature took essential steps to address shortcomings of prior authorization in the 2019-2020 session [2]. However, number of concerns related to prior authorizations remain and were unfortunately not addressed. We are making the following recommendation to further improve prior authorizations in Minnesota and reduce its negative impact on clinicians and patients.

DISCUSSION

Issue: Mid-Year Formulary Changes

When Minnesotans enroll in a given health plan, they often sign annual contracts. In many instances, patients choose plans based on provided coverage, especially for formulary medications as published by the plan. However, currently, there are no restrictions for such plans to change their formulary mid-year while the insured will have no recourse for the remainder of the plan year. Consequently, a previously covered medication under a plan's formulary may suddenly be no longer covered by a patient's plan leading to a need to change a previously effective treatment, delay in receiving treatment, additional cost, additional administrative burden (e.g., obtaining prior authorization) and/or adverse outcome.

> **Recommendations:**
> We recommend that plans be required to continue to honor formulary pricing for medications that an insured was prescribed and covered under the plan's formulary during the plan year for the duration of that plan year.

Issue: Duration of Validity

In many cases, prior authorizations are approved for a limited duration and require reapproval for the continuation of healthcare services. In some cases, such as when the prior authorization is for a healthcare service with limited duration, diagnostic services, or a single procedure, it may make sense. However, in many other instances, where prior authorization is for a healthcare service such as

medications that are required for ongoing or maintenance treatment, limiting the duration of the prior authorization, from a clinical standpoint, makes very little sense. In fact, ongoing need for a treatment is often an indication of its efficacy and necessity. This is especially true in the treatment of chronic conditions. For example, a patient with a blood clotting disorder who requires a certain blood thinning medication, is likely to require that medication for life and requiring reapproval of a previously approved prior authorization will only serve to delay or potentially interrupt her life-saving care.

Recommendations:

In order to alleviate the need for reapproval of a previously approved prior authorization, we recommend that in cases where ongoing treatment is required, an approved prior authorization be valid for at least 1 year, and for chronic conditions, especially those requiring maintenance therapy, the approved prior authorization to be valid for the length of the treatment without the need to seek reapproval.

Issue: Prior Authorization When Switching Plans

Under Minnesota law, when switching insurance plans, prior authorizations from the previous plan are only valid for 60-days and another prior authorization must be obtained from the new plan. If a healthcare service was deemed to be medically necessary and/or appropriate for a given patient by one health plan, changing health plans should not alter its medical necessity and/or appropriateness.

Recommendations:

When switching health plans, if a prior authorization was obtained by a patient while covered under another Minnesota health plan, then it should continue to be honored by the new Minnesota health plan under the same terms and for the duration of the original authorization, eliminating the need to reobtain approval from the new plan.

Issue: Standardization of Prior Authorization Forms

Each insurer often utilizes a unique prior authorization form and when submitted electronically, each insurer has a unique portal for submission of prior authorization further adding to the administrative burden associated with prior authorizations.

Recommendations:

We recommend that insurance plans in Minnesota be required to utilize a standardized (common) prior authorization form and have available a single common web portal where clinicians can submit prior authorization forms to any insurance plan.

REFERENCES

1. https://www.ama-assn.org/system/files/2021-04/prior-authorization-survey.pdf
2. SF 3204/HF 3398