How Prior Authorization Protects Patients

MINNESOTA COUNCIL of HEALTH PLANS

AT A GLANCE:

- **Prior authorization is a tool that health plans use to ensure treatment is a covered service and appropriate for a specific patient.**
- **Prior authorizations support patients with cost-effective, quality care by preventing dangerous medication combinations; supporting appropriate utilization of services; and examining courses of treatment that can be misused, abused or addictive.**
- **Most treatments and medications do not require prior authorization.**
- **When prior authorization is required, providers must seek prior approval from the patient's health plan before proceeding with that course of treatment.**

How does prior authorization work in Minnesota?

Prior authorization ensures plans have the management tools needed to improve health care outcomes and control costs. The process gives a patient's health plan a chance to review how appropriate a specific medical treatment or medication is for treating a condition. For example, some brand-name medications are very costly, so a health plan may conclude a generic or another lower-cost alternative will work just as well in treating the medical condition.

Plans also use prior authorization to help deploy care coordination and management, including activating plan case managers, and ensuring that referrals to other providers are in-network for the patient and appointments are made. This not only improves care and outcomes, but it increases affordability for the patient and reduces stress. For example, prior authorization for planned surgeries can result in the activation of these types of services.

Prior authorization is also utilized to ensure that:

- Providers adhere to nationally recognized care criteria;
- Medications are safe, effective, and provide value for specific populations;
- Drugs and devices are not used for clinical indications other than those approved by the FDA or supported by medical evidence;
- The administering clinician has the appropriate training, such as limiting prescribing of chemotherapy medications to oncologists;
- Dialogue with clinicians is tailored and patient-focused to promote adherence and improve outcomes;
- Members newly prescribed a medication get counseling, peer support, or community-based support, if appropriate.

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Prior authorization programs include provider feedback

Prior authorization programs developed by health plans incorporate physician input and are designed with the goals of improving quality and protecting patient safety. Most medications and treatments also do not require prior authorization.

Health plans also regularly review treatments subject to prior authorization

Some treatments may no longer warrant prior authorization due to low variation in utilization or updates to standards of care. Regular review can also help identify services — including new and emerging therapies — where the evidence base on effectiveness is incomplete or where there are safety concerns. Prior authorization is also not required if you have an emergency and/or need emergency medication.

Further limits to prior authorization aren't the answer

The Minnesota Council of Health Plans opposes any new legislation or administrative action that limits the ability of health plans to use tools such as prior authorization to rein in the growing cost of health care. Health care is expensive and unnecessary out-of-pocket costs hurt the consumer. Consumer protections for prior authorizations are also in place.

In 2020, a new law for fully insured Minnesotans required:

- Electronically submitted prior authorizations have a decision communicated no later than 5 business days after receipt;
- Prior authorizations submitted by phone, fax or mail have a decision communicated no later than 6 business days after receipt;
- Urgent prior authorizations have a decision communicated within 48 hours of receipt;
- Denials of prior authorizations for medical and behavioral health services be determined by a like-specialty reviewer.

BY THE NUMBERS

Nearly 85% of commercial enrollees are in plans that limit prior authorization to less than 10% of prescription medications.

Over 90% of commercial enrollees are in plans that limit prior authorization to less than 25% of medical services.

(Source: AHIP)

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