WHEREAS, A primary concern of our American Medical Association is to optimize individual medical care and the betterment of public health; and

WHEREAS, The original justification for prior authorization of medications was to restrain the escalation of the cost of medical care; and

WHEREAS, The list price of a drug greatly differs from the net price, which incorporates discounts and rebates, and that the use of list price leads to misleading implications for health care policy as reported in studies; and

WHEREAS, The factor of net cost of a medication to the insurer is likely a strong factor in determination to cover, or not cover, a given prescription; and

WHEREAS, There is a trend, in the opinion of many, for prescribed medications to be denied prior authorization even when the cost of a medication is low; and

WHEREAS, The prescribing physicians is in the best position to choose the appropriate medication for an individual patient given the multiple factors to consider; and

WHEREAS, Information as to the actual cost basis involved in prior authorization would be useful in contesting adverse prior authorization determinations as well as in advocacy for more medically appropriate determinations in general; and

WHEREAS, There are numerous sources of information on aggregate pharmaceutical prices (including net) and spending, but none that report on the influence of the various factors on the process of prior authorization for an individual prescription; and

WHEREAS, The federal government has processes for gathering information already in place, such as the Prescription Drug Pricing Dashboard as well as the Congressional Budget Office, but not at the granular level of individual prescriptions; and

WHEREAS, There have been bipartisan attempts in the last several years to increase the transparency of drug pricing and costs which have not passed Congress; therefore be it

RESOLVED, That our American Medical Association advocate to the federal government that third party payors and surrogates include economic information on the costs of medications denied prior authorization and, where applicable, comparative costs of alternative approved or suggested medications for each rejected prior authorization (Directive to Take Action).
Fiscal Note: TBD

Received: 4/30/2023

References:


RELEVANT AMA POLICY

Prior Authorization Relief in Medicare Advantage Plans H-320.938

Our AMA supports legislation and/or regulations that would apply the following processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

a. List services and prescription medications that require a PA on a website and ensure that patient informational materials include full disclosure of any PA requirements.
b. Notify providers of any changes to PA requirements at least 45 days prior to change.
c. Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.
d. Standardize a PA request form.
e. Minimize PA requirements as much as possible within each plan and eliminate the application of PA to services and prescription medications that are routinely approved.
f. Pay for services and prescription medications for which PA has been approved unless fraudulently obtained.
g. Allow continuation of medications already being administered or prescribed when a patient changes health plans, and only change such medications with the approval of the ordering physician.
h. Make an easily accessible and responsive direct communication tool available to resolve disagreements between health plan and ordering provider.
i. Define a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans.

Citation: Res. 814, I-18; Reaffirmed: A-22

Private Health Insurance Formulary Transparency H-125.979

1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.

2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.

3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term.

4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.

6. Our AMA (a) promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.

7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.

8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.