ECONOMIC FINDING • JANUARY 2023

Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare

Based on BFI Working Paper 2023-08, "Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare," by Zarek Brot-Goldberg, University of Chicago; Samantha Burn, Harvard University; Timothy Layton, Harvard University; and Boris Vabson, Harvard University

Beneficiaries of Medicare Part D who face restrictions on a drug reduce their use by 26.8%, reducing drug spending by $96 per beneficiary-year, while only generating about $10 in paperwork costs.

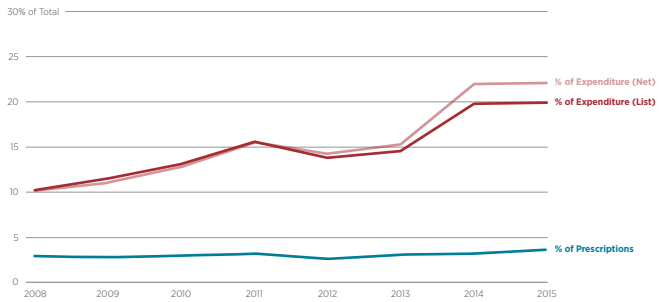
Administrative costs make up between 20 to 34% of health care expenditures, roughly 1-4% of GDP. Often characterized as wasteful, these costs are also spent on beneficial activities such as auditing claims for fraud, overbilling, or wasteful care, as well as enforcing compliance with managed care restrictions that limit access to costly providers, services, and drugs. Likewise, while increased efficiency could reduce administrative costs, their outright elimination would likely have deleterious effects.

This paper begins with the premise that bureaucracy has both costs and benefits. Managed care policies that restrict health care use trade off administrative burden for potential reductions in moral hazard[1] and lower costs of insurance provision. The authors characterize this trade-off for prior authorization restrictions for prescription drugs, whereby patients can only receive insurance coverage for certain drugs (typically high-cost, on-patent drugs) if they receive explicit authorization; otherwise, they must pay the full cost out of pocket. Acquiring the necessary authorization requires the patient's physician to fill out pre-specified paperwork to justify the drug's prescription.

The goal of these policies is to restrict access to costly drugs to only those patients for whom those drugs provide the highest value. However, prior authorization comes with significant administrative costs: an average of 20.4 manpower hours per physician per week for physician practices in 2009; 34% of physicians report having at least one staff member who works exclusively on prior authorization requests.

That said, there are benefits to this process. Briefly, prior authorization allows providers to

Figure 1 • Use of Prior Authorization



Note: This figure shows the use of prior authorization restrictions in claims for beneficiaries in the authors' sample. The use of prior authorization increased over this period. By 2015, 3.6% of filled Part D claims in involved a prior authorization requirement, accounting for 22% of overall gross spending, and 20% of overall spending net of rebates. The blue dotted line plots the share of all filled prescriptions requiring prior authorization. The solid red line weights those prescriptions by their list price, such that it measures the share of total gross spending that required prior authorization. The dashed red line weights those prescriptions by their net price (list price net of rebate), such that it measures the share of total net spending that required prior authorization.

[1] Moral hazard occurs when an economic agent (e.g., a person, household, business) has an incentive to increase its exposure to risk because it does not bear the full costs of that risk. For example, a bank with fully insured deposits, or even implied insurance by a government's too-big-to-fail policy, may take on higher risk knowing that those risks will be covered.

Becker Friedman Institute
FOR ECONOMICS AT UCHICAGO

directly communicate information to insurers about the patient's suitability for the drug, allowing insurers to target coverage denials to low-value use. Put another way, all of that paperwork signals the provider's beliefs about a patient's suitability for the drug. One imagines a doctor thinking: "I am not going through all of this hassle unless it is truly necessary."

To examine this question and related issues, the authors study prior authorization empirically in Medicare Part D, the public drug insurance program for the elderly in the United States, focusing on the Low-Income Subsidy (LIS) program. The LIS program has two appealing features: First, LIS beneficiaries effectively pay nothing out of pocket for covered drugs, making prior authorization the primary feature of the insurance contract that shapes drug demand. Second, LIS beneficiaries frequently face default rules that assign them to a randomly chosen, and binding, plan if they do not make an active plan choice.

Please see the working paper for more details on the authors' research design, but they begin by measuring the effect of prior authorization on drug utilization by comparing (within a given drug, region, and year) utilization for beneficiaries who are enrolled in plans that *have authorization restrictions* on that drug, against those assigned to plans that cover the drug *without restriction*, to find the following:

- Prior authorization restrictions reduce the use of focal drugs by 26.8%, with slightly larger relative effects among non-white and older patients, and smaller relative effects on drugs in high-benefit classes.
- Accounting for substitution to other medications (roughly half of patients do so), the authors estimate that the status quo use of prior authorization policies reduced total drug spending by 3.6%, or $96 per beneficiary-year, while only generating approximately $10 in paperwork costs.
- This reduction in spending is comprised of a $112 per beneficiary-year reduction in spending on restricted drugs and a $16 per beneficiary-year increase in spending on cheaper, unrestricted drugs.

Bottom line: Prior authorization restrictions are a powerful tool for reducing health care costs. Though they generate substantial administrative costs, these costs are small relative to the reductions in drug spending achieved by the restrictions, and those costs are also decreasing over time. Additionally, this work suggests that the first-order effect of prior authorization is not wasteful spending on bureaucratic processes; instead, the first-order effects are on drug utilization.

The authors close with a rich discussion on the welfare effects of prior authorization restrictions, as well as implications for other policy options, and readers would do well to visit this section. One case in point: a better understanding of administrative costs could shed light on the relative merits of health care systems in the US (where non-price rationing is done through managed care policies that generate administrative costs) vs. other OECD countries (where queue-based systems generate costs by forcing people to wait).

READ THE WORKING PAPER

NO. 2023-08 · JANUARY 2023

Rationing Medicine Through Bureaucracy: Authorization Restrictions in Medicare

bfi.uchicago.edu/working-paper/2023-08

ABOUT OUR SCHOLAR

Zarek Brot-Goldberg
Assistant Professor,
Harris School of Public Policy
harris.uchicago.edu/directory/zarek-brot-goldberg

THE UNIVERSITY OF CHICAGO
HARRIS SCHOOL
OF PUBLIC POLICY