AMERICAN LUNG ASSOCIATION®

Barriers to Asthma Guidelines-Based Care Coverage

The American Lung Association's Asthma Guidelines-Based Care Coverage Project examines coverage of and barriers to guidelines-based asthma care in Medicaid programs across all 50 states, the District of Columbia and Puerto Rico. Lack of coverage of asthma medications and services creates problems for patients to access and adhere to recommended treatments, leading to poor patient outcomes. While coverage is a critical factor in patient access, barriers also impede patients from getting timely care to manage their asthma and prevent exacerbations. This document explains some of the barriers faced by asthma patients and analyzes the frequency of these barriers in state Medicaid programs in 2019.

Age Limits and Age Restrictions: Age limits indicate that the treatment is only covered if a patient is under a certain age and age restrictions indicate that the treatment is only covered if a patient is over a certain age. Some medications may not be appropriate for patients of certain ages, so age limits and restrictions are only considered to be barriers if they contradict the guidelines that the Food and Drug Administration (FDA) sets based on science and patient safety. In these cases, age limits and restrictions can delay patients from accessing a medication, even if a physician determines that the medication is appropriate for them.

Copayments: A copayment is an additional payment for a treatment covered by a health plan. Research has shown that cost-sharing, such as copayments, can reduce prescription drug use among Medicaid recipients.[i] Publicly-insured populations, such as those who rely on Medicaid for healthcare coverage, are susceptible to medication nonadherence when required to pay for medication,[ii] and the reduced use of recommended asthma medications negatively impacts their health. Even relatively small cost-sharing between $1 and $5 is associated with reduced use of care, including necessary services.[iii] For Medicaid patients with asthma, copays can force patients to choose between medications and other necessary expenses such as food or housing.

Durable Medical Equipment (DME): Durable medical equipment (DME) includes devices for patients that can withstand repeated use, primarily used for a medical purpose and appropriate for home use.[iv] Devices for asthma patients, such as nebulizers, peak flow meters and valved-holding chambers, sometimes fall under this category. When medical devices are classified as DME, patients must go to DME suppliers in order to receive their medical device and for the medical device to be covered by their health plan. To supply DME, pharmacies must obtain additional accreditation. However, since not all pharmacies pursue or meet the additional DME supplier standards, patients may not be able to obtain DME at their regular pharmacy, creating additional accessibility issues that may prevent them from receiving the device that they need to manage their asthma.

Eligibility Criteria: Eligibility criteria are additional qualifications that patients must fulfill or experience before a treatment or service is covered. Some examples include experiencing a certain number of asthma exacerbations or hospitalizations, quitting smoking or enrolling in disease management programs. These criteria provide an additional layer of requirements that prevent patients from accessing the care they need in a timely manner.

Prior Authorization: Prior authorizations require providers to get approval from the insurance company (in this case Medicaid or Medicaid-managed care plans) before the treatment will be covered. For medications, these requirements can add a lengthy administrative process between providers writing a prescription and patients actually receiving the recommended treatment. Prior authorization can also require providers to obtain advance approval from the health plan before a treatment or service like allergy testing or a home visit, causing delays in patient access to necessary care and even causing some patients to abandon treatment for their condition.[v]

Quantity Limits: Quantity limits are limits on the number of treatments covered each month or over a certain amount of time. For example, medical device coverage may be limited to a certain number of medical devices per year, which impedes treatment for patients who may lose their device or need a second one. This is especially problematic for children, who may need an inhaler or other medical device both at home and at school or other locations where they spend time.

Specialty Visit Limitations: Specialty visit limitations restrict the number of times a patient can visit specialists per year. These limits may prevent asthma patients from seeing specialists like allergists and pulmonologists when they need them. Limiting the number of times patients with complex conditions can see a specialist impedes access to appropriate care that can help manage their condition.

Step Therapy: Step therapy restricts access to treatments by requiring that patients attempt and fail another treatment first. Step therapy prevents providers from providing care they believe would be best for their patient immediately and requires patients to cycle through potentially less-effective or ineffective medication for their condition.

Barriers for Asthma Care Coverage in 2019

Barriers to accessing guidelines-based asthma care persist across all seven categories of care. Table 1 summarizes these trends to show the three most common barriers imposed by health plans across Medicaid programs in all 50 states, D.C. and Puerto Rico for 2018 to 2019. Detailed data on the frequency of barriers for each component of care in state Medicaid programs is available in Appendix 1.

Table 1: Common Barriers to Asthma Care by Category of Care (in %), 2018-2019

Quick Relief Medications	Controller Medications	Medical Devices	Allergy Testing	Allergen Immunotherapy	Home Visits	Self-Management Education
Prior Authorization (84.6)	Prior Authorization (100.0)	DME (94.1)	Copayment (39.2)	Quantity Limits (37.3)	Prior Authorization (55.0)	Quantity Limits (26.1)
Quantity Limits (80.8)	Quantity Limits (90.4)	Quantity Limits (80.4)	Quantity Limits (39.2)	Copayment (35.3)	Eligibility Criteria (50.0)	Copayment (21.7)
Copayment (75.0)	Step Therapy (90.4)	Copayment (60.8)	Prior Authorization (11.8)	Prior Authorization (17.6)	Quantity Limits (45.0)	Age Limits (13.0) & Age Restrictions (13.0)

Note: The percentages in parentheses indicate the percentage of state Medicaid programs for which the barrier exists; for example, quantity limits are a barrier for self-management education in 26.1 percent of state Medicaid programs. In categories with more than one component (quick relief and controller medications, medical devices and allergy testing), the number in parenthesis represents the percentage of state Medicaid programs for which the barrier exists for at least one medication/device/test; for example, prior authorization is a barrier for at least one quick relief medication in 84.6 percent of state Medicaid programs.

Copays, quantity limits, and prior authorization are consistently top barriers across all seven categories of care. Quantity limits are the number one barrier for allergen immunotherapy and self-management education and one of the three most common barriers for all seven categories of care. Prior authorization is the most common barrier for quick relief medications, controller medications and home visits, while copays are the most common barrier for allergy testing. Additionally, DME is the top barrier for medical devices, although this barrier is only applicable to that category of care and thus does not show up in other categories.

Barriers were particularly frequent in the controller medications category, where prior authorization, quantity limits and step therapy were identified as barriers for at least one controller medication in more than 90 percent of state Medicaid programs. For this category of care, Lung Association staff calculated the percentage of state Medicaid programs for which these were barriers for at least nine controller medications (or half of the 18 controller medications tracked through this project) as well. Prior authorization is a barrier for at least nine controller medications in 30.8 percent of state Medicaid programs, quantity limits are a barrier for at least nine controller medications in 69.2 percent of state Medicaid programs, and step therapy is a barrier for at least nine controller medications in 5.8 percent of state Medicaid programs.

Healthcare providers that adhere to asthma guidelines-based care can help their patients better manage their asthma. However, the American Lung Association's Asthma Guidelines-Based Care Coverage Project found many barriers in state Medicaid programs in all 50 states, D.C. and Puerto Rico in 2018-2019. Barriers are associated with reduced medication adherence and can delay and prevent patients from accessing the treatments and services that they need to manage their asthma. Removing these barriers could make it easier for healthcare providers and patients to follow guidelines-based care and improve health outcomes. To find state-specific coverage and barriers information in different state Medicaid programs, please visit www.lung.org/asthma-care-coverage.

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Appendix 1

Frequency of Barriers for Treatments and Services Among State Medicaid Programs Covering a Category of Care in 50 US States, the District of Columbia, and Puerto Rico (in %), 2018-2019

Barriers		Quick Relief Medication	Controller Medication	Medical Devices	Allergy Testing	Allergen Immunotherapy	Home Visits	Asthma Self-Management Education
Age Limits	Yes, is a barrier	5.8	50.0	9.8	2.0	2.0	35.0	13.0
	No, not a barrier	80.8	46.2	39.2	47.1	43.1	40.0	39.1
	Not available	13.5	3.8	51.0	51.0	54.9	25.0	47.8
Age Restrictions	Yes, is a barrier	1.9	23.1	0	2.0	2.0	20.0	13.0
	No, not a barrier	84.6	59.6	49.0	47.1	43.1	55.0	41.3
	Not available	13.5	17.3	51.0	51.0	54.9	25.0	45.7
Copayment	Yes, is a barrier	75.0	76.9	60.8	39.2	35.3	10.0	21.7
	No, not a barrier	23.1	19.2	21.6	33.3	33.3	65.0	54.3
	Not available	1.9	3.8	17.6	27.5	31.4	25.0	23.9
Durable Medical Equipment (DME)	Yes, is a barrier	N/A	N/A	94.1	N/A	N/A	N/A	N/A
	No, not a barrier			0				
	Not available			5.9				
Eligibility Criteria	Yes, is a barrier	0	28.8	2.0	2.0	2.0	50.0	10.9
	No, not a barrier	88.5	51.9	49.0	45.1	41.2	20.0	41.3
	Not available	11.5	19.2	49.0	52.9	56.9	30.0	47.8
Prior Authorization	Yes, is a barrier	84.6	100.0	39.2	11.8	17.6	55.0	8.7
	No, not a barrier	13.5	0	29.4	51.0	49.0	15.0	56.5
	Not available	1.9	0	31.4	37.3	33.3	30.0	34.8
Quantity Limits	Yes, is a barrier	80.8	90.4	80.4	39.2	37.3	45.0	26.1
	No, not a barrier	19.2	9.6	3.9	19.6	21.6	25.0	30.4
	Not available	0	0	15.9	41.2	41.2	30.0	43.5
Specialty Visit Limitation	Yes, is a barrier	N/A	N/A	N/A	2.0	2.0	0	2.2
	No, not a barrier				43.1	41.2	65.0	47.8
	Not available				54.9	56.9	35.0	50.0
Step Therapy	Yes, is a barrier	73.1	90.4	N/A	2.0	2.0	5.0	2.2
	No, not a barrier	25.0	7.7		45.1	41.2	60.0	47.8
	Not available	1.9	1.9		52.9	56.9	35.0	50.0

Note: The percentages in parentheses indicate the percentage of state Medicaid programs for which the barrier exists; for example, age limits are a barrier for home visits in 35 percent of state Medicaid programs, age limits are not a barrier for home visits in 40 percent of state Medicaid programs, and information is not available to determine whether age limits are a barrier for home visits for 25 percent of state Medicaid programs. In categories with more than one component (quick relief and controller medications, medical devices and allergy testing), the number in parenthesis represents the percentage of state Medicaid programs for which the barrier exists for at least one medication/device/test; for example, copayment is a barrier for at least one quick relief medication in 75 percent of state Medicaid programs. Not all barriers are applicable to all categories of care, as indicated by N/A or Not Applicable.

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