DISRUPTIVE DIALOGUE

HEALTHCARE 101
PRIVATE INSURANCE - II

OVERVIEW OF PRIVATE HEALTH INSURANCE IN THE U.S.

PART 2 – BARRIERS TO ACCESS & CARE

QUICK REVIEW OF HEALTHCARE 101 EPISODE 1 – THE BASICS

- Health insurance can be confusing when comparing plans and understanding eligibility.
- The cost of your insurance varies based on a number of factors but usually includes:
  - Premiums – Monthly payment whether care is used or not, but often includes preventive care
    - Premiums cover a lot of preventive care – do your homework to see what your plan covers – we will discuss in detail in Part 3.
  - Deductibles – out of pocket costs before an insurer starts paying anything.
  - Co-Pays and Co-Insurance – patients share of costs after annual deductible is met and coverage kicks in.

- Private Insurance is usually:
  - Employer sponsored – large and small group plans
  - ACA Market Place – for individuals not enrolling through their employer

- Enrollment Periods are near the end of the year.
- WE NEED TO BECOME BETTER CONSUMERS OF HEALTHCARE TO MAKE IT WORK!
- DO YOUR HOMEWORK AHEAD OF TIME.

BARRIERS TO ACCESS AND CARE

Overview

- Insurance policies can slow care delivery.
- Delays/denials may occur if prior authorization required.
- Comes with complexity and high out-of-pocket costs.
- Mix of access and financial protection.
- Often feels confusing and impersonal.

Common ways Carriers can impact access

- These barriers are sometimes referred to as **utilization management tools** or **administrative hurdles.**
- **They are sometimes used** to control costs, other times as a byproduct of administrative processes—that can make it harder for patients to access care, medications, or services.
- These often draw the ire of providers and patients.
- Numerous states are passing legislation to address this issue, but Congress needs to act!

BARRIERS TO CARE IN PRIVATE INSURANCE

- **Prior Authorization Requirements**
- **Step Therapy (“Fail First” Policies)**
- **High Cost-Sharing**
- **Non-medical switching**
- **Quantity Limits and Formularies**
- **Delays in Payment or Pre-Certification**

- ***These are common barriers to access and care but it is not an exhaustive list.***

BARRIERS TO CARE IN PRIVATE INSURANCE

Prior Authorization Requirements

- Patients or providers must get insurer approval **before** certain treatments, tests, or prescriptions can be covered.
- Can delay care and require significant paperwork from physicians.

Your Options

- ***Denials are common, but not final***
- Many prior authorization denials can be successfully appealed.
- You typically have 60 to 180 days from the denial to file an appeal.
- Patients can request a reason for denial, gather medical evidence, and file appeals with their insurance provider.
- Work with your physician office or a patient advocate to write a **Prior Authorization Appeal Letter**
- **Physicians and patient advocates can help**

- https://www.solace.health/articles/prior-authorization-denied#:~:text=If%20your%20prior%20authorization%20is%20denied%2C%20request%20a%20copy%20of,appeal%20and%20additional%20supporting%20documentation.

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BARRIERS TO CARE IN PRIVATE INSURANCE

Step Therapy ("Fail First" Policies)

- Often occurs with high-cost medications. (ex. Specialty drugs, biologics and mental health medications).

- Patients must first try a **lower-cost or insurer-preferred treatment** (like a generic drug) and prove it was ineffective before the insurer will cover a more expensive option.

Your Options

- ***Communicate*** with your healthcare provider and insurance company as soon as possible.

- Ask your healthcare provider about the possibility of prior authorization to override step therapy requirements ***ahead of time***.

- ***Explore exceptions*** to step therapy based on specific medical conditions and health plans.

- Be prepared to work with your provider to explore exceptions, and appeal decisions if necessary, ***using the insurance company's process.***

BARRIERS TO CARE IN PRIVATE INSURANCE

High-Cost Sharing

- **High deductibles, co-pays, and coinsurance** can discourage patients from seeking care.

- Pharmaceutical companies provide patient assistance for high-cost drugs but insurers are creating work-arounds to avoid this:
  - Co-Pay Accumulators
  - Co-Pay Maximizers
  - Alternative Funding Programs

- If you find out from your physician that one of these programs is in place, ***talk to your HR department*** and call your local legislators.

Your Options

- Talk to your physician and your pharmacist about ***lower cost options*** that they believe will work just as well.

- **State and local programs:** may offer programs to help with prescription drug costs for people with lower incomes.

- **Manufacturer assistance programs:** Check the drug manufacturer's website or by asking your doctor or pharmacist.

- **Charitable organizations:** Several non-profit organizations offer financial assistance for prescription drugs. Check with organizations like the Patient Advocate Foundation or the Good Days Fund, according to America's Essential Hospitals.

BARRIERS TO CARE IN PRIVATE INSURANCE

High-Cost Sharing (cont)

Be Pro-Active

- If you currently take expensive medications, do some research when choosing your benefit plan during enrollment period.
  - You need to understand Your Prescription Drug Coverage:

Review your plan's formulary

- A formulary is a list of prescription drugs covered by your insurance plan.
- Understand which drugs are covered and at what cost (copays, coinsurance), and if there are any restrictions (PA's, step therapy).

Compare plans:

- Carefully compare plans to see which offers the best coverage for your specific medications and overall cost-sharing.
- Some plans offer lower cost-sharing at preferred in-network pharmacies versus standard pharmacies.
- Out-of-network pharmacies often have the highest cost-sharing.

Mail-order pharmacies - Some plans offer lower costs or discounts for using mail-order pharmacies for maintenance medications.

Trial periods for new medications

- Discuss with your doctor if a trial period with a lower dose or a shorter duration is possible to assess its effectiveness and minimize upfront costs.

- https://essentialhospitals.org/wp-content/uploads/2018/11/CostofCarePracticeBrief4.pdf
- https://www.google.com/search?cs=0&sca_esv=a0f38eb77c23691f&sxsrf=AE3TifMtqoJQ86WXiY3oY7yZv4kVML2UjA%3A1753804286507&q=Review+your+plan%27s+formulary&sa=X&ved=2ahUKEwje3NiLtuKOAxUjHkQIHZpgKmQQxccNegQIGhAD&mstk=AUtExfA4OjB8THfVk-4XGZdBXb5cydWO7K26rJE9XxV-I9fdOU5nojKAXBerYOCRPY_lIDxNJVGUGlk-bQPrPtCWZ10opwYF7X8G3EwRd-N_zxyqK_XwrtINV687Rh3PLerUGpQtL23aw7-SQYVGaFb2REuyKjcm6nh6E_X-_PI0hl2dHG4&csui=3

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BARRIERS TO CARE IN PRIVATE INSURANCE

Non-Medical Switching

- When a patient is forced to change from their medication (or device) to a different, often cheaper, alternative.
- This typically happens because of **insurance or pharmacy benefit manager (PBM) policies**—not because the doctor recommended it.
- Step Therapy can increase healthcare costs, according to news-medical.net.
- It can lead to increased health risks, treatment disruptions, and negative impacts on patients' overall well-being.

There is Hope

- Review your insurance plans' formulary (list of covered medications) and understand your coverage.

- **Appeal the decision:** Work with your doctor to appeal the switch to your insurance company.
  - Many states have appeal processes in place.

- **Monitor** how the new medication makes you feel, and any other changes you notice.

- **Document everything:** Keep a detailed record of your health status and any adverse effects from the switch.

- **Explore alternative treatment options:** If the switch is unavoidable, discuss alternative treatment options with your doctor that might be a better fit for your individual needs.

- **Contact your elected officials:** Explain the impact of non-medical switching and urge them to support legislation that protects patients.

https://infusioncenter.org/advocacy/explore-issues/non-medical-switching/#:~:text=Non%2DMedical%20Switching%20Action%20Campaigns,the%20Infusion%20Center%20Locator%20or

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BARRIERS TO CARE IN PRIVATE INSURANCE

Quantity Limits and Formularies

- Prescription drug coverage often includes **formulary tiers** and **quantity limits** (e.g., limiting the number of pills per month).
- Some drugs are only covered after proving the patient meets strict clinical criteria.

Delays in Payment or Pre-Certification

- Slow processing of claims and pre-certifications can delay care.
- Providers sometimes refuse to schedule expensive services until the insurer confirms coverage.
- Many communications between physicians and insurers are by fax and need to move to electronic forms.

PATIENT'S PERSPECTIVE OF PRIVATE INSURANCE

PRO's

- ❖ Lots of choices – PPO's, HMO's, EPO,s etc.
- ❖ Choice of plans via ACA Marketplace.
- ❖ Preventive services are usually covered.
- ❖ Financial protection from catastrophic costs

CON's

- ❖ High and rising out-of-pocket costs.
- ❖ Limited billing and coverage transparency.
- ❖ Surprise out-of-network bills.
- ❖ Complex rules and administrative burden.
- ❖ Barriers to Access & Care (ex. prior authorizations).

SUMMARY

- **We must become better consumers.**
- **Do your research and don't wait till the last minute.**
- **Work with your healthcare practitioners to navigate the medical landscape.**
- **If you are denied or delayed care, don't give up – you have rights and you can overcome barriers put in front of you.**
- **Communicate with your legislators and let them know when insurance policies are hurting you.**