Episode 8: Who is Really Calling The Shots When It Comes To Patient Care?

Note: This is a machine transcription. Please excuse any punctuation or other weirdness:)

Intro:

A survey of 600 doctors found that 89% said they no longer have adequate influence and the health care decisions for their patients, 87%, reported that health insurers interfere with their ability to prescribe individualized treatments. The survey also found that because of their frustration, many doctors said they are thinking of leaving the profession and would not recommend a career in medicine to others.

And the bottom line is this.

Some medical professionals feel angry and frustrated knowing that unqualified insurance company personnel have the power to override their professional judgment and that the long term health of their patients is being compromised so health plans can achieve short-term cost savings.

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Get Savvy with your host, Sandy Kibling, a healthcare professional changing how healthcare knowledge is shared.

Podcast

Hello and thanks for spending some time with me today as we discuss who is in charge of your care?

What we will discuss:

1) Who is in Charge of Your Care?
2) Discuss the Prior Authorization Process and Step Therapy and How it May Control the Care You Receive.
3) Do you have Options?
- Straight Talk with your provider
- Appealing your Insurance Companies Decision
- For medications…Biosimilars – what are they and are they the answer to patient equity and access?

Who Is In Charge of Your Care?

Now the obvious answer is your provider. In most cases this is true, but what is also true is there are sometimes restrictions with the prior authorization process that your provider is required to follow per health insurance companies' guidelines. Health Insurance companies may put into place a rigid prior authorization process that requires limits to the procedure or medications that may be used for your condition.

What is a Prior Authorization?

Prior authorization is a requirement that a provider, physician, hospital, etc. obtains approval from your health insurance plan before prescribing a specific medication for you or performing a medical procedure. Without this prior approval, your health insurance plan may not pay for your treatment, leaving you responsible for the full bill.

Just as a note prior authorization may also be referred to as pre-certification, predetermination, and pre-approval.

While in some cases prior authorizations can be seen as favorable to the health insurance companies, prior authorizations are used as a checks and balances to make sure that provider offices, hospitals etc. are not adding extra services to pad a bill to get higher reimbursement.

So prior authorizations are not a bad thing, but it is important to understand your rights.

By using prior authorization, your insurer wants to make sure that:

- You really need it: The service or drug you're requesting must be medically necessary.

- It's recommended for your situation: The service or drug must follow up-to-date recommendations for the medical problem you're dealing with.

- It makes financial sense: The procedure or drug should be the most economical treatment option available for your condition.

For example, Drug A (cheap) and Drug B (expensive) both treat your condition. If your healthcare provider prescribes Drug B the more expensive drug, your health plan may want to know why Drug A (cheaper) won't work just as well. If you can show that Drug B is a better option, it may be pre-authorized. If there's no medical reason why Drug B was chosen over the cheaper Drug A, your health plan may refuse to authorize its use. This is sometimes referred to as step therapy.

- Prior Authorizations also make sure the service isn't being duplicated: This is a concern when multiple specialists are involved in your care.

For example, your lung doctor ordered a chest CT scan, not realizing that, just two weeks ago, you had a chest CT ordered by your Primary Care doctor. In this case, your insurer won't pre-authorize the second scan until it makes sure that your lung doctor has seen the scan you had two weeks ago and believes an additional scan is necessary.

- Verifies a reoccurring service is actually helping you:

For example, if you've been having physical therapy for three months and your doctor is requesting authorization for another three months, is the physical therapy actually helping? If you're making slow, measurable progress, the additional three months may well be pre-authorized. If you're not making any progress at all, or if the PT is actually making you feel worse, your health plan might not authorize any further PT sessions until it speaks with your healthcare provider.

What is Step Therapy

To go more in depth with step therapy is a form of prior authorization that requires patients in this case to try a "preferred" drug—that is, a less-expensive before the plan will cover a different, more expensive one.

The idea is it will reduce your cost, the providers cost and the insurance companies cost and while this may be true, is it the right clinical decision for your situation?

To convey this a bit better, I like to provide real examples and today I am choosing to share my personal health information in hopes that it helps better explain step therapy and perhaps you can apply to your own situation.

I was diagnosed with a vein occlusion in my left eye in 2015 and was recommended to see a retina specialist. A vein occlusion is a blockage in an artery or vein in the back of my eye. This impacts the blood flow because a blood clot is blocking the retinal vein. This can cause swelling in the back of the eye and if not treated and may lead to blindness.

This typically occurs in individuals later in life so getting this diagnosis in my late 40's was concerning. The treatment is eye injections every 4-8 weeks to keep the swelling down while the blood clot dissipates, or I develop new veins around the clot for blood flow.

The drug that I was put on initially was Avastin an oncology drug used for the treatment of Colon Cancer. Now you be asking what the heck and why would that drug be used for treatment? The answer is because it is cheaper.

It does work in keeping the swelling down but is it the right drug for me? I would also add that this drug is not FDA approved for my diagnosis.

The alternative drugs are Eylea and Lucentis which are more expensive. The question is if the more expensive drug is the better drug, and provides the most optimal outcome, shouldn't my retina specialist make that call? Ideally yes, but realistically no.

This is where step therapy comes in. Prior to my visit my providers office submits a prior authorization request to my insurance company. Even if my retina specialist thinks that the Eylea is better than Avastin he does not get to choose.

The insurance company's requirements state that they must use the most cost-effective drug first and when it proves in effective my provider's office must provide the justification which is usually mounds of paperwork and medical records my health insurance company reviews and then the expensive drug is approved.

After 5 years of being on the lower cost drug with mediocre results and relapses in terms of frequency of injections, I was finally moved to Eylea.

Currently I have had four injections of Eylea and have had amazing results and have been moved to observation meaning the drug is working well in maintaining the swelling allowing me to go 3 months out before going in to be evaluated versus going in every 4-5 week for an eye injection.

I have since spoke with several retina specialists and all have agreed given my age and years to preserve eyesight, they would never have recommended Avastin rather they would have put me on Eyelea. My retina specialist and I were never given that option, my insurance plan with prohibitive authorization protocols and their step therapy (use the lower cost medication 1st than move to more expensive) made the decision for me.

In terms of cost, I am on a PPO plan with 80% coverage by insurance and 20% by me. On the lower cost drug per visit my responsibility was $53 when moved to the higher cost drug my responsibility was $450. I understand the cost due to the unregulated pharmaceutical industry and this impacts health insurance companies, my provider and me.

Still when it come my eyesight and my options, I want this to be between my retina specialist and me. It wasn't…

What Are Your Options?

If your insurer denies coverage for your drug, even after you have gone through step therapy, consider an appeal. (Not every insurer allows step therapy appeals, so contact yours to discuss your options.) If you decide to appeal, one of the best ways to build your case is to get your doctor's input. Ask them about any backup documentation or medical notes that could help you prove your prescription or procedure is medically necessary.

If that doesn't work or you need your preferred medication immediately, you still have options. Talk to your doctor about alternative medications that don't require step therapy, as most plans offer coverage for one or more alternatives.

I know in my situation I was more passive than I should have been, and I regret this as I love to read and be creative and do the work, I do every day and I would do anything to preserve my eyesight including paying the $450 for the more expensive drug if it meant my long term outcome would be more successful.

I would also add that I went to the Eyelea website and was able to apply for a grant that covered the copay for the drug, now when I go in my responsibility from a copay perspective is $37 dollars versus $450. So make sure ask your provider's office if they know of any organizations that helps with cos. This is what I did and it was a huge cost savings for me and peace of mind.

If your situation is filling a prescription medication and using a covered alternative isn't possible, ask your doctor about filling a 90-day supply, which can be more affordable than a 30-day supply. Your doctor may also have free samples of the drug you need. If you qualify for a patient assistance program or manufacturer discount card, they can also help you save. Search for your drug on GoodRx.com and look for the "Savings Tips" tab on the left for more information. Lastly, don't forget evaluating other options. Cost Plus Drugs is new company and working hard to provide options to get your medications at a manufacturers cost allowing in some cases significant discounts. Check out Episode 3 if you would like to learn more.

Alternative Options - BioSimilars

So what is a biosimilar…used to treat complex diseases and autoimmune conditions. To keep it simple it is a biological product highly similar to a brand drug and has no clinically meaningful differences from an existing FDA-approved product in terms of safety, purity and potency.

For many people, the biggest difference between a brand drug and a biosimilar may be the cost. Patients can receive the same benefits from biosimilars as brand drugs potentially at less cost to them or their insurance company. Access to biosimilar drugs to treat a complex disease or autoimmune conditions does more than provide patients critical access to life-saving medication; it also helps achieve more equitable health outcomes.

- Example: Lucentis used for treatment of macular degeneration, diabetic macular edema, or retinal vein occlusion, a biosimilar Byooviz launched July 1, 2022, allowing for the product to be commercially available to all patients. Byooviz is estimated to offer a 40% discount compared to the list price of Lucentis.

There are barriers to access due to provider, patient and health insurance companies' knowledge as well as health insurance company reimbursements. I was recently representing a retina group and we had some great conversations about biosimilars with the insurance companies and are beginning to see more options in terms of approvals and reimbursement to provide for care.

Biosimilars have the potential to change healthcare in fundamental ways: providing patients with access to more affordable, equally effective treatments and offering doctors more treatment options. And, as a result, hopefully healthcare systems may be able to funnel the long-term savings into overall improvements for patient care.
I am providing a resource that provides an in-depth study if you would like to read more.

In closing know your options and have a conversation with your provider to discuss the options that are best for you. Knowledge is essential to make sure you understand your rights, the right questions to ask and to how navigate a path that is beneficial for you and your health situation.

For our next episode we will discuss Patient Health equity…providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

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Until next time, Get Savvy!