National Council Hill Day 2017

Access Barriers: An Advocacy Toolbox

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AfPA’s Mission

The Alliance for Patient Access (AfPA) is a national network of physicians whose mission is to ensure patients access to approved therapies and appropriate clinical care.

AfPA accomplishes its mission through educating physicians on policy priorities and training them to be effective advocates for their patients.
Common Patient Access Challenges
Advanced and Innovative Treatments will:

- Help more patients
- Better control symptoms
- Reduce side effects
The Bad News

These treatments will likely be out of reach for many patients.
Anticipated Health Plan Barriers

• Prior Authorization
• High Out-of-Pocket Costs
• Step Therapy Protocols
• Non-medical Switching
Restrictive Health Plan Design

- Insurer preference of older, less expensive treatments
- Utilization management tactics to steer patient preferences
Prior Authorization

**How Prior Authorization Impacts Access to Care**

While health care providers complete health insurance paperwork...

...the patients who need them must wait.

Onerous health plan authorizations take time meant for patient care.
Any of these physicians can diagnose hepatitis C. But some states allow only specialists to prescribe the cure.

Prescriber restrictions limit treatment access for patients with hepatitis C.
High Out-Of-Pocket Costs - Specialty Tiers

<table>
<thead>
<tr>
<th>Tier</th>
<th>Patient Payment</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lowest co-payment</td>
<td>Most generic prescription drugs</td>
</tr>
<tr>
<td>2</td>
<td>Higher co-payment</td>
<td>Brand-name prescription drugs categorized as preferred by an insurance company</td>
</tr>
<tr>
<td>3</td>
<td>Higher co-payment than the first or second tier co-payments</td>
<td>Brand-name prescription drugs categorized as “Non-preferred” by an insurance company</td>
</tr>
<tr>
<td>4</td>
<td>Highest copayment or coinsurance (patients pay a percentage of the drug’s cost). Medicare defines specialty-tier medicines by an individual, per-month cost that exceeds $500 per medicine.</td>
<td>Unique, high-cost prescription drugs</td>
</tr>
</tbody>
</table>
Step Therapy

STEP THERAPY is on the rise:

27% in 2005
67% in 2013

These policies may not take into account a person’s medical situation or history.

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Step Therapy

Major health conditions affected by STEP THERAPY:

- mental illness
- rheumatoid arthritis
- psoriasis
- hepatitis C
- HIV/AIDS
- psoriatic arthritis

For example:
Patients with psoriasis and psoriatic arthritis, treatment access was delayed or denied

- 48% denied at initial approval due to step therapy
- 39% had to appeal a denied or incomplete request
- 52% failed to receive original Rx within 90 days

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Non-Medical Switching

https://www.youtube.com/watch?v=2I67kYOh_sk
Non-Medical Switching

Cost-Motivated Treatment Changes & Non-Medical Switching
Commercial Health Plans Analysis

Non-medical switching occurs when health plans drive stable patients to switch from their current medication to a less expensive alternative. It can occur several different ways: by changing the list of approved drugs, by incentivizing pharmacists or physicians to switch a patient’s medication, or by limiting or eliminating the use of co-pay coupons that patients need to afford their medication.

Non-medical switching can hurt patients, who may see symptoms re-emerge or lose ground on stabilizing chronic conditions. Given non-medical switching’s detrimental impact on patients, the Institute for Patient Access was compelled to ask: Does non-medical switching actually generate the cost savings that health plans envision?

Findings Summary

To explore this question, the Institute for Patient Access examined a subset of 2011-2015 data from Truven’s MarketScan® Commercial Claims and Encounters and Medicare Supplemental database, which includes information for 39 million people.

A potentially cost-motivated change in treatment can yield higher average non-drug expenses later on.

<table>
<thead>
<tr>
<th>Disease State</th>
<th>No Switch</th>
<th>Switch to Lower-Cost Rx</th>
<th>Multiple Switches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>$975</td>
<td>$1,035</td>
<td>$1,425</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>$2,859</td>
<td>$4,141</td>
<td>$4,886</td>
</tr>
<tr>
<td>COPD</td>
<td>$1,307</td>
<td>$2,316</td>
<td>$3,171</td>
</tr>
<tr>
<td>Crohn’s disease</td>
<td>$2,072</td>
<td>$4,499</td>
<td>$4,890</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>$1,829</td>
<td>$1,977</td>
<td>$2,042</td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>$1,766</td>
<td>$4,362</td>
<td>$2,625</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>$1,467</td>
<td>$1,997</td>
<td>$1,540</td>
</tr>
<tr>
<td>Psoriasis</td>
<td>$588</td>
<td>$648</td>
<td>$671</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>$1,474</td>
<td>$1,894</td>
<td>$1,714</td>
</tr>
</tbody>
</table>

Figures are per-member, per-month averages. Increases are measured from six months prior to the patients’ diagnosis to 12 months after initial diagnosis, which may explain why even patients who do not switch medication experience an increase in health care expenses.
Restrictive Health Plan Design

- Time, manpower and expense burden physicians’ offices
- Distracts from time and focus on actual patient care
- Delays access for patients
How can policymakers and advocates limit health plans' interference with patient care?
Legislative Responses

- Streamline paperwork
- Require interoperability
- Offer bypass options
- Establish out-of-pocket limits
- Specify coverage of stable patients
Shaping Better Health Plans

Share patient, physician, and advocate perspective with:

• Health plan medical directors
• Centers for Medicare and Medicaid Services’ administrators
• State insurance commissioners
• State Medicaid officials