

Continuity of Care Policy Principles and Priorities

Strong, cohesive and organized patient advocacy for the protection of accessible health care is essential in today's cost driven environment. Without such advocacy, the debate will be focused on measures that are designed to provide short term savings, at the expense of patient health and long term costs. This is precisely why the NAF was created - to ensure neuropathy patients obtain the necessary resources to access individualized treatment to improve their quality of life.

Insurance benefits are continually getting fewer and fewer. Patients expect that they in fact have full coverage, when they do not. Further, high co-payments and restricted formularies can cause patients to consume fewer medications. The financial burden of paying for prescription drugs could be a strain for anyone, but it has a potentially devastating impact for those living with chronic conditions like neuropathy. To this end the NAF created the below continuity of care positions focusing on formulary transparency, access to providers, out-of-pocket costs, step therapy and prior authorization in hopes of helping patients obtain and maintain medications and treatments they need.

Formulary Transparency

Issue and Background

When purchasing health insurance patients need certain information to make decisions about selecting insurance that is best for them such as accurate and current information regarding medication coverage, out of pocket (OOP) costs, prior authorization (PA) requirements, and step therapy protocols. Unfortunately this information is more often than not difficult to obtain.

Formulary transparency is also important after insurance is purchased. Formularies are changed frequently. Patients are often unaware of the changes in costs until they reach the pharmacy counter or receive a call from the company that administers their infusion which often leads to delays in treatment. Strong formulary transparency laws make it easier for patients to choose a plan that will cover prescription drugs and treatments they need and easier throughout the plan year to maintain continuity of care.

NAF Position

The NAF supports policy that require the following:

- Maintain a clear searchable listing of medications/treatments covered in a plan's formulary by drug name and specific disease/condition.
- Display up to date formularies on the insurer's website and if formulary changes are made, those changes must be available online within 24-72 hours.
- Disclose special requirements for each medication including step therapy and prior authorization.
- Disclose all co-payment and co-insurance OOP costs for each medication.
- Patients should be provided an explanation of the amount of coverage for out of network providers or non-covered services, and any rights of appeal that exist when out of network providers or non-covered services are medically necessary.
- Plans should be prohibited from removing a drug or making formulary changes during the plan year. However, if a mid-year change does occur the plan must provide written notice to the patient at least 60 days prior to the date the change becomes effective; or at the time a patient requests a refill provide such enrollee with a 60 day supply of the drug.

Access to Providers

Issue and Background

Neuropathy patients have specialized needs and select insurance plans based on access to providers who are specialists in practice areas such as neurology. Frequently, the selection of an insurance plan

comes about because of information contained in directories provided by insurers. Many insurance directories are not frequently updated or are outright inaccurate. These inaccurate provider directories can mislead a person about coverage and cause an insured to pick a health insurance plan that is not the most beneficial or in the best interests of the person or their family and doesn't meet their needs.

NAF Position

The NAF supports the below which help provide accurate and reliable information about insurance benefits:

- Ensures that provider and hospital information is made available to consumers before they purchase a plan so that so they can choose a plan that best meets their needs.
- Must provide consumers with the most up-to-date provider and hospital network information, including immediate notification when a provider or hospital is no longer in network or accepting new patients, and disclosing any fees associated with using that provider or healthcare service.
- Printed directories that are updated every three months to include the most current information at the time of printing, and electronic directories that are updated within three days of an insurer learning of a change to directory information.
- Requirements that insurers provide coverage when a patient relies on inaccurate information in a directory, at a cost that is no greater than if the benefit were obtained from a participating provider.
- Establishing and maintaining adequate arrangements to ensure consumers have reasonable access to providers and hospitals located near their home or business address.

Out-of-Pocket Costs

Issue and Background

Health insurers have historically charged fixed co-pays for different tiers of medications. As an example the co-pays might be set at \$10/\$20/\$50 for the three tiers. Some insurers are moving vital medications (mostly biologics) into a fourth specialty tier. Specialty tiers require patients to pay a percentage of their drug cost – often 25% to 50% - rather than a fixed dollar amount co-payment. High cost sharing, also known as co-insurance, is a barrier to medication access for patients with chronic, disabling, and life threatening conditions and may result in serious harm by restricting medications leading to negative health outcomes and additional costs to the healthcare system.

NAF Position

Ensuring that neuropathy patients have access to affordable quality treatments and medications is a guiding principle of the NAF and therefore supports policy that includes the following:

- Limits the cost of a 30 day supply of a single prescription medication to no more than \$150 a month
- Limits the total aggregate monthly out of pocket cost for all prescription medications
- Limits the total annual out of pocket expenditures for all prescription medications at a maximum of 50% of the ACA total out of pocket limits for an individual or family plan
- Plans must ensure the ability to select specialty practice health care providers within a reasonable travel time and distance – taking into account the conditions for provider access in rural areas
- Insurance plans must ensure a sufficient range of services
- Insurance plans must not exclude any type of health care provider as a class
- We are seeking relief for patients who are forced to pay maximum out-of-pocket expenses twice in one year due to a job change/loss or insurance change
- When beneficiaries change plans involuntarily, they should not have to start from the beginning in terms of their out-of-pocket expenses.

Step Therapy

Issue and Background

An increasing number of insurers are utilizing step therapy or fail first policies that require patients to try and fail one or more formulary covered medications before providing coverage for the originally prescribed non-formulary or non-preferred medication. "Step therapy" or "fail-first" is the process whereby health plans and insurers frequently deny coverage of proven and effective medications. Step therapy requires medications within a class of drugs to be used before a second-line medication is tried. Step therapy is based solely on cost and does not take into consideration patients' unique needs.

NAF Position

The NAF supports policy that provides limitations on step therapy/fail first protocols and believes the following provisions are essential to protect patients:

- Permit a prescriber to override the step therapy when patients are stable on a medication
- Permit a physician to override the step therapy if the physician expects the treatment to be ineffective; will cause or will likely cause an adverse reaction by or physical harm to the patient; or is not in the best interest of the patient, based on medical necessity
- Require health insurance plans to incorporate step therapy approval and override processes in their preauthorization applications
- Prohibit plans from requiring patients from having to fail a prescription medication more than once
- Limit any single step therapy protocol to a maximum of 60 days
- In circumstances where an insured is changing health insurance plans, the new plan may not require the patient to repeat step therapy when that person is already being treated for a medical condition by a prescription drug provided that the drug is appropriately prescribed and is considered safe and effective for the patient's condition
- When a health insurance plan changes formulary design, the plan cannot limit or exclude coverage for a drug for an insured if the drug previously had been approved for coverage by the plan for a medical condition of the person and the plan's prescribing provider continues to prescribe the drug for the medical condition.

Prior Authorization

Issue and Background

Before medications/treatments are dispensed, many insurance companies require a cumbersome process called prior authorization (PA). Physicians must fill out a PA form whenever a provider prescribes a specialty medicine or treatment that is not covered under the insurer's formulary, placing an unnecessary burden on patients, pharmacies and doctors. Under this system, physicians and pharmacists spend many hours completing and processing these forms, and they are often forced to wait days before receiving notification of a prescription approval or denial. They must also repeatedly follow up with insurers to confirm that all the necessary paperwork has been submitted.

NAF Position

The NAF supports policy that would standardize PA protocols and streamline patient access to vital medications and treatments in the following ways:

- Establish a single standardized form (paper or electronic) for providers to submit PA requests
- Require PA requests to be completed within 48 hours of submission or receive automatic approval.
- Improve adherence and patient care by ensuring that PA's are valid for a minimum of one year.