Neuropathy Action Foundation (NAF)
Essential Benefits Position Statement
November 10, 2011

Essential Benefits should be designed to foster and protect patient access to individualized and quality health care with affordable and predictable out-of pocket costs, where providers and their patients choose from a broad array of treatment options and the incentives to innovate are maintained. Two of the most contentious topics under debate are the scope of essential benefits as they relate to specialty tiers/co-insurance and insurers' application of medical necessity criteria when making coverage decisions.

Background

The Patient Protection and Affordable Care Act (ACA) established and took the first steps in defining a set of core health services, called "Essential Benefits," which must be covered by all health insurance plans sold through state exchanges. The way in which Essential Benefits are designed will directly impact neuropathy patient access to quality care, and the lives of millions who suffer from neuropathy will depend on whether Essential Benefits are inclusive, affordable and meet patient needs.

As the U.S. Department of Health and Human Services (HHS) establishes the parameters of the Essential Benefits package, it is imperative that HHS include a wide range of health care products and services that meet diverse patient needs – including those of lower and middle income families – and ensure that every family has access to affordable, quality care. The Essential Benefits design should ensure that decisions about how to treat neuropathy patients remain with the patients and their health care providers, and not with the government or insurance companies.

The out-of-pocket costs for neuropathy patients should be both affordable and transparent. Some benefit designs feature so-called "specialty tiers" for newer or expensive drugs, which require patients to pay exorbitant coinsurance for treatment, rather than a traditional copayment.

Why Essential Benefits Must NOT Include Specialty Tiers

Due to the substantial shift in medication costs from health plans to the patient caused by specialty-tiers, treatments and medications can become prohibitively expensive and the patient may experience large out-of-pocket costs. Tiers are intended to offset a health plan's costs for expensive drugs while encouraging lower utilization of expensive specialty drugs by patients. However, specialty-tiers can be counterproductive and, ultimately, raise health care costs in general if the tiers lead to non-adherence to therapy and excess hospitalization. Treatments and medications such as biologics that are in the specialty-tier often do not have generic alternatives, require special handling and are the only drug available, leaving patients with no effective alternative therapy. For example, the impact of specialty-tiers on intravenous immunoglobulin (IVIG) therapies is of particular interest to our community. The burdensome coinsurance rates for these drugs forces patients to pay out-of-pocket expenses ranging from $652.00 to $8,344 per month.

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NAF's Position on Essential Benefits

1. ***Patients' Out of Pocket Exposure of Essential Benefits Should Be Affordable and Transparent*** - Health plan formularies and out-of-pocket costs included in essential benefits must be clearly defined in order for patients, in cooperation with their providers, to make effective choices. The Secretary of HHS should exclude specialty tiers in essential benefit plan design, as specialty tiers run counter to the ACA's goals and provisions, which promote consumer awareness, and require that benefits be of the same scope as the typical employer plan, transparent with regards to insurance coverage and cost sharing obligations, and prohibitive of discrimination.

2. ***Essential Benefits That Ensure Access to Affordable Quality Health Care Will Improve Health Outcomes and Potentially Lower Health Care Expenditures*** - Whether coinsurance or copayments, patient out-of-pocket costs should be designed such that they fall within a limited and narrow range across the full array of disease categories. Higher copayments and coinsurance increase patient out-of-pocket costs and can cause some patients to forego prescribed treatments, which is counter-intuitive to the basic concept of insurance protection and the goals of the Affordable Care Act.

3. **Medical Necessity Definitions Must Protect Patient Access and Provider Autonomy -** Just because a benefit is covered does not mean that health plans pay for it in every circumstance. Health plans frequently rule treatments and services as not medically necessary unless they are supported by randomized, controlled studies. This is not right and is dangerous for those who suffer from rare neuropathies.

   Medical necessity language must allow medically appropriate off-label use of Food and Drug Administration-approved drugs and devices. Additionally, all language must clarify that a treatment, medication or service is "medically necessary" when, in the considered, prudent and good faith judgment of the treating provider, it is reasonably required to protect life, prevent a significant illness or disability, or alleviate or avoid severe pain.

In determining whether to authorize a service, the Plan/Insurer must defer to the treating provider judgment, unless it can produce credible evidence that a less expensive service is more or equally as efficacious as that prescribed or recommended by the treating provider, or that the treating provider's prescription or recommendation was not the product of considered, prudent or good faith judgment.