



Advocacy TOOLKIT



At times, accessing optimal care for skin conditions can seem daunting.

This toolkit is designed to help patients, advocates and health care providers understand the barriers they face – and find solutions that allow patients to get the care they need.

TABLE OF CONTENTS

2	How to Pick the Right Insurance Plan
4	How to Talk to Your Employer about Your Health Care Needs
5	How to Identify Access Barriers
7	How to Handle High-Cost Medications
7	How to Understand Prescription Denials
9	How to Appeal a Commercial Insurance Denial
10	How to File a Complaint with Your Insurance Commissioner
11	How to Appeal a Medicare Prescription Denial
12	How to Advocate for Patient Access

HOW TO

PICK THE RIGHT INSURANCE PLAN

STEP 1: CHOOSE YOUR SOURCE



Employer Health Insurance

subsidized by your employer



Government Exchanges

found at [HealthCare.gov](https://www.healthcare.gov)



Private Exchanges

STEP 2: COMPARE PLANS

Common options include:

HMO – Health Maintenance Organization

These plans require you to stay in network except for emergencies, and they require a referral to see specialist. You may have lower out-of-pocket costs but also less freedom to choose a clinician.

PPO – Preferred Provider Organization

You can access out-of-network clinicians, but they are more expensive than in-network clinicians. You may have higher out-of-pocket costs but will have more options and won't need a referral to see a specialist.

EPO – Exclusive Provider Organization

These plans require you to stay in the network except for emergencies. No referral is needed, and out-of-pocket costs may be lower, but you have less freedom to choose a clinician.

POS – Point of Service Plan

These plans allow you to go out of network, but in-network care is less expensive. You do need a referral to see a specialist.

WHAT IS A HIGH-DEDUCTIBLE HEALTH PLAN?

These plans feature lower premiums in exchange for higher out-of-pocket costs. They are paired with a health savings account, where you can deposit pretax dollars to pay health care expenses.

STEP 3: COMPARE NETWORKS

Health plans maintain networks of preferred clinicians and facilities.

Make sure the clinicians you want to see are part of the plan's network. Also, consider whether you have a large enough network for current or future needs.

STEP 4: CONSIDER OUT-OF-POCKET COSTS

Take into account:



Premiums:

The monthly amount you pay to maintain health insurance coverage



Deductible:

The amount you pay out of pocket before insurance kicks in at its highest level



Co-pay:

A flat fee you pay each time you receive a health care service or procedure



Coinsurance:

The percentage of a medical charge you will pay



Out-of-pocket maximum:

The amount you must pay before insurance starts covering 100% of your medical expenses

HIGHER PREMIUMS, MORE COVERAGE.

In general, plans with higher premiums provide lower out-of-pocket costs. You may want this type of plan if you frequently see a clinician or use emergency care.



HOW TO

TALK TO YOUR EMPLOYER ABOUT YOUR HEALTH CARE NEEDS

You choose your health plan, but employers often choose which plans and insurance providers will be an option for you. That's why it can be critical to convey to your employer the importance of coverage for medications and services you need.

Employers can also play a role in resolving situations where you are denied access to medication you need. For example, employers can challenge a pharmacy benefit manager – the third party contracted by health insurers

to manage a plan's prescription drug benefits – on decisions about which drugs are covered and what their associated co-pay is.

Having a conversation with an employer can be an important step.

You might consider:

- Offering background on the medication you or a dependent are taking
- If appropriate, discussing what the medication is used for and why it is necessary
- Explaining why other medications on the formulary won't work

The Americans with Disabilities Act protects you from being fired from your job due to a disability. In the interest of productivity, absenteeism and work-life balance, it is in your employer's best interest to keep you and your family as healthy as possible.



HOW TO

IDENTIFY ACCESS BARRIERS

Accessing the treatment your health care provider prescribes can be a difficult process. You may encounter some of the following challenges.



STEP THERAPY:

An insurance requirement that patients try an older or lower-cost medication and prove it doesn't work for them before "stepping up" to the drug their provider prescribed. Also known as "fail first"

In some cases, step therapy makes sense. A logical progression of treatment options may represent best practices or clinical guidelines. In other instances, step therapy can:

- Be excessive, arbitrary and even damaging to patients' health
- Prioritize insurer profits at the expense of patient care
- Allow skin conditions to worsen or patients to suffer unnecessarily
- Undermine the relationship between the physician and patient



CO-PAY ACCUMULATOR PROGRAMS:

Insurance programs that allow the use of co-pay cards but do not apply the balance of those cards to help pay down patients' annual deductibles

Co-pay cards are a standard tool to help patients with chronic conditions cover the cost of expensive medications. When their balance runs out, patients whose health plan has a co-pay accumulator program will discover that they still owe the full balance on their annual deductible – hundreds or even thousands of dollars.

Patients may then be forced to:

- Empty savings, borrow from family or friends, or forego other monthly payments to cover the hefty out-of-pocket bill for their medication, or
- Abandon the treatment they need



PRIOR AUTHORIZATION:

A process whereby insurance companies must approve a physician-prescribed drug, procedure or test before a patient can get coverage

Insurers claim that prior authorization limits the unnecessary use of expensive treatments. But patients and their health care providers may face:

- Delays of weeks, even months, which can be frustrating, painful or even dangerous for patients
- Hours of clinicians and their staff filling out forms and submitting labs and patient records
- A lengthy appeals process if the insurer denies coverage, sometimes repeatedly
- Such high levels of frustration that patients abandon treatment altogether



NON-MEDICAL SWITCHING:

A process whereby insurers push stable patients off their current medication and onto a drug that's less expensive or more profitable for the insurer

Insurers may stop covering a particular medication or place it on a specialty tier, which requires high-cost sharing. Whatever the method, non-medical switching can cause patients to:

- Experience new side effects
- Face re-emerging symptoms that had been under control
- Experience adverse interactions with medication they take for other conditions
- Lose hope after having worked tirelessly with their provider to identify the right treatment



WHY ALL THE BARRIERS?

Many access barriers result from the work of middlemen known as pharmacy benefit managers.

These companies manage prescription drug plans for health insurers. They negotiate with pharmaceutical manufacturers, wholesalers and pharmacies to determine:

- Which medications are covered
- What they'll cost patients

Pharmacy benefit managers profit by driving patients to "preferred" medications – those that generate a high rebate for them. They often make it more difficult, and often more expensive, for patients to access other medications.

HOW TO

HANDLE HIGH-COST MEDICATIONS

Sometimes the medication you've been prescribed costs more than you can afford.

Your clinician can help you identify solutions. Some options include:

- Working with your clinician to identify alternative medication options
- Using a manufacturer-provided co-pay card to reduce your out-of-pocket cost
- Exploring assistance programs available from manufacturers, non-profits or local organizations
- Check the drug manufacturer's website to see if you qualify for a patient assistance program, which may be able to offer financial assistance for the cost of your medication
- Comparing pharmacies to find the best price for your medication
 - Programs like GoodRx will compare prices for pharmacies in your area
 - Check to see if your preferred pharmacy will price match a less expensive pharmacy
 - Consider asking your clinician for a longer, 60- or 90-day supply
- Consider mail-order medications with a 90-day supply, which typically has a discounted co-pay
- If you are on Medicare, review Part D prescription plans yearly as formularies change



HOW TO

UNDERSTAND PRESCRIPTION DENIALS

Your health plan could deny your prescription for many reasons.

Examples include:

- **A processing error**, such as a missing authorization code, payment not being received or paperwork not being filled out quickly enough
- **Medication limits**, if you've reached the maximum dose, quantity or intervals between doses
- **A medication formulary issue**. Based on your health plan's list of covered drugs, your insurance may deny a prescription for a brand-name drug and require a generic or biosimilar instead
- **Coverage rules**. The medication could be one that your insurance plan does not cover
- **Prior authorization**, where your health plan must approve required paperwork from your clinician before you can receive the medication
- **Step therapy**, where your health plan requires you to try and fail other medications before covering your prescribed treatment

To determine why you've been denied, review your explanation of benefits. If you need clarification, contact your insurance provider or health care team for information.

Denials are discouraging, but they are not final. You can appeal. The process for appeals differs depending upon whether you have commercial insurers or are covered by Medicare.

DENIALS ARE NOT FINAL.

You can appeal to Medicare or your commercial insurer.

HOW TO

APPEAL A COMMERCIAL INSURANCE DENIAL

Appealing an insurance denial can be a multi-step process.

- 1 First find out why you were denied.**
Your insurance company's denial letter should include the reason.
- 2 Next, inform your health care team.**
Some medical offices have staff who work directly with the insurance company on the next steps. If not, they can at least advise you on how to proceed.
- 3 Then file an internal appeal.**
The insurance company will review its decision. There could be multiple rounds to this appeal.
- 4** If denied, you can then **file an external appeal.** A third-party reviews the denial and comes back with a decision. The insurance company has no say in this ruling.
- 5** As a final option, **consider a peer-to-peer review.** Your clinician will speak about the denial directly with a health care professional working for the insurance company. Contact information for appeals and peer-to-peer reviews should be on the denial letter your insurer sends you.



LETTERS MAKE A DIFFERENCE

Letters from your clinician can play an important role in your appeal.

Letters of medical necessity allow your clinician to outline your need for a specific treatment. The question of whether a particular medication or device is covered often boils down to whether the insurer recognizes it as a medical necessity.

Letters of support should be included in your appeal even if your insurer does not require a letter of necessity. Letters of support might include:

- Any medical reasons treatment or services should be approved
- Clinician's notes on your response to the medication or treatment
- The results of labs or tests related to the desired treatment or service
- Peer-reviewed articles or clinical guidelines supporting your treatment or service
- Reasons why the treatment or service is cost effective

HOW TO

FILE A COMPLAINT WITH YOUR INSURANCE COMMISSIONER

Every state provides oversight of insurance companies. Aside from their regulatory role, states also provide liaison services between insurance companies and the consumers they serve.

If you complete the commercial insurance appeals process without success, or you perceive that your insurer mishandled the process, you may want to file a complaint with your state's insurance commissioner.

Aside from the reason for your complaint, the following information may be required:

- Name and contact information of the patient or provider filing the complaint
- Name of insurance company, type of insurance and state where the plan was purchased
- Claim information, including policy and claim numbers, and dates
- What you consider to be a fair resolution

Information and state-specific links for filing a complaint are available at: [Complaint – Derma Care Access Network](#)

Most states are required to follow up in a defined period, usually 30-45 days.



HOW TO

APPEAL A MEDICARE PRESCRIPTION DENIAL

For Medicare patients, the appeals process looks a little different.

If you have **ALREADY PURCHASED** your medication and it was not covered, you or your clinician must send an appeal in writing. You have two options:



1 Write a letter.

You or your clinician can write a letter to your plan explaining why you are appealing, the medical reasons your denied treatment is necessary and why medications covered by the plan will not work. You can include a statement from your clinician and relevant medical records.



2 Complete the “Model Redetermination Request” form.

This form asks for the same information as the letter and provides a space to ask for an expedited decision. If you are approved for an expedited decision, you will have an answer within 72 hours.



If you have **NOT YET PURCHASED** the prescription, you or your clinician can request a coverage determination or exceptions from your plan. You have several options:

- ✓ Fill out the “Model Redetermination Request” form
- ✓ Write a letter with the details outlined above
- ✓ Call and speak with a plan representative
- ✓ For an exception, ask your clinician to provide written medical reasons why your exception should be approved

You can also ask for the decision to be expedited if you have yet to purchase your medication. The appeals process plays out in five steps.



The appeal is sent to the plan to review.



If you are denied again, you or your clinician can file an appeal with an Independent Review Entity.



If the outcome is unsatisfactory, you can then request a decision from the Office of Medicare Hearings and Appeals.



You then can ask for a review by the Medicare Appeals Council.



Your final appeals option is to ask the federal district court for a judicial review.
To get a judicial review, however, your case must meet the minimum dollar amount of \$1,850.*

Details on these steps will be provided in your denial letter.

**The judicial review dollar amount is subject to change.*

HOW TO

ADVOCATE FOR PATIENT ACCESS

In addition to working through individual access challenges, you can advocate for policy that reduces the hurdles between patients and the treatment they need.

Contacting your state or federal representatives can be a valuable way to push for a more streamlined, patient-friendly health care system.



WRITING A LETTER TO YOUR STATE OR FEDERAL LEGISLATOR

✓ Show a connection

Send it to your legislator, not legislators in other districts. If you know the legislator or have a connection, explain that in the first paragraph.

✓ Make it personal

Use plain paper or your letterhead. You can mention the organization you work with, but talk about the situation and its impact on you.

✓ Include a call to action

Ask the legislator if they will support your position and request a reply to your letter.

✓ Be respectful

Persuasion works better when done in a respectful tone.

✓ Be accurate and timely

Double check names, spelling and the address. Include your home address in the letter as well. And ensure the letter is received before a bill is voted on.

✓ Give thanks

Express gratitude. Legislators seldom get thanks for the work they do. You can thank them for their dedication even if you also say you were disappointed by how they voted.

✓ Stay focused

Keep your letter to one page. Discuss one issue per letter. Ask for the action you want in the first paragraph. Refer to legislation by its name and bill number.

IDENTIFYING YOUR REPRESENTATIVE

Every person has two United States senators and one United State representative. Find the names of your federal legislators: <https://www.congress.gov/members/find-your-member>

You also have state-level senators and representatives. Find the names of your state legislators: https://openstates.org/find_your_legislator/

MAKING A DIFFERENCE

In addition to contacting legislators directly, you can get involved with advocacy through social media or local organizations. You can also contact your local medical and dermatological societies to share your patient advocacy story. A single advocate can be a powerful force for positive change, and when advocates work together they can amplify their impact.



The Derma Care Access Network focuses on ensuring patients can access life-changing medications to improve their quality of life. While working with clinicians and stakeholders, DCAN raises the patient's voice in state and federal policy issues to make a meaningful impact in removing health care barriers.

To learn more, visit www.dermacareaccess.org



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