

IG Copays and Deductibles on the Rise



By Kris McFalls and Terry Stone

No person or entity is immune to the consequences of increasing healthcare costs. American employers experienced a 119 percent premium increase between 1998 and 2008.¹ To keep employees insured, many employers have been forced to shift some of the costs to employees through higher copays, coinsurance and deductibles, in addition to sharing a higher cost of premiums. For patients requiring immune globulin (IG), the increased burden has forced them to make some very tough decisions that could have lifelong consequences on their health and financial stability. As a result, more and more patients are seeking help to pay for their out-of-pocket IG expenses.

While the monthly cost of IG exceeds the average American monthly income, the profit margins for IG at the provider level are quite small and are shrinking. At times, Medicare reimbursement doesn't cover providers' acquisition and administration costs, which has forced many infusion clinics to close their doors to Medicare patients altogether. Private insurers faced with increasing healthcare costs have followed Medicare's lead by cutting reimbursement rates to providers. The end result is that patients are asked to share more of the financial burden.

A Historical Look at Copayments

Patients often first look to the provider of their IG for some financial relief. Their belief is that because the provider is billing thousands of dollars a month, it can afford not to collect from patients who are adding a great deal of revenue to their bottom line. In fact, in the not-too-distant past, patients frequently demanded providers write off their copayments in return for their business, and providers often agreed. For their part, many providers offered gifts and promised not to charge copayments in an effort to get more business. Taking a historical look at the hemophilia community provides some understanding of practices of the time that caused insurance companies to restructure their reimbursement policies.

Hemophilia is a disorder in which one of the 13 proteins

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needed to form blood clots is reduced or missing entirely. The clotting process, or clotting cascade, requires all proteins to work together to make a clot. When one of the proteins is deficient, the clotting process stops at that protein, and bleeding continues. There are different severity levels of hemophilia: mild, moderate and severe. People with hemophilia do not bleed faster than others; they simply bleed longer. The treatment for hemophilia is to replace

the missing or deficient protein via clotting factor that is administered through an IV. Prophylactic treatment continues to be the protocol for approximately 60 percent of all hemophilia patients who are classified as severe.



And clotting factor is very expensive. For an adult hemophilia patient, therapy can cost as much as \$350,000 per year, and years ago, profit margins for providers were large. Under those circumstances, many patients felt that providers could afford to give some of that money back to the patients. And, prior to new federal regulations, some hemophilia homecare companies offered patients enticements to stay with their service or come to them for service. Gifts such as pagers for emergency use, large refrigerators for factor storage, and even help with general expenses like rent, were not uncommon. As this kind of assistance continued, over time, patients felt entitled to these extras.

Current Reimbursement Policies and Law

As costs soared and abuse increased, insurance companies took a hard look at the cost of expensive medication such as factor and IG. To rein in costs, insurance companies changed their reimbursement policies, resulting in drastically decreased reimbursement rates for providers. And, as part of the cost-cutting measures, third-party administrators of prescription drug programs, known as pharmacy benefit managers (PBMs), were employed. It is PBMs who negotiate special contract rates with drug manufacturers to help reduce costs for insurers. In addition, some insurance com-

panies opened their own specialty pharmacies to provide medications exclusively to their members, while other insurers restricted provider options to a select few. As a result, specialty pharmacies that continue to provide services to select patient groups, such as the IG and factor communities, are experiencing market compression with reimbursement rates far less than in previous years.

Government, too, soon caught on to the abuse in the system and enacted many laws to stop it. These laws, which are regulated by the Office of the Inspector General (OIG), specifically prohibit giving goods and services to patients and routinely waiving copayments and deductibles. If a gift or service has a value greater than \$10, and if the accumulative yearly value of gifts is greater than \$50, the giver is subject to fines and penalties. However, there is one exception to the latter law that allows companies to forgive copayments or deductibles based on financial need. Specifically, the law states that "non-routine, unadvertised waivers of copayments or deductible amounts [can be] based on individual determinations of financial need or

exhaustion of reasonable collection efforts."²

The waiving of copayments and deductibles based on financial need is known as charity care, financial assistance or compassionate care. Regardless of the name,

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IG Manufacturer Loyalty Programs

IG manufacturers will provide temporary access to patients' product in the event of loss of insurance. However, patients must first sign up for the manufacturer's service to qualify. These links, phone numbers and email addresses will bring patients directly to where they can sign up.

Baxter Gammagard GARDian:

<http://www.mygardian.com/gardian>

CSL Behring Assurance:

<http://www.cslbehringassurance.com>

Grifols:

(800) GRIFOLS, option 3

Octapharma:

reimbursement@octapharma.com

Talecris Gamunex Connexions:

<https://www.gamunexconnexions.com>

providers will not advertise that they have this kind of program, because doing so is strictly prohibited by OIG regulations. To inquire about qualifications, patients need to ask to speak with a reimbursement specialist at the facility where they have outstanding debt. They should be ready to give information regarding their income, and if requested, provide proof. While each provider may have different eligibility requirements, patients need not be destitute to qualify for assistance. Also, patients may qualify one year but not the next. Each year, providers review and update their policies, and each year, patients are required to resubmit their applications.

Accessing Financial Assistance

While currently there are no programs to specifically help cover out-of-pocket IG expenses, there are programs that may help cover the costs of other prescriptions patients may need. Organizations such as NeedyMeds will help pay for other medications, freeing up patients' money to help cover the costs of IG. More information can be found at www.needymeds.org.

Primary immune deficient patients with private insurance may qualify for premium assistance through Patient Services Inc. Assistance is limited and based on financial need. Information about premium assistance can be found at www.uneedpsi.org.

If patients lose their insurance coverage, IG manufacturers have loyalty programs that will give them temporary access to their particular product. However, patients must sign up for the service before they need it. See IG Manufacturer Loyalty Programs on page 14.

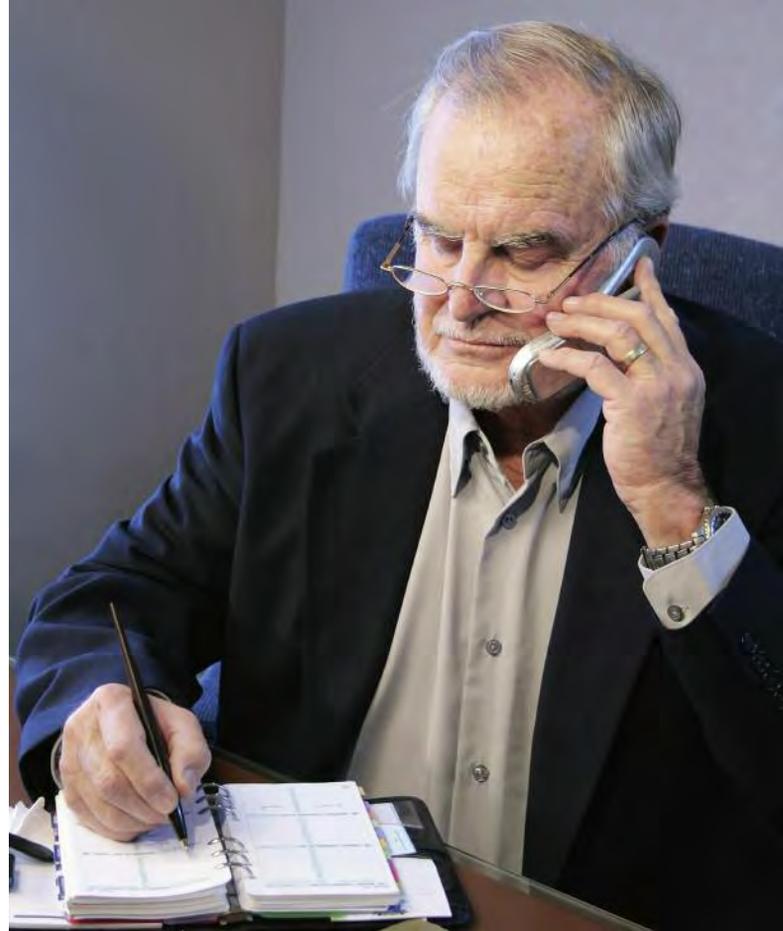
When faced with the large bills that inevitably come, many patients are tempted to reach for their credit cards. A credit card is happily accepted by most providers, but interest payments on the charges increase the amount of the bills. Instead, patients should ask their providers if they will work out a payment plan. Many providers are happy to set up a payment plan with little or no interest, as long as the patients continue with their service.

Also, patients should ask for discounts. If credit cards or tax refunds are used to pay balances in full, patients should request a cash discount. Providers may say no, but the answer is definitely no if the request is not made.

Bills should be compared with patients' explanation of benefits (EOB) statements. When insurance companies have contracts with providers, providers agree to give a discount to patients covered by a particular insurance. Any amount owed above the contracted rate is supposed to be written off and not transferred to patients. Mistakes happen,

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however, and it is not uncommon for patients to be billed for things they are not responsible for paying. Patients should not pay any amount greater than what their insurance states that they owe. If there is a discrepancy, patients should copy their EOB and send it to their provider. In return, they should ask for a detailed statement explaining the discrepancy. Patients may also need to call their insurance company to request help working with their provider. And, if patients are not satisfied with the answers they get from either the provider or the insurance company, they shouldn't be afraid to ask for a supervisor. They just need to make notes of the date and time of the call, who they spoke



with and the outcome of the call. In the end, the bill belongs to the patient. So, like anything else of value, they should make sure they are getting what they pay for, and are not paying for anything they don't owe.

Preparation Is the Best Defense

Dealing with a chronic illness can be difficult enough, but the added worry and stress of financial obligations can be overwhelming for patients. If history repeats, patients will continue to bear the burden of increased premiums and out-of-pocket costs for their healthcare. The best defense, however, is for patients to get educated and have a plan in place before they get into a crisis mode. Most importantly, they should not be afraid to ask for help. ■

References

1. The Henry J. Kaiser Family Foundation. *Focus on Health Reform. Health Care and the Middle Class: More Costs and Less Coverage.* July 2009. Accessed at www.kff.org/healthreform/upload/7951.pdf.
2. Office of Inspector General. *Offering Gifts and Other Inducements to Beneficiaries.* August 2002. Accessed at oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf.

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