Access to Care is More Than “Having Insurance”

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The Alliance for Patient Access (allianceforpatientaccess.org), founded in 2006, is a national network of physicians dedicated to ensuring patient access to approved therapies and appropriate clinical care. AfPA accomplishes this mission by recruiting, training and mobilizing policy-minded physicians to be effective advocates for patient access. AfPA is organized as a non-profit 501(c)(4) corporation and headed by an independent board of directors. Its physician leadership is supported by policy advocacy management and public affairs consultants. In 2012, AfPA established the Institute for Patient Access (IfPA), a related 501(c)(3) non-profit corporation. In keeping with its mission to promote a better understanding of the benefits of the physician-patient relationship in the provision of quality healthcare, IfPA sponsors policy research and educational programming.

Upward of 15 million uninsured people will soon be eligible to sign up for private coverage during the federal insurance marketplace’s special enrollment period. President Joe Biden ordered the reopening from February 15 to May 15 so more Americans could enroll in a plan of their choice.

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However, having insurance coverage is not the same as having access to care. Insured patients, even neonates, still face barriers that keep them from optimal health care. Among them:

- High out-of-pocket costs. The monthly premium patients pay to maintain their insurance coverage is just one of many costs. Patients incur additional costs, including the annual deductible they must meet, before reaping the full benefit of their insurance. Plans with low premiums often have a high deductible, which can keep patients from seeking care. Even once the deductible is met, patients still face co-pays and, in some instances, co-insurance. The variable nature of these expenses makes them difficult to predict, deterring parents from seeking care or filling prescriptions for themselves or their children.
- Unnecessary non-medical switching. Insurers may push patients to take the medication that’s least expensive or most profitable for the insurer. To encourage the switch, the insurance company may stop covering a patient’s current medication or may move the medication to a specialty tier, which drives up the cost for patients. Patients are left to face the potential health effects of abrupt or inappropriate medication changes.
- Burdensome step therapy. Insurers may require patients to “fail first” on an insurer-preferred medication before gaining access to their physician-prescribed medication. Again, the insurer generally prefers medications that cost them less. Forcing patients to step through one therapy before moving on allows the insurer to delay as long as possible, paying for the expensive medication the patient needs. Meanwhile, patients are strapped with unnecessary costs. And the time it takes to go through the steps allows their condition to worsen, which can impact the overall health of a new baby.
- Excessive use of prior authorization. While patients who primarily feel the pain of the first three barriers mentioned, health care providers are also wringing their hands over exorbitant prior authorization. They and their staff must spend hours completing forms and submitting records to prove their patients should get the medication or procedure prescribed. Insurers are known for denying initial requests, sending health care providers through the appeals process, all while patients suffer in waiting.