LEADING THE SCIENCE AND PRACTICE OF CLINICAL NUTRITION

American Society for Parenteral and Enteral Nutrition

March 2015

Results of Provider and Consumer Survey on Nutrition Therapy Insurance Coverage

Introduction:

The purpose of this study was to determine if current changes in insurance coverage, some of which was brought about by the Affordable Care Act, is adversely affecting patient access to nutritional health care. The study was initiated after one member of the committee noted that patients were being told that since, after switching insurance, their provider was no longer “In Network” and that they could no longer see the provider. Also, at the same time the same provider was informed by the healthcare system where inpatients were being care for that a large insurance company would no longer be accepted due to ‘business practices’ and that patients covered by that plan would be allowed to finish up any ongoing treatments but afterwards would have to be treated at other facilities. Discussion with other providers in the area revealed similar stories and the survey was created to see if these were random events or indications of a larger issues.

After development by the A.S.P.E.N. Public Policy Committee, the survey was sent out to members of A.S.P.E.N., National Home Infusion Association (NHIA), and the Oley Foundation who represents patients, caregivers and clinicians. The survey data collection period was early December 2014 to early January 2015. The questions were designed to see if access to nutrition care was being affected and, if so, how did the providers and patients deal with the issues. The results were tabulated and are presented below.

Results:

Data from Providers:

- The data was collected from across the United States with the majority of responding providers being RDs, a total of 179 clinicians completed the survey.

- Of those responding, 22% stated that they had stopped accepting some insurance policies due to various reasons ranging from inadequate reimbursement to not being allowed to be a part of the provider pool.
- Half of the providers continued to care for the patients, possibly without reimbursement, while the other half discharged their patients from their practice, in most cases helping the patient transition to another care provider.
- Similar answers were seen in response to questions about facilities to which the provider would normally send patients, ie the facility could no longer care for the patient.
- Of more interest was the response to the question “Have any current patients complained that they can no longer see you since your are not ‘In Network’” Forty-six percent of the providers answered “Yes” to this question and in 82% of the cases the patient was required to switch to another provider.
- When Home Care companies were presented with similar questions 78% of them responded that they also had to refuse to service patients with only 21% being due to lack of coverage while the others were due to either inadequate reimbursement, 27.5% (the offered reimbursement reportedly did not cover the costs of treatment) and the rest, 50.7% being due to the company not being ‘In Network”.
- Of more concern is that 72% of home care companies reported that they had had to discharge patients from their services due to insurance issues. The majority of the patients were referred to other home care companies but at least 16% were simply discharged from care.

Data from Consumers and Caregivers:

A similar survey was sent to consumers and caregivers in an attempt to see if changes in insurance coverage had affected their care. There were 115 respondents who completed the survey. For this population, 37% reported that their insurance policy had changed while over 90% reported changes in the benefits offered by their policies.
Adverse affects of these changes included:

- No longer being able to see their previous provider
- No longer having previously approved medications covered
- No longer have nutritional supplements covered
- No longer having equipment deemed necessary for safe administration of EN covered
- Patients having to cover ‘out of pocket’ previously covered expenses

In contrast to responses from providers and home care companies, over 65% of patients reported that they received no assistance from either their provider or home care company in finding a new provider or supplier for nutritional care.

<u>Specific patient stories gathered from this survey include</u>:

- I have Medicare parts A & B but no prescription coverage. I recently lost my secondary insurance coverage so I sometimes skip medication and feedings because I cannot afford to pay.
- Transition to Medicare with secondary insurance is just starting so don't really know who covers what. Previously employer insurance was excellent and covered all necessary HPN therapy including hydration.
- Being forced into an HMO drastically affected medication and supplement coverage. Our monthly bill went from close to $0 to now around $300.
- When I switched insurance, I couldn't get in to an insurance approved PCP for 6 weeks and was advised that Total Parenteral Nutrition (TPN) wouldn't be covered until new MD could see me and get it authorized. They suggested I go to ER for my daily TPN and fluids if it was needed. I finally got a case manager who could see the many issues with this plan, including crazy financial impact, so I was able to get an override for 6 weeks of TPN, port changes, and medical care until I could get established with the new PCP.
- We moved to another state and learned the county we moved to does not have many insurance providers because it contains the most elite hospitals who will not accept the pittance government exchanges promote. Due to the severity & rareness of my disease I have no choice but to swallow the costs of ALL uncovered things (Tube Placements, Feed Supplies, PICC placements & IV supplies, etc.) I truly worry about our healthcare system's rationing and likely change to the European model where people in my situation die because they do not receive the necessary care- Darwin's "survival of the fittest" theory now applies to the healthcare system where only those who don't need healthcare in America will survive.
- When my company switched insurance, our TPN formula and supply cost went from $20/week to $20 / day! I was given the wrong information and considered responsible for $480.00 before I applied for financial hardship.
- My previous health insurance covered TPN and I was down to three days a week. When I went on Medicare they required me to be on TPN at least 4 days per week and now they are denying coverage.
- My Pharmacy is not "in network" where I live despite the parent company having the pharmacy in network elsewhere. My out of network out of pocket family deductible went from 8K to 20K, I am not sure what is going to happen.

Summary:
The Affordable Care Act was enacted to ensure that the citizens of this country have access to health care. Among the promises made were that “You will be able to keep seeing your current doctor” and that “Your benefits will not change”. It is apparent that this is not true for a significant majority of patients who are no longer able to see their previous health care provider or obtain previously covered nutritional treatments.