



Opportunities for Patients Arising From the Practicalities of Health Care

By Daniel Kantor, MD, FAAN, FANA



Although patient care does not recognize boundaries of days, nights, weekends, or holidays, a new year does mean that our patients have a resetting of their deductibles, and this has a palpable effect on their willingness or ability to adhere to diagnostic and treatment plans.

In the past, patients could choose between high-deductible but low monthly premium health care insurance plans and low-deductible but high monthly premium plans; increasingly, it seems that available insurance plans have both high deductibles and high monthly premiums. This means that patients often wait to follow their neurologists' recommendations only once their yearly deductible is met. The relatively good news for patients with multiple sclerosis (MS) is that due to the significant cost of MS disease-modifying therapies (DMTs), deductibles are often met during the first month or so of the year. Because our patients with MS are not necessarily hamstrung by their deductibles, we have an opportunity to deliver optimal care for these patients. However, patients who are new to therapy may not yet realize how quickly their deductibles will be met, and it behooves us and members of our practice to counsel patients regarding this.

Some of our patients, however, have separate medical and prescription deductibles, which means that although they may quickly meet their prescription deductible, they are financially constrained by their medical deductible. Patients may delay MRIs, other diagnostic testing, physician follow-ups, and specialist consultations. As we increasingly place our patients with MS on highly effective DMTs with the potential for life-altering side effects, practical barriers to patients engaging in their care and adhering to monitoring plans have the potential to be dangerous. We need to counsel our patients on why risk evaluation and mitigation strategies (REMSs) are important, and how these programs are

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designed (and vetted by the Food and Drug Administration) to protect them from harm. As an advocacy issue, it would be reasonable to require the cost of testing mandated by an REMS program to be built into the cost of DMTs (and either borne by the pharmaceutical manufacturer or fall under patients' health care insurance pharmacy benefits).

To help neurologists deliver even better care for our patients, it is vital for us to work together to streamline the delivery of care; this is why the Precision Innovative Network has launched a group purchasing organization, followed by an independent physician organization, while sharing objective digital data that inform and improve the care of both individual patients with MS and the MS population overall.

It is impossible for neurologists to be stewards of health care because we not only have little control over the cost of health care, we also do not even know the true cost. In MS, the largest driver of costs is DMTs, and although wholesale acquisition costs are publicly available, formularies are decided by the large rebates paid back by pharmaceutical manufacturers to pharmacy benefit managers and insur-



ers. Increasingly, we have witnessed the demand for further transparency in health care, yet the rebate system remains shrouded in proprietary and secret negotiations between multinational corporations and behemoth payors. Doctors have mostly gotten used to the Sunshine Act (Section 6002 of the Affordable Care Act of 2010), and it is time to expand the definition of covered entities to include pharmacy benefit managers and insurance companies so that the public can track payments between pharmaceutical manufacturers and payors to help us understand the true cost of medications. Payments for physician services (Evaluation and Management codes) are basically benchmarked against the Medicare fee schedule set by the Federal Government, yet pharmaceuticals have variable costs that are nontransparent. Instead of advocating for the Centers for Medicare & Medicaid Services (CMS) to be allowed to negotiate the price of pharmaceuticals (which would have the unintended, but natural consequence, of having medications taken off the Medicare formulary), we should advocate for CMS to create a fee schedule for pharmaceuticals (just as it does for Current Procedural Terminology (CPT) codes). This system would increase patient access because it is unlikely that pharmaceutical manufacturers would make the decision to opt out of Medicare and be labeled as nonparticipating. In a timely fashion, one of our colleagues, Dr. Bhupen Khatri,

recently authored an excellent book that addresses many of these issues.¹

As we continue to advocate for the care of our patients, the pace of MS research continues to increase asymptotically, as evidenced by the beginning of our conference season with the third annual stand-alone Americas Committee for Treatment and Research in Multiple Sclerosis forum, held in San Diego, California. Due to the rapid pace of research presentations, it is important to engage with the community through social media in between issues of *Practical Neurology*. ■

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1. Khatri B. Healthcare 911. Milwaukee, WI: HenschelHAUSPublishing; 2018.

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