ABC'S: THE BASICS

5 Ways Your Insurer May Prevent You From Getting Your Medicine

We've talked about the 5 things to consider when choosing your health coverage and the 5 questions to ask about your prescription medicine coverage, but it is also important to know the barriers insurance may still impose to accessing the medicines you need. Knowing these ahead of time can help you ask the right questions and look for coverage that works best for you.

Here are 5 ways your insurer may prevent you from getting your medicine:

1. Prior authorization

Your insurer may require your doctor to obtain approval from the insurance company before they will cover a medicine that is not on your plan's preferred drug list (also known as a **formulary**). This process can often be burdensome and time consuming, potentially causing delays in access to needed treatments, which in turn, may negatively affect your overall health.

2. Step therapy

Also known as fail first, your insurer may require you to demonstrate that other medicines on your plan's formulary don't give you relief before they agree to cover the cost of the original medicine your doctor prescribed.

3. Non-medical switching

Your insurer can actually require you to switch to another medicine, even if your current medicine is working. Insurers do this by changing the medicines covered on their formulary or by making it difficult to continue your medicine. In some cases, patients who are required to switch medicines may not respond to the new therapy, or may have a bad reaction – a major consequence of non-medical switching for patients with diseases like rheumatoid arthritis, Crohn's and mental health conditions. Some patients may even switch back to their originally prescribed medicine and no longer respond to the treatment that was working, sending them back to step one in trying to manage their condition.

4. High out-of-pocket costs

Insurers are increasingly subjecting prescription drugs to a deductible or imposing higher cost sharing for medicines, especially when compared to other health care services. These costs may come in the form of a **deductible** (the amount you have to pay before your insurance will start covering any expenses), **a copay** (*a fixed cost* you may have to pay when you visit the doctor or pick up a prescription medicine, once you've met the deductible) or **co-insurance** (*a percentage of the total cost* you may have to pay to pick up a prescription medicine once you've met the deductible). These out-of-pocket costs can be real barriers to access because unlike a visit to the hospital where you'll be treated no matter what, if you can't pay for your medicine, you have to leave the pharmacy without it.

5. Not covered at all

Insurers can limit the medicines they cover by not placing them on a formulary. Finding out if the medicines you need are covered before you pick a plan is critical, but sometimes that information can be hard to find. Call insurance plans directly to get a copy of a plan's formulary (or list of covered medicines) and find out if the medicines you need are covered and what you'll have to pay for them at the pharmacy. If you find out that a medicine is not covered and you are not able to switch plans, you can ask to go through an exceptions process to gain coverage for a medicine that is not on the formulary.