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Could stopping 'thousand cuts' by insurers and PBMs help rheumatology's workforce shortage?

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IN COLLABORATION WITH CSRO
Coalition of State Rheumatology Organizations

I am hearing more and more often from colleagues about the number of rheumatologists taking early retirement because of the frustration of having doctor-patient shared decision-making taken out of their hands and given to the insurance companies and their pharmacy benefit managers (PBMs). Often the right medication for the patient is not available on the formulary, causing unnecessary administrative barriers to providing care. When you put that together with the decreased reimbursement and the many obstacles to the "buy-and-bill" model, many rheumatologists have just had enough and called it quits earlier than they thought they would. This is a significant contributor to the growing workforce problem in rheumatology <https://www.sciencedirect.com/science/article/pii/S0049017220301396?via%3Dihub> .

Many of the issues affecting the availability of medications happen throughout the development and distribution of a drug treatment – regulatory approval and obstacles to commercial launch, such as patent thickets, "pay for delay," and

plans and PBMs as to whether, when, and even where a medication can be used. Here is where much of the frustration begins, amplified by the knowledge that profit for the PBM is the driving force behind formulary construction.

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To support rheumatologists in addressing these challenges, the Coalition of State Rheumatology Organizations started a “Reporting Insurance/Payer Issues” page <https://csro.info/forms/insurance_notification.php> . Here, rheumatologists can describe issues or complaints they have with payers regarding patient care. The responses we’ve received so far always have a sense of urgency and frustration in the description of whatever obstacle to care is being thrown up by an insurance company or PBM.

One of the recent issues that has arisen via the CSRO’s reporting form involves a new policy for an insurance plan that removes the availability of the intravenous formulation of a medication if it has a subcutaneous (sub Q) formulation. It is a commercial version of the Medicare self-administered drug list, but worse. At least Medicare takes the time to look at the actual usage of a formulation before moving it from Part B to Part D. This new policy flatly states that no patients will have access to the IV formulation until the sub Q formulation has been tried. This includes switching all stable IV patients over to the sub Q formulation. Because the IV formulation is weight based, switching patients from IV to sub Q can reduce their dosage by more than 50%. It

“buy and bill” offer no revenue to the insurance company, while sub Q medications increase profits through rebates, fees, and other price concessions.

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The CSRO outlined these concerns in its Jan. 18, 2022, response <https://csro.info/advocacy/correspondence> to the insurance company’s reply to the coalition’s original letter, urging them to value patients over profits. In this response, the CSRO addressed nonmedical switching, site of care cost, outcome documentation, and grandfathering stable patients, and finished with a discussion on ERISA (Employee Retirement Income Security Act of 1974) protections.

While our Reporting Insurance/Payer Issues form cannot handle reimbursement issues, there needs to be a word about money and profit when it comes to physicians. Physicians whose specialties have few to no procedures, including rheumatologists, rely on office visits and ancillary services such as infusion suites for income. That income sustains their practice and maintains all their attendant expenses. Many of the recent policies put forth by health plans not only intrude on the doctor-patient relationship in treatment decisions, but also reduce reimbursements and place obstacles to “buy and bill,” shifting revenue from the physician to the insurance company.

All these insurance/payer issues boil down to a version of “death by a thousand cuts.” These cuts harm patients and impede rheumatologists’ ability to sustain their practices. They are a type of moral injury (among the many we see in health care providers) that are causing rheumatologists to retire early. Clearly,

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