Alternative Funding Programs FAQ

LET MY DOCTORS DECIDE
Action Network

WHAT ARE ALTERNATIVE FUNDING PROGRAMS?

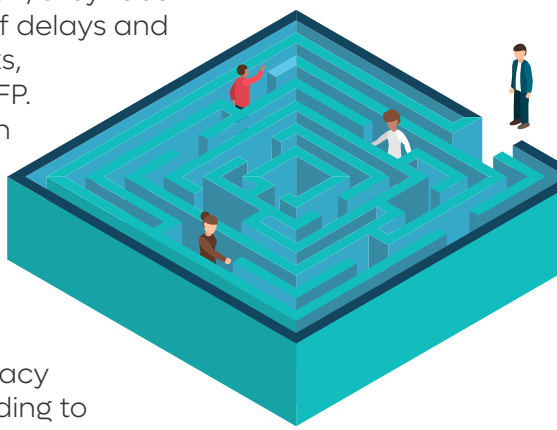
Alternative Funding Programs (AFPs) are third parties that shift or deflect coverage for specialty drugs and treatments on behalf of a health plan sponsor, like an employer. AFPs target small to mid size companies with self-funded health insurance plans. These vendors misrepresent cost saving measures by encouraging employers to redirect the responsibility of covering certain specialty drugs by removing them from their lists of covered drugs. This is known as exclusions or "carve outs."

Employers – often abruptly and without advanced notice – will inform the employee that since the insurance plan will no longer cover their specialty drug they are considered "uninsured" and then an AFP steps in to refer them to a charitable organization or a patient assistant program (PAP) as a "last resort." As a result, patients must then navigate a maze of delays and confusing procedures to prove eligibility.

WHAT IS A PAP?

A **PAP – patient assistance program –** is designed to help underserved and under-insured communities. Resources and budgets for most charitable organizations and PAPs are often overtaxed and under-funded. In steering otherwise insured patients to PAPs, funds are more quickly depleted and not available to patients who are truly in need.

WHAT DO PATIENTS ENCOUNTER WHEN USING AN AFP?



Once a patient is determined uninsured by the employer or sponsor plan, they face confusing AFP eligibility requirements. Patients must navigate a maze of delays and procedures with lengthy applications and extensive background checks, including providing sensitive, confidential financial information to the AFP. This process can take several weeks – sometimes months – during which the patient may ration their existing medicine supplies or choose to forgo the drug.

Even if patients make it through the cumbersome AFP process, enrollment in a PAP only lasts six months to a year, on average. Patients must repeat the drawn-out application and review steps each time. Parameters of coverage change frequently because pharmacy benefit managers (PBMs) can enact different rules and regulations, leading to more delays and higher costs.

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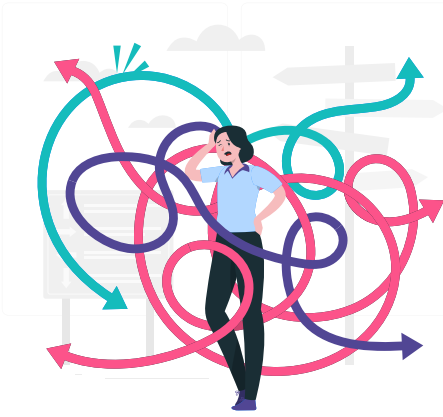
If a patient is denied enrollment, there is a long, complicated appeals process. If patients decide not to pursue the appeals process, their out-of-pocket costs increase, and this spending does not count towards their deductibles. If patients can't get a PAP to cover treatment, patients may turn to unregulated options. Without third-party oversight for safety compliance and medical efficacy, patients could be exposed to substandard or counterfeit products. Complications and increased costs can be challenging, and patients will often forgo the much-needed specialty drugs and treatments altogether.



WHAT'S IN IT FOR AFPs?

Studies indicate that AFPs pocket between **20% and 30% of the total drug costs** when they redirect a patient to a PAP or charitable organization. A 2022 survey found that **31% of health plans are considering using AFPs**, and **8% are already using them**.

WHAT IS NECESSARY TO PROTECT HEALTH CARE ACCESS FOR PATIENTS?

Public policy action can close this harmful loophole that allows AFPs and health plan sponsors to mislead patients into thinking they are uninsured, and that PAPs are the only alternative for coverage of specialized drugs and treatments. Restricting access to doctor-recommended treatments increases costs for patients and lowers their quality of care.

Let My Doctors Decide Action Network is working with patient advocates, disease-specialty organizations, and other key stakeholders to advance meaningful change and eliminate unnecessary AFP access barriers.

It's time to put patients first.

Let My Doctors Decide Action Network 501(c)(4) brings together patient advocates, providers, experts, and other health care leaders in an effort to advance meaningful policy reforms to eliminate unnecessary health care access barriers.

We believe patients and their trusted providers should be empowered to make treatment and other care decisions, without restrictions imposed by insurance companies, their PBMs, and other third-party entities that interfere with thedoctor-patient relationship.

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