Virtual Event Transcript
Medicare Part D in 2026: What Patients Need to Know Featuring Saira Sultan and Kay Scanlan

July 22, 2026

In science and medicine, information is constantly changing and may become out-of-date as new data emerge. All articles and interviews are informational only, should never be considered medical advice, and should never be acted on without review with your health care team.

This text is based on a computer-generated transcript and has been compiled and edited. However, it will not accurately capture everything said during the webinar. The timestamp is approximately 10-minutes off due to editing. The complete recording of this webinar is available on-demand.

00:10:30.000 --> 00:10:38.000
Hello, and welcome to today's webinar, Medicare Part D in 2026: What CLL Patients Need to Know.

00:10:38.000 --> 00:10:43.000
I am Perla Salazar, Program Coordinator at the CLL Society.

00:10:43.000 --> 00:10:52.000
Prior to beginning, we would like to mention a few pre-event items. All attendees in this webinar are muted and only the speakers are on camera.

00:10:52.000 --> 00:10:58.000
We ask you to please direct all questions to the Q&A section displayed on your screen.

00:10:58.000 --> 00:11:09.000
Questions will be sent directly to our speakers and CLL Society staff and are not visible to the audience. After today's event, you will receive a very brief survey and we greatly appreciate your feedback.

00:11:09.000 --> 00:11:24.000
This webinar is being recorded and will be made available to everyone on the CLL Society website. Closed captions are available. If you want to turn them on or off, go to Captions and select Show Captions or Hide Captions.

00:11:24.000 --> 00:11:33.000
This program was made possible through generous donors like you and our Policy Institute supporters AstraZeneca and BeOne.

00:11:33.000 --> 00:11:40.000
At this time, I would like to welcome our speaker, Saira Sultan.

00:11:40.000 --> 00:11:58.000
Good morning everybody or good afternoon. Nice to be with you today. We are, I'll introduce both myself and our speaker, Kay Scanlan. I am President and CEO of Connect 4 Strategies and also Director of Government Affairs and Public Policy for the CLL Society…

00:11:58.000 --> 00:12:03.000
and joining me today is Kay Scanlan, Principal at Consilium Strategies.

00:12:03.000 --> 00:12:20.000
I jokingly sometimes say that Kay has forgotten more about Medicare than I ever knew. So, you have a great speaker with you today, and I would like to make sure that you are as interactive as you can be under this context, so please keep your questions coming…

00:12:20.000 --> 00:12:35.000
throughout our webinar, we'll try to get to them as fast as we can. Hold on to your questions, though, because if we don't get to them today on the webinar, we'll ask you to resubmit them at the end of the webinar.

00:12:35.000 --> 00:12:38.000
So, today's discussion on next slide, please.

00:12:38.000 --> 00:12:54.000
We'll focus on what has changed in Medicare in 2026. There are some important changes we previewed last year for you all, and we'll discuss both what's already changed in 2026 and what to look ahead for as well.

00:12:54.000 --> 00:13:08.000
We'll also talk about how Part D plans and sponsors seem to be responding to the changes, both in their financial liability due to the Part D benefit redesign, as well as to formulary changes.

00:13:08.000 --> 00:13:16.000
And with respect to formulary changes, we'll be talking about utilization management and what that means for our community...

00:13:16.000 --> 00:13:29.000
including step therapy for BTK inhibitors, as well as what the National Comprehensive Cancer Network has been able to do with regard to revising CLL guidelines.

00:13:29.000 --> 00:13:36.000

And finally, what to do if you are told that your plan denied coverage for your CLL treatment.

00:13:36.000 --> 00:13:38.000
Next slide, please.

00:13:38.000 --> 00:13:57.000
Of course, why this matters is that Medicare rules and changes in financial responsibilities and also incentives for health plans and for intermediaries has a direct effect on whether our patients are able to receive the treatments that your doctors provide or recommend to you.

00:13:57.000 --> 00:14:11.000
Plans can delay or deny or restrict access through all sorts of administrative hurdles and requirements. And these barriers are often used in high-cost cancer treatments like the ones our patients take.

00:14:11.000 --> 00:14:30.000
Understanding how the system works will help you and us respond quickly and effectively. You directly with your health plan and your doctors, but also the CLL Society in how we approach some of the policy issues that are implicated in these denials or delays you may see.

00:14:30.000 --> 00:14:33.000
Next slide, please.

00:14:33.000 --> 00:14:49.000
So, the next two slides deal with key terms that I understand these slides were provided to you all in advance. So, we laid out some glossary terms, both in this slide, and you can go to the next slide now, and in the next slide,..

00:14:49.000 --> 00:15:04.000
and these, we will try our best to make sure that we are going through these as we explain and as we discuss these topics, but they are here for you as reference. And then, of course, will be provided to you…

00:15:04.000 --> 00:15:08.000
at the end on our website as well.

00:15:08.000 --> 00:15:18.000
So, with that, I'd like to turn it over to my colleague Kay Scanlan to start the discussion on what's changed in 2026. Kay, if you'd like to come off camera…

00:15:18.000 --> 00:15:20.000
and unmute,..

00:15:20.000 --> 00:15:21.000
we're ready to go.

00:15:21.000 --> 00:15:23.000
I am on camera and unmuted.

00:15:23.000 --> 00:15:25.000
Okay, take it away.

00:15:25.000 --> 00:15:34.000
Okay. Well, everything that follows today pretty much starts here. Basically, Congress changed the financial incentives, so plans change their behavior.

00:15:34.000 --> 00:15:49.000
And I think in a lot of ways, this is, this may be the most important slide in the presentation because it explains why patients are facing changes and frustrations and everything else. So, if you felt like your Part D plan suddenly seems more difficult to deal with…

00:15:49.000 --> 00:16:07.000
you're probably not imagining it, but it's not personal. It's that something very important has changed. Congress redesigned the Medicare Part D benefit. One of the biggest goals, and I think we all agree it's a good one, was protecting patients. And that's by putting a cap on annual out-of-pocket prescription drug costs.

00:16:07.000 --> 00:16:20.000
The other thing is negotiated prices. So basically, trying to keep Medicare healthy, trying to save money from some drugs, it'll save patients money. For CLL,..

00:16:20.000 --> 00:16:26.000
probably not. But the trade off in these things that are good…

00:16:26.000 --> 00:16:33.000
is that now Part D plans are responsible for a much bigger share of the cost of expensive medications.

00:16:33.000 --> 00:16:38.000
And one thing I've learned over the years is that whenever…

00:16:38.000 --> 00:16:48.000

Congress or CMS changes financial incentives, behaviors change. That's every single time, and that's exactly what we're seeing now. So,..

00:16:48.000 --> 00:17:05.000
plans aren't responding because they suddenly dislike expensive drugs or actually really prefer one drug over another. They're responding because they're now paying much more of the bill, and how much they pay and how much they get paid can depend on which drug…

00:17:05.000 --> 00:17:20.000
they're providing. So, we're going to be seeing more prior authorization, more step therapy, more formulary management, and generally a bit more or a lot more administrative hurdles before patients can actually get their…

00:17:20.000 --> 00:17:29.000
treatment. And I think understanding why this is happening makes the system much less frustrating. Once you understand the incentives, the behavior starts to make sense.

00:17:29.000 --> 00:17:33.000
So, I think if we go to the next slide,..

00:17:33.000 --> 00:17:37.000
we have,..

00:17:37.000 --> 00:17:43.000
I thought the poll question was up here. Excellent. Okay.

00:17:43.000 --> 00:17:47.000
So, the next what we're seeing…

00:17:47.000 --> 00:17:52.000
is a lot more market consolidation. You may be finding that your…

00:17:52.000 --> 00:17:55.000
Part D…

00:17:55.000 --> 00:18:10.000
premium is higher. You may find that your deductible is higher. You may be finding any of those types of things. You might find that instead of paying $20 for certain prescriptions, you're paying 20 percent.

00:18:10.000 --> 00:18:29.000

And I think all of these things are emerging this year. I think some plans are going to be taking longer. So, when we do get to the poll question, we might see that some people are experiencing zero problems and maybe because they're not receiving treatment right now. It might be because they started treatment two years ago. It could be any number of things.

00:18:29.000 --> 00:18:34.000
We expect that over time we're going to see more plans…

00:18:34.000 --> 00:18:38.000
catching up with the ones who are really aggressive now…

00:18:38.000 --> 00:18:44.000
and changes over time as well. So, if we want to move to the next slide.

00:18:44.000 --> 00:18:47.000
So, here's our poll question.

00:18:47.000 --> 00:18:51.000
I will read the poll question as well as the answers.

00:18:51.000 --> 00:18:59.000
How did your Part D prescription drug costs - now remember to think about premiums, deductibles, and co-payments -..

00:18:59.000 --> 00:19:02.000
change in 2026…

00:19:02.000 --> 00:19:07.000
compared to last year in 2025? Did you find that they went down?

00:19:07.000 --> 00:19:10.000
They stayed about the same?

00:19:10.000 --> 00:19:12.000
They went up?

00:19:12.000 --> 00:19:14.000
I'm not sure yet…

00:19:14.000 --> 00:19:23.000
Or I don't have a Part D plan in Medicare.

00:19:23.000 --> 00:19:29.000
So, we can go to the next slide and we'll have poll results for you momentarily as Kay continues.

00:19:29.000 --> 00:19:46.000
Thank you, Saira. I'm really curious about this because we're hearing very different experiences around the country. And we're hearing different things from patients and from providers. So, people are experiencing this differently, so it'll be exciting to see what everyone has to say.

00:19:46.000 --> 00:19:50.000
One of the things that…

00:19:50.000 --> 00:20:01.000
we've already spoken about, and something that catches many patients off guard is sometimes you'll hear the word denied, and immediately you think, my insurance won't cover my treatment.

00:20:01.000 --> 00:20:09.000
That's often not what's happening. Very often, the patients, the plan is just saying, we need more information…

00:20:09.000 --> 00:20:14.000
or your doctor needs to request an exemption,..

00:20:14.000 --> 00:20:22.000
or we want to go through a different prior authorizer, another prior authorization process before we'll approve the treatment.

00:20:22.000 --> 00:20:30.000
Those are all frustrating, but they're very different from a final determination that a drug won't be covered.

00:20:30.000 --> 00:20:47.000
So, when you look at the initial claim denials, over 70% of specialty claims face initial denials. If you know that, you know that, okay, 70%, well, I could probably expect that this is what I'm going to face.

00:20:47.000 --> 00:21:02.000
The next question is, how do I deal with it or how do I help my provider deal with it? So, one message that I hope everyone remembers today is this initial denial is often the beginning of the process, not the end of it.

00:21:02.000 --> 00:21:13.000
You don't quietly just, you know, get off the phone with the pharmacy, assuming that nothing can be done. That's when your oncology team needs to know that there's a problem.

00:21:13.000 --> 00:21:15.000
So, if we want to switch to the next slide.

00:21:15.000 --> 00:21:25.000
Actually before we go there, let's see if we can't bring up those poll results now.

00:21:25.000 --> 00:21:35.000
So, it seems like a significant number, a good third, found that their prescription drug costs did indeed go up.

00:21:35.000 --> 00:21:42.000
Another 33% are, don't have Medicare Part D. That's helpful to know for context.

00:21:42.000 --> 00:22:00.000
And it seems like at least less than 20% are seeing that they stayed the same, or they're not sure as yet.

00:22:00.000 --> 00:22:01.000
Yeah.

00:22:01.000 --> 00:22:02.000
So, of the people who do have Part D plans, it looks like a significant number found that they went up Kay, which is, I guess you would expect.

00:22:02.000 --> 00:22:11.000
Yeah, and I think, I mean, the big piece of information here is that we're now two years into…

00:22:11.000 --> 00:22:13.000
Part D redesign…

00:22:13.000 --> 00:22:26.000
where costs, out-of-pocket costs, are supposed to go down. And we're also at the beginning of the price negotiation implementation. So,..

00:22:26.000 --> 00:22:36.000
both of those things were designed to decrease costs. And what we're seeing is three percent. Now that's three percent and you look,..

00:22:36.000 --> 00:22:51.000
a third of people, you know, are not, don't have Medicare, so it's probably closer to eight to nine percent. But still, that's a significant minority when you're looking at implementation of something that was designed to actually reduce costs.

00:22:51.000 --> 00:23:08.000
And Kay, would you say that that is, in part related to the fact that oftentimes we think about there's now a cap on our out-of-pocket spending, and so shouldn't costs have gone down for us, but premiums were not included in the calculation of out-of-pocket costs, yes?

00:23:08.000 --> 00:23:24.000
Right. And I think, yes, premiums were not included in calculation of cost. We included them in the question because we wanted to get to that answer. The other thing is that with these changes in incentives and kind of…

00:23:24.000 --> 00:23:32.000
pushing plans to cover to pay for more of the drugs, that they cover a greater percentage of the costs.

00:23:32.000 --> 00:23:47.000
We've seen a lot of issuers just get out of the Part D business altogether. So, patients have fewer choices, and the choices they have, they have to look very carefully at them, and sometimes those are the more costly ones, maybe…

00:23:47.000 --> 00:23:56.000
you know, a year ago, two years ago, they were in something that was cheaper. They had to switch plans because their plan no longer exists.

00:23:56.000 --> 00:23:58.000
So,..

00:23:58.000 --> 00:24:07.000
yep. So, if we go to the next slide, we'll get to a phrase that you'll hear over and over again.

00:24:07.000 --> 00:24:10.000
Aha, what is utilization management?

00:24:10.000 --> 00:24:17.000
It's the name for the insurance rules or processes that control access to treatment.

00:24:17.000 --> 00:24:27.000
So, it sounds like something only health policy people would say. Fortunately, you don't need to remember the phrase. You've probably already experienced it.

00:24:27.000 --> 00:24:38.000
If you've ever heard your doctor needs to send in more information, or we're waiting to hear from your doctor's office, or your insurance wants you to try another drug first…

00:24:38.000 --> 00:24:46.000
or there's a quantity limit or a dosage limit, you're experiencing utilization management.

00:24:46.000 --> 00:25:02.000
From the plan's perspective, these are to manage their spending. From the patient's perspective, it feels like paperwork that stands between you and your treatment. And when you've got cancer, that's the last thing in the world you want.

00:25:02.000 --> 00:25:12.000
Just remember, though, that most utilization management issues are administrative problems or paperwork problems, and they can usually be solved.

00:25:12.000 --> 00:25:21.000
Unfortunately, we're seeing more and more of these tools being used and its impact, it's putting a big burden on your providers.

00:25:21.000 --> 00:25:24.000
If we want to move to the next slide.

00:25:24.000 --> 00:25:34.000
So here are some trends, right? We're going to be expecting more utilization management, not less. None of us has a crystal ball…

00:25:34.000 --> 00:25:56.000
but the trends are becoming pretty clear. We're seeing prior authorization use more often, we're seeing greater use of something that we'll talk about later, step therapy, which means basically the plan is saying, hey, you know, I understand you want this patient to take this or this combination or this dosage or this specific brand,..

00:25:56.000 --> 00:26:02.000
great. What we need you to do, though, is have them try this other one that we…

00:26:02.000 --> 00:26:12.000
prefer first, and if they fail or they can't tolerate it or whatever, then fine, we'll let you use the one…

00:26:12.000 --> 00:26:22.000
that you've originally prescribed. So, we're seeing a lot more of that. We're also seeing them pay a lot closer attention to high-cost specialty medications.

00:26:22.000 --> 00:26:27.000
And I'm not saying that to worry anyone. It's because…

00:26:27.000 --> 00:26:29.000
I want you to be prepared,..

00:26:29.000 --> 00:26:38.000
when you understand what's likely to happen when you understand why it's likely to happen, it's easier to respond faster when it does happen.

00:26:38.000 --> 00:26:42.000
And that raises an important question. If we want to move to the next slide.

00:26:42.000 --> 00:27:05.000
Okay, as you get on the previous slide, the last bullet, new negotiated drug controls. And one of the questions we received from a webinar attendee is whether zanubrutinib is going to be affected,..

00:27:05.000 --> 00:27:06.000
Yeah

00:27:06.000 --> 00:27:15.000
affected by the Part D changes. I know you're going to talk a little bit about NCCN later on, but did you have something to say here? Because we, of course, we know that two drugs have been negotiated, two CLL drugs, but not yet zanubrutinib. So does it escape…

00:27:15.000 --> 00:27:19.000
what you're talking about in utilization management, or does it not?

00:27:19.000 --> 00:27:24.000
If I were going to crystal ball, which I said I don't do,..

00:27:24.000 --> 00:27:26.000
what I would say is this,..

00:27:26.000 --> 00:27:40.000

we're going to see a real tightening on zanubrutinib this year, probably last year, this year, the year after, probably right on up to 2029, 2030. And then…

00:27:40.000 --> 00:27:46.000
we're going to see it suddenly looser. So, your plans are going to want you to be taking zanubrutinib.

00:27:46.000 --> 00:27:53.000
And the reason why is acalabrutinib and…

00:27:53.000 --> 00:28:00.000
Imbruvica now, I'm forgetting the technical name for that, so I apologize. I'll say “I”.

00:28:00.000 --> 00:28:04.000
Those are both subject to negotiation.

00:28:04.000 --> 00:28:19.000
And that means that Medicare kind of collects a bunch of information from the manufacturer. They look at how much they charge for non-Medicare, non-federal programs. They average it all up. They look at the dosage, they average all that up…

00:28:19.000 --> 00:28:32.000
and they come up with a negotiated price. Now, when I say negotiated, that's kind of a loose term. There's, you know, there are definite ceilings on how much they can…

00:28:32.000 --> 00:28:45.000
put in an offer, start the negotiation with. So, what this does because the negotiated price comes with the theoretical benefit to manufacturers, which is that…

00:28:45.000 --> 00:29:00.000
plans have to put them on their formulary. So that means that the manufacturer isn't going to be going to the plan and saying, hey, you know, we'll give you X amount of a rebate that you can put in your own pocket if you put our drug first, if you prefer it, etc, etc. They can't,..

00:29:00.000 --> 00:29:09.000
they can't do that anymore, you know, that incentive was taken away. So, these negotiated drugs are going to become less attractive because…

00:29:09.000 --> 00:29:13.000
they're less able to get these rebates that they like.

00:29:13.000 --> 00:29:19.000

So, when you look at zanubrutinib, you're going to see something completely different because…

00:29:19.000 --> 00:29:29.000
they will never, they likely will never be subject to negotiation, because the rules changed on orphan drugs so that they're exempted…

00:29:29.000 --> 00:29:33.000
right now, from negotiation ever.

00:29:33.000 --> 00:29:41.000
What they do have is a temporary situation where the plans pay a higher percentage…

00:29:41.000 --> 00:29:42.000
of the cost…

00:29:42.000 --> 00:29:45.000
than they do for the other drugs.

00:29:45.000 --> 00:30:00.000
And that's because, you know, there's this manufacturer discount that really increased how much manufacturers pay, and they, Congress, didn't want small manufacturers to have to bear that burden, because it could crush them. So, they said, okay, tell you what, if you're a small manufacturer,..

00:30:00.000 --> 00:30:15.000
we'll, like, phase this in. So, and instead of Medicare, federal government picking up the slack, they said plans have to. So immediately these drugs became far less attractive, and especially when they're costly.

00:30:15.000 --> 00:30:24.000
I mean, if it's not a very expensive drug, it's not as much of a big deal. If it is expensive, it can be a big deal.

00:30:24.000 --> 00:30:28.000
So, does that answer the question, do you think?

00:30:28.000 --> 00:30:29.000
Okay,..

00:30:29.000 --> 00:30:43.000
I think it does. Thank you, Kay. And I think it answers a related question too about why is it the plans make it so difficult to get these necessary treatments. You know, denying

and dragging on the process with these extra steps. And yes, it's true that patients are sick and they need timely medicine…

00:30:43.000 --> 00:30:56.000
but I think this webinar and what Kay is talking about will help folks understand some of the financial incentives that make it…

00:30:56.000 --> 00:31:07.000
understandable, but not okay by any means for plans to be doing what they're doing. But it's a financial incentive. And so that's, I think, what we're talking about here today.

00:31:07.000 --> 00:31:09.000
Absolutely, absolutely.

00:31:09.000 --> 00:31:10.000
Thanks, Kay.

00:31:10.000 --> 00:31:13.000
So,..

00:31:13.000 --> 00:31:20.000
here's the big question. Your physician knows you. Your insurance company applies general rules.

00:31:20.000 --> 00:31:28.000
So, this really does get to the heart of today's discussion. Your oncologist knows your CLL/SLL,..

00:31:28.000 --> 00:31:44.000
they know your other medical conditions. They know your treatment history, your medications that you're taking now, medications you've taken in the past and not done well with. They know your goals, they know whether you're a person who travels extensively,..

00:31:44.000 --> 00:31:53.000
foreign travel, do you go across the country. Basically, they know you. Your insurance company doesn't know any of these things.

00:31:53.000 --> 00:31:59.000
What it has are coverage rules. Most of the time, those rules work reasonably well. Sometimes they don't.

00:31:59.000 --> 00:32:04.000

And that's when physicians and patients need to advocate for individualized care.

00:32:04.000 --> 00:32:16.000
So, the goal isn't to fight insurance companies. The goal is to make sure the insurance rules don't override good medical judgment.

00:32:16.000 --> 00:32:25.000
So that is it in a nutshell. They're going to make rules that decide what CLL treatment is quote “best”.

00:32:25.000 --> 00:32:31.000
Your doctor looks at you and decides what treatment is best for you.

00:32:31.000 --> 00:32:34.000
Your job is to make sure…

00:32:34.000 --> 00:32:45.000
that you get what your doctor wants rather and what you want, rather than what the insurance company wants. And again, it's a paperwork issue.

00:32:45.000 --> 00:32:52.000
Well, that segues really nicely into the next slide on our next poll question.

00:32:52.000 --> 00:33:01.000
Have you ever had your treatment delayed or denied? We should probably say, due to insurance issues.

00:33:01.000 --> 00:33:09.000
So not because your doctor didn't, you know, is denying you something, but your insurance company denied or delayed you access.

00:33:09.000 --> 00:33:14.000
The answer choices are yes for a BTK inhibitor.

00:33:14.000 --> 00:33:17.000
Yes, for a different medication.

00:33:17.000 --> 00:33:20.000
No, never.

00:33:20.000 --> 00:33:24.000
Or not sure or I don't remember.

00:33:24.000 --> 00:33:28.000
And it is not uncommon…

00:33:28.000 --> 00:33:32.000
for patients to not be sure.

00:33:32.000 --> 00:33:35.000
And say a bit more about that, Kay. Why is that?

00:33:35.000 --> 00:33:38.000
A lot of it's going on behind the scenes.

00:33:38.000 --> 00:33:48.000
So, your doctor may have looked at your insurance before you've even walked into the office, right? So, they know what is the…

00:33:48.000 --> 00:34:06.000
easiest treatment to get through your insurance. They know what's the least expensive, they know what's likely to get approved for today, so that you can get your treatment right away. They know, they may very well know those things before you even walk into the office.

00:34:06.000 --> 00:34:14.000
And all of these prior authorization things, all of these step therapy things, formulary issues aren't…

00:34:14.000 --> 00:34:30.000
affecting things from your perspective. They're affecting things before the decisions are even made. So, I mean, one thing that you can do when you speak with your clinician is ask, ask them whether and how much whether or not,

00:34:30.000 --> 00:34:33.000
if insurance issues didn't matter,..

00:34:33.000 --> 00:34:39.000
what treatment would they prescribe, and just see if you get a different answer, and whether it's worth,..

00:34:39.000 --> 00:34:42.000
you know, and discuss that with your clinician.

00:34:42.000 --> 00:34:51.000

And I know we'll get into that more in a minute. Why don't we go ahead and see the poll results on this one before we keep going?

00:34:51.000 --> 00:35:08.000
Very surprising. No, never. So, I think to Kay's point a moment ago, we really should be perhaps including in our discussions with our physicians, would you have chosen a different medication for me today had it not been but for…

00:35:08.000 --> 00:35:15.000
insurance-related issues. I think that's a really good question, Kay, to arm our community with so that…

00:35:15.000 --> 00:35:24.000
do they really know whether something is being denied to them by insurance and already factored into the doctor's decisions.

00:35:24.000 --> 00:35:38.000
And then, yeah, almost 20% said, yes, they have in fact for a different medication, not a BTK inhibitor, but for a different medication, had their treatment delayed due to insurance issues.

00:35:38.000 --> 00:35:44.000
And that might be related to a combination with venetoclax or any of those things…

00:35:44.000 --> 00:35:46.000
which I know you'll talk about in a little bit.

00:35:46.000 --> 00:35:49.000
Yeah, absolutely.

00:35:49.000 --> 00:35:51.000
So,

00:35:51.000 --> 00:35:53.000
want to keep going?

00:35:53.000 --> 00:35:56.000
Absolutely, let's do that.

00:35:56.000 --> 00:36:00.000
Okay.

00:36:00.000 --> 00:36:03.000

Step therapy.

00:36:03.000 --> 00:36:10.000
It's a problem. And we touched upon it briefly in kind of explaining what it is.

00:36:10.000 --> 00:36:16.000
So, in a way, this is one of my favorite slides because I think it represents a really important development for patients

00:36:16.000 --> 00:36:22.000
Step therapy is built on a really simple assumption. It assumes one drug can be substituted for another.

00:36:22.000 --> 00:36:26.000
Okay, in some diseases, that's a reasonable assumption.

00:36:26.000 --> 00:36:42.000
In CLL, not so much. Your oncologist isn't necessarily choosing a BTK inhibitor because it's their favorite. They're looking at you and your cardiovascular history, whether or not you have headaches, your bleeding risk, drug interactions, all the things we talked about before…

00:36:42.000 --> 00:36:48.000
the patient-specific factors. And those factors really matter.

00:36:48.000 --> 00:36:54.000
And something that I think is pretty exciting is that…

00:36:54.000 --> 00:36:59.000
NCCN, that's the National Comprehensive Cancer Network,..

00:36:59.000 --> 00:37:00.000
and

00:37:00.000 --> 00:37:05.000
NCCN puts out guidelines, and one of the reasons they did it is…

00:37:05.000 --> 00:37:12.000
they wanted to make sure that the care that people receive at comprehensive cancer centers…

00:37:12.000 --> 00:37:16.000
is accessible to patients who aren't close to one of their centers.

00:37:16.000 --> 00:37:37.000
And the way they do that is they put the guidelines out there. They put the guidelines there so that they're accessible. And those guidelines are hugely important. They're important enough that Congress and CMS said, hey, look at NCCN guidelines and make sure that whatever you're doing with your formulary, with your coverage policies…

00:37:37.000 --> 00:37:41.000
aligns with NCCN guidelines.

00:37:41.000 --> 00:37:42.000
And…

00:37:42.000 --> 00:37:47.000
NCCN recently made very explicit what CLL…

00:37:47.000 --> 00:37:55.000
clinicians have understood for a really long time, and that's that BTK inhibitors are not necessarily interchangeable, and they're not interchangeable…

00:37:55.000 --> 00:37:59.000
for some patients, they're very much not interchangeable.

00:37:59.000 --> 00:38:12.000
And that sounds, the change that they made sounds like a small wording change, but it isn't. Since Part D plans are expected to have coverage policies consistent with accepted clinical guidelines,..

00:38:12.000 --> 00:38:17.000
once NCCN said the drugs aren't interchangeable,..

00:38:17.000 --> 00:38:25.000
it becomes or should become much harder to justify forcing patients to fail one BTK inhibitor before receiving another….

00:38:25.000 --> 00:38:29.000
without any clinical rationale. So,..

00:38:29.000 --> 00:38:32.000
basically, NCCN is saying…

00:38:32.000 --> 00:38:43.000

these aren't interchangeable. NCCN says, look at patient-specific factors and that the clinician makes the treatment. The treating clinician…

00:38:43.000 --> 00:38:45.000
makes the treatment decision.

00:38:45.000 --> 00:38:47.000
So,..

00:38:47.000 --> 00:38:55.000
the right BTK inhibitor depends on the patient, not the price, and not the cost to the plan.

00:38:55.000 --> 00:38:56.000
So,..

00:38:56.000 --> 00:38:59.000
suppose your insurance company still says no.

00:38:59.000 --> 00:39:04.000
If we go to the next slide, we can talk about what to do next.

00:39:04.000 --> 00:39:13.000
As you get into talking about what to do, I want to just make sure we answer a couple of questions here.

00:39:13.000 --> 00:39:28.000
We have a question about whether zanubrutinib and acalabrutinib will be affected the same or differently, and where does Jaypirca fit, I'm never going to say that right, Jaypirca fit into the mix as well.

00:39:28.000 --> 00:39:29.000
Yeah.

00:39:29.000 --> 00:39:35.000
I expect, and I'm going to use initials if I have trouble pronouncing that.

00:39:35.000 --> 00:39:44.000
Well, the questioner used the brand name of the drug, so I'm just repeating it back to you.

00:39:44.000 --> 00:39:45.000
Okay.

00:39:45.000 --> 00:39:54.000
And I'm going to not repeat it. Because I saw, sometimes you say easy for you to say this time I saw one, so I'm laying off of it.

00:39:54.000 --> 00:39:55.000
So,..

00:39:55.000 --> 00:40:00.000
we do expect to see a lot more…

00:40:00.000 --> 00:40:10.000
prior authorization, tougher prior authorization, and potentially step therapy. And we expect to see that on “J”, and we expect to see that on “Z”.

00:40:10.000 --> 00:40:12.000
Okay.

00:40:12.000 --> 00:40:21.000
And that's because on both of those it's because they cost the insurance company more…

00:40:21.000 --> 00:40:31.000
and it's simply that. So, they may want you to try a different drug. They may want you to try a drug that they've made a better deal with the manufacturer with.

00:40:31.000 --> 00:40:37.000
But that's, that's what we expect to see is a bit…

00:40:37.000 --> 00:40:41.000
more of a squeeze on “J” and “Z”,..

00:40:41.000 --> 00:40:55.000
and less of a squeeze on “I” and “B”. And when we get to combination therapy, I think we're going to be, I think we already do see logistics problems on that one. So,..

00:40:55.000 --> 00:41:01.000
let's move from understanding what step therapy denials are…

00:41:01.000 --> 00:41:07.000
to how we might solve them.

00:41:07.000 --> 00:41:12.000

So, if your insurance company says we want you to try a different BTK inhibitor first,..

00:41:12.000 --> 00:41:16.000
don't assume the conversation is over.

00:41:16.000 --> 00:41:19.000
Like a denial, it's often just the beginning.

00:41:19.000 --> 00:41:28.000
And remember that your insurance company is looking at cost. Your physician is looking at you. Those are two very different questions.

00:41:28.000 --> 00:41:32.000
So NCCN guidelines…

00:41:32.000 --> 00:41:40.000
very much give a strong foundation for an appeal, a reconsideration, a peer to peer,..

00:41:40.000 --> 00:41:53.000
any of those things, instead of simply saying, I prefer this medication, your doctor can now say nationally recognized treatment guidelines that Part D plans are required to a day or two…

00:41:53.000 --> 00:42:11.000
say that these BTK inhibitors are not interchangeable. So, I mean, this isn't about one drug being better. It's about recognizing that different patients need different drugs. And who knows? It's not the insurance company, because they're making one big decision for the entire, their entire cover population.

00:42:11.000 --> 00:42:14.000
It's your doctor, your doctor who knows you.

00:42:14.000 --> 00:42:27.000
And most oncology offices deal with these every day. I will tell you that it is incredibly, incredibly burdensome, but…

00:42:27.000 --> 00:42:34.000
it is less burdensome once you and your clinician know how to frame these appeals.

00:42:34.000 --> 00:42:43.000
So, what does that appeal look like if we want to go to the next slide?

00:42:43.000 --> 00:42:45.000

Okay, the first thing,..

00:42:45.000 --> 00:42:49.000
ask for an expedited clinical exception.

00:42:49.000 --> 00:42:56.000
Time matters most in cancer care. So, this slide is really an action plan for step therapy.

00:42:56.000 --> 00:43:04.000
If step therapy is standing between you and the treatment your clinician prescribed or would have preferred to prescribe,..

00:43:04.000 --> 00:43:06.000
if you don't,..

00:43:06.000 --> 00:43:19.000
if you don't know, then don't, don't settle for that initial answer. Talk to your team, your care team, and ask whether an expedited clinical exception is appropriate. And the key word is expedited.

00:43:19.000 --> 00:43:29.000
Cancer treatment isn't something patients should have to wait weeks to sort out or months or submit documentation multiple, multiple times.

00:43:29.000 --> 00:43:38.000
And going through an appeal isn't saying we don't like your rules. It's saying these rules don't fit this patient. They don't fit this patient and this drug.

00:43:38.000 --> 00:43:49.000
And one thing I've learned is that individualized medicine doesn't stop when your doctor writes a prescription. Sometimes individualized medicine also means individualized insurance review.

00:43:49.000 --> 00:43:56.000
So, if I could give everyone just a piece of advice, stay engaged.

00:43:56.000 --> 00:44:02.000
Stay engaged with your Part D plan and your clinician team, ask questions,..

00:44:02.000 --> 00:44:13.000
follow up. And if you're in the process of trying to push through something like step therapy, don't assume that silence means progress.

00:44:13.000 --> 00:44:28.000
So, let's suppose we're not looking necessarily at a step therapy issue. Let's imagine the problem happens at the pharmacy level. So, if we want to move to the next slide.

00:44:28.000 --> 00:44:30.000
Okay.

00:44:30.000 --> 00:44:32.000
Sometimes…

00:44:32.000 --> 00:44:41.000
you may find that your BTK inhibitor is denied or you get to the pharmacy and it's too expensive.

00:44:41.000 --> 00:44:53.000
Right? And when I say get to the pharmacy, I mean, you know, if this is going to a specialty pharmacy that's delivering it to you, you may hear from the pharmacy. You're interaction is not going to be over the counter, it's going to be by phone.

00:44:53.000 --> 00:45:00.000
So, first off, don't panic, don't get off the phone. Start asking questions.

00:45:00.000 --> 00:45:16.000
And this actually is a fairly practical slide. If you picture this, you get a call from the pharmacy. You're expecting them to say, oh, we've got your prescription. It's coming whenever, or you're looking online to see when it's being delivered. And instead you're told…

00:45:16.000 --> 00:45:19.000
insurance rejected the claim.

00:45:19.000 --> 00:45:21.000
And I can't imagine…

00:45:21.000 --> 00:45:27.000
very many more stressful moments than that. So, what I'd like you to do is first don't panic.

00:45:27.000 --> 00:45:29.000
Second,..

00:45:29.000 --> 00:45:34.000
don't simply walk away or get off the phone and say, okay, or any of that.

00:45:34.000 --> 00:45:48.000
You want to ask the pharmacist what's causing the pharmacist, or whoever you're on the phone with, what's causing the rejection. Is it prior authorization? Is it a need for more documentation? Is it formulary issue?

00:45:48.000 --> 00:45:52.000
Is it step therapy? Is it…

00:45:52.000 --> 00:45:59.000
something to do with, for example, they want you to pay $2,000…

00:45:59.000 --> 00:46:07.000
at, you know, for your first fill, and you're like, well, wait a minute, I'm on the, the prescription payment plan with Medicare. I'm supposed to pay monthly.

00:46:07.000 --> 00:46:18.000
That's another thing that could happen. The more specific the information you get, the easier it is for you and your oncology team and your care partner to solve the problem.

00:46:18.000 --> 00:46:21.000
So, the most important thing is…

00:46:21.000 --> 00:46:35.000
contact your clinician's office that same day. Don't wait until next week. Don't wait until two days from now. Treatment delays are much easier to solve when everyone knows about them early.

00:46:35.000 --> 00:46:37.000
So again,..

00:46:37.000 --> 00:46:45.000
most insurance problems are paperwork problems, and while paperwork problems are frustrating, they're usually solvable.

00:46:45.000 --> 00:46:49.000
And if the problem can't be solved immediately, there are still additional options.

00:46:49.000 --> 00:46:54.000
So, if we want to get to the next slide.

00:46:54.000 --> 00:46:59.000
Okay, so you have more resources than you may realize.

00:46:59.000 --> 00:47:07.000
Fortunately, patients aren't expected to navigate this stuff alone. You and your clinician…

00:47:07.000 --> 00:47:09.000
can act on your behalf.

00:47:09.000 --> 00:47:17.000
Your clinician can work with you on appeal rights, on reconsiderations, on all of those things.

00:47:17.000 --> 00:47:33.000
A lot of oncology offices have an entire staff behind them who work on these issues every single day. And manufacturers also often have patient support programs. Everyone has the same goal. They want to keep your treatment moving.

00:47:33.000 --> 00:47:45.000
So, for example, bridge programs can sometimes help prevent treatment interruption while insurance issues are being resolved, but they're not appropriate in every situation. They're absolutely worth asking about.

00:47:45.000 --> 00:47:52.000
The important thing is not to struggle with this by yourself.

00:47:52.000 --> 00:47:56.000
You want to let the people whose job it is to help, help.

00:47:56.000 --> 00:47:58.000
So,

00:47:58.000 --> 00:48:06.000
I think we have a poll question coming up. So, I'm curious about how many people have actually experienced step therapy. And we may have,..

00:48:06.000 --> 00:48:12.000
I expect we'll have pretty much a very similar set of answers as we head to the first one.

00:48:12.000 --> 00:48:20.000
Yeah, why don't we go ahead to the next poll question?

00:48:20.000 --> 00:48:27.000
So have you ever been asked to switch drugs or quote “try another one first”,..

00:48:27.000 --> 00:48:34.000
before your treatment was covered, before the treatment that was initially prescribed to you by your physician…

00:48:34.000 --> 00:48:36.000
was covered?

00:48:36.000 --> 00:48:46.000
So rather than a delay question, where you delayed in getting it, this time the question has to do with whether you were asked to try another one first.

00:48:46.000 --> 00:48:50.000
And your choices are yes, for my BTK inhibitor.

00:48:50.000 --> 00:48:53.000
Yes, for a different medication.

00:48:53.000 --> 00:48:54.000
No, never.

00:48:54.000 --> 00:49:00.000
Or not sure, I don't remember.

00:49:00.000 --> 00:49:08.000
And as you're thinking about that, and before we pull up the poll results, maybe I'll just take a moment here to…

00:49:08.000 --> 00:49:21.000
ask and maybe help answer a couple of questions along with Kay. Kay, one of the questions we've had is whether the things you're describing on the webinar today apply to Medicare as well as to Medicare Advantage.

00:49:21.000 --> 00:49:27.000
And I think the answer is yes. In fact, maybe more so. But Kay,..

00:49:27.000 --> 00:49:29.000
Yes.

00:49:29.000 --> 00:49:38.000
So, if you have Medicare Advantage, you probably have a Medicare Advantage that has a Part D plan attached to it, right?

00:49:38.000 --> 00:49:45.000
If you have regular Medicare, you have fee-for-service, claims get submitted….

00:49:45.000 --> 00:49:49.000
and your prescription drugs go through a Part D plan.

00:49:49.000 --> 00:49:58.000
So basically, everyone, whether you're Medicare Advantage or Medicare fee-for-service,..

00:49:58.000 --> 00:50:06.000
you're still, if you're looking at BTK inhibitors at oral treatments, you're still dealing primarily with Part D.

00:50:06.000 --> 00:50:09.000
There are some…

00:50:09.000 --> 00:50:19.000
pushes and shoves and things like that that are going to make the Medicare Advantage side for your doctor's office look a little bit…

00:50:19.000 --> 00:50:22.000
more difficult. And that's going to be because…

00:50:22.000 --> 00:50:26.000
a lot of,..

00:50:26.000 --> 00:50:30.000
for example, if you have an oncologist who is…

00:50:30.000 --> 00:50:41.000
giving Medicaid, not giving, where you're getting your medications directly from your clinician's office, or from or if you're at a hospital, from the hospital pharmacy,...

00:50:41.000 --> 00:50:51.000
if it's Medicare Advantage, and if it's one of these drugs that has, you know, been through Medicare negotiation, and that's only “I”,..

00:50:51.000 --> 00:51:04.000
ibrutinib first. Next year it'll be acalabrutinib, which is going to be a much bigger volume problem.

00:51:04.000 --> 00:51:13.000

You're going to see that impacting Medicare Advantage patients a lot more, I believe, when it comes to next year, just because of so many different…

00:51:13.000 --> 00:51:18.000
hands the money has to go through…

00:51:18.000 --> 00:51:28.000
because the pharmacy is going to pay whatever it is the pharmacy is supposed to pay, and then they're supposed to be made whole,..

00:51:28.000 --> 00:51:31.000
meaning get the negotiated price.

00:51:31.000 --> 00:51:37.000
By going through this transition of the transaction facilitator thing,..

00:51:37.000 --> 00:51:48.000
and the Medicare Advantage plan is kind of in the middle on that, so right now we're seeing without Medicare Advantage, it's taking over a month for pharmacies to get their money.

00:51:48.000 --> 00:51:58.000
When you add Medicare Advantage to it, it's going to be much, much longer. So that's something I think we're going to be looking at next year.

00:51:58.000 --> 00:51:59.000
Yeah.

00:51:59.000 --> 00:52:00.000
Is.

00:52:00.000 --> 00:52:13.000
I think we've done, I know we have done previous webinars that should be available on our website on the difference between Medicare and Medicare Advantage plans, and I think it's worth, given how many questions we have,..

00:52:13.000 --> 00:52:32.000
I would refer us to that webinar as well, and we'll certainly make sure there's a link to it in the follow-up that we send out to attendees today. But please don't think that a lower cost, initially lower cost, Medicare Advantage plan…

00:52:32.000 --> 00:52:44.000

is necessarily beneficial. These same issues will be happening in a Medicare Advantage plan, and as Kay just said, maybe even more exacerbated than what you're seeing in a traditional plan.

00:52:44.000 --> 00:53:01.000
And the lower cost is, while important to help us all manage costs in our healthcare costs, there is an offset in the amount of time and effort and trials and tribulations you'll go through in a Medicare Advantage plan.

00:53:01.000 --> 00:53:20.000
And that will be true whether even though Medicare Advantage plans do have to follow NCCN guidelines as well, and it will be true whether you've been on a treatment already for a year and are being asked again to go through and provide all this documentation and all the different…

00:53:20.000 --> 00:53:28.000
scenarios Kay is laying out. That will be true regardless, unfortunately, whether you've been on your treatment already or not.

00:53:28.000 --> 00:53:34.000
Saira, if it's good with you, we got a couple questions in advance,..

00:53:34.000 --> 00:53:36.000
it's okay if I.

00:53:36.000 --> 00:53:37.000
Yeah, please.

00:53:37.000 --> 00:53:38.000
Answer a couple of those right now. Okay.

00:53:38.000 --> 00:53:39.000
Yeah.

00:53:39.000 --> 00:53:41.000
One was…

00:53:41.000 --> 00:53:47.000
whether there are any changes were coming up on the pricing of acalabrutinib.

00:53:47.000 --> 00:53:54.000
And this is, this individual suggested that they were going to potentially be changing their Part D plan…

00:53:54.000 --> 00:54:09.000
to accommodate potentially needing that, that drug, which is super smart. The pricing changes are not going to impact, the pricing changes themselves. When we see next year,..

00:54:09.000 --> 00:54:12.000
negotiated price will kick in…

00:54:12.000 --> 00:54:30.000
for acalabrutinib. So yes, that will be happening. Will it affect what you pay for it, what your out-of-pocket costs? Will it affect that directly? No. Not over the entirety of the year. You may see slight differences in what,..

00:54:30.000 --> 00:54:33.000
you know, first fill...

00:54:33.000 --> 00:54:38.000
charges, it will definitely be all the way up to the maximum. So…

00:54:38.000 --> 00:54:54.000
you're not going to really see that. But what you will probably be seeing is more prior authorization next year. And when you look at which plans, please be sure, don't just look at the formulary itself,..

00:54:54.000 --> 00:55:03.000
plans have all sorts of documents behind that. Make sure that you're looking at the information on the exact plan that you're thinking about enrolling in.

00:55:03.000 --> 00:55:09.000
Because if you're looking at something like a United Healthcare or whatever, you're going to be seeing…

00:55:09.000 --> 00:55:24.000
a ton of different formularies that they have. Make sure you're looking at the right one. And don't just look at whether or not the particular drug's included. Go deeper on that and look into what types of utilization management…

00:55:24.000 --> 00:55:39.000
they are applying. They should have that information upfront and it should tell you whether it's prior authorization. You'll probably see that. I would expect you'd see that on almost all of them. Some of them are going to say prior authorization with step

00:55:39.000 --> 00:55:56.000
therapy. But make sure that when you enroll, that you know what you're, you know what the coverage rules look like for it. And if you see something different, if you see something, say something. Reach out to the CLL Society, reach out to your doctor,..

00:55:56.000 --> 00:56:05.000
let them know that what this, you switched plans specifically to be able to accommodate this treatment that you absolutely need…

00:56:05.000 --> 00:56:13.000
and what you're seeing from the plan is completely different from what you saw that made you think enrolling with them was a good idea.

00:56:13.000 --> 00:56:14.000
So.

00:56:14.000 --> 00:56:34.000
Yeah, I want to highlight that point that Kay, you just made about reaching out to the CLL Society. It was due to outreach to the CLL Society that in fact the CLL Society spearheaded the effort to get a change made to the NCCN guidelines that Kay referenced earlier.

00:56:34.000 --> 00:56:49.000
And so hearing from you all in response to what you're hearing today, in response, I'll discuss in a minute at the end of our webinar, a survey we'll be sending out to you all about some of these experiences.

00:56:49.000 --> 00:57:02.000
And then also, we'll be putting together a toolkit. So, you don't necessarily have to take notes on every single thing Kay is suggesting you do, because we will be working on a toolkit to distribute to patients and to providers…

00:57:02.000 --> 00:57:30.000
later this year, and so actually at the end of, once we have your survey results, we'll then be able to prepare the toolkit. So, all these things should be responsive to the kinds of experiences you're having. And yes, we hear from some of you, but we certainly would like to hear from more of you.

00:57:30.000 --> 00:57:31.000
Yeah.

00:57:31.000 --> 00:57:37.000

So, I really appreciate, Kay, the shout out to reach out to the CLL Society as you're experiencing these different things. And while we can't tell you what the right Part D plan is for you or exactly what is being…

00:57:37.000 --> 00:57:52.000
sort of where which drugs will be stepped through or see other utilization management happening in your particular plan, we will provide in the toolkit, as Kay is talking about today, which is where to look…

00:57:52.000 --> 00:57:56.000
for some of these roadblocks, if you will.

00:57:56.000 --> 00:58:05.000
And I had another question from an individual with a Medicare Advantage plan through BCBS of Florida…

00:58:05.000 --> 00:58:25.000
and it's multiple parts. The first part acknowledges something that is very frustrating to patients. You enroll in Medicare Advantage, you find that it is a monster to deal with. Your clinician that you were using before is no longer with them, et cetera, et cetera, et cetera. Lots of changes.

00:58:25.000 --> 00:58:40.000
But you can't go to Medicare fee-for-service and get a supplemental very easily because you can get denied on the supplemental or they can just charge you way too much money. Make it very, very unaffordable. One thing…

00:58:40.000 --> 00:58:43.000
that I think all of this chaos…

00:58:43.000 --> 00:58:46.000
may be giving a bit of a…

00:58:46.000 --> 00:58:59.000
silver lining for patients who are not happy being in Medicare Advantage and feel like they're stuck. Keep an eye on the plan you're enrolled in. There is at least some, if not a lot, of…

00:58:59.000 --> 00:59:13.000
kind of departures from Medicare Advantage, your plan may no longer be offered. The issuer, the under, you know Blue Cross Blue Shield, for example, Cigna, may no longer be working

00:59:13.000 --> 00:59:18.000
you know, doing plans in your area. If that happens, you do…

00:59:18.000 --> 00:59:35.000
have the ability to go back to Medicare fee-for-service with a Medicare supplement that does not have that medical underwriting, meaning they're not going to ask you for, you know what kind of conditions you have. They're not going to look and see you, see that you have CLL, know you're expensive, and just charge you an arm and a leg. None of that's going to happen.

00:59:35.000 --> 00:59:39.000
The other thing is that…

00:59:39.000 --> 00:59:48.000
always remember that as much as there may be some interplay with this, is the BTK inhibitors are Part D…

00:59:48.000 --> 00:59:50.000
right? So,..

00:59:50.000 --> 00:59:55.000
those are Part D drugs. So, whatever you're,..

00:59:55.000 --> 01:00:06.000
you've got it's not going to necessarily be Medicare Advantage itself. It's going to be the Part D plan associated with it, probably run by the same company, but…

01:00:06.000 --> 01:00:09.000
slightly different.

01:00:09.000 --> 01:00:13.000
One of the other questions was about cost.

01:00:13.000 --> 01:00:27.000
That these medications are expensive and yes, they are. The good news is that there is a cap. There's a cap. It's I believe 2,100 now. Next year it'll go up. It goes up each year. It'll go up each year, maybe 2,200. But then,..

01:00:27.000 --> 01:00:43.000
the other part of it is that you can divide what you pay over time over the entire plan year. So, you don't have to pay the whole amount right up front. Instead, you enroll in the Medicare payment program,..

01:00:43.000 --> 01:00:58.000
you have, you fill your prescription, you stop paying for drugs when they're delivered, you don't have to give a credit card or anything else to the specialty pharmacy. If you go to the pharmacy counter, you don't have to give them any money. Everything is much smoother.

01:00:58.000 --> 01:01:06.000
So, it is huge as far as making it easier for Medicare beneficiaries.

01:01:06.000 --> 01:01:07.000
And I think.

01:01:07.000 --> 01:01:14.000
Why don't we take a look at the poll question results?

01:01:14.000 --> 01:01:26.000
So the question was, have you ever been asked to switch drugs to try another one first before your treatment was covered? And it seems like well over half said, no, that has never happened to them.

01:01:26.000 --> 01:01:36.000
Almost 20% said yes, in fact, that has happened to them, but not for a BTK inhibitor, but for a different medication.

01:01:36.000 --> 01:01:38.000
Okay, any thoughts on that?

01:01:38.000 --> 01:01:44.000
This really does mirror what we saw on the prior authorization question.

01:01:44.000 --> 01:01:53.000
And it's different from what we're hearing from clinicians, which kind of makes me think that a lot of the…

01:01:53.000 --> 01:02:05.000
things that are there that patients may not see them, that the clinician's office, if you're getting the exact prescription, it's because your doctor's office has been fighting…

01:02:05.000 --> 01:02:08.000
for you to be able to get your prescription.

01:02:08.000 --> 01:02:25.000

There's also the possibility that, you know, if your doctor believes that one is as good as the other, they may very well decide to go with the one that's easiest to get through your insurance, which, you know, that's, and again, this is one of the reasons that we suggested earlier…

01:02:25.000 --> 01:02:34.000
that when you're talking to your physician, when you're putting together a treatment plan, you know, as you're asking questions, ask a question about…

01:02:34.000 --> 01:02:43.000
insurance, how much that's kind of influencing. Not that your doctor's going to give you something that doesn't work because it's easier, but…

01:02:43.000 --> 01:03:02.000
is there something they might have done, might do differently if not for insurance?

01:03:02.000 --> 01:03:03.000
Oh, sure.

01:03:03.000 --> 01:03:07.000
Okay, I know Kay is going to switch gears now and start and talk a little bit about fixed duration therapy. We do have a couple of questions about supplemental insurance Kay. So, I might just say very briefly that a Medicare plan allows you to buy…

01:03:07.000 --> 01:03:20.000
a part, a Part D plan and a supplement, whereas a Medicare Advantage plan does not, and a supplement, supplemental plan is just an additional coverage for your out-of-pocket costs….

01:03:20.000 --> 01:03:22.000
but not Part D out-of-pocket costs.

01:03:22.000 --> 01:03:24.000
But not Part D out-of-pocket costs.

01:03:24.000 --> 01:03:33.000
I know when you say for your out-of-pocket costs, it sounds so awesome, right? But no, not your Part D out-of-pocket costs.

01:03:33.000 --> 01:03:35.000
So yeah.

01:03:35.000 --> 01:03:37.000

Great.

01:03:37.000 --> 01:03:38.000
Thank you, Kay.

01:03:38.000 --> 01:03:40.000
Supplemental. You are very welcome.

01:03:40.000 --> 01:03:43.000
Okay.

01:03:43.000 --> 01:03:46.000
All right, so…

01:03:46.000 --> 01:03:49.000
let me find where my…

01:03:49.000 --> 01:03:53.000
and I do apologize, I was flipping around…

01:03:53.000 --> 01:03:57.000
on the slides that I have in front of me.

01:03:57.000 --> 01:04:00.000
You're starting slide 24 at fixed duration.

01:04:00.000 --> 01:04:05.000
You got it.

01:04:05.000 --> 01:04:07.000
As I scroll through and again, I apologize.

01:04:07.000 --> 01:04:14.000
That's all right. Why don't I take a minute to deal with a couple of extra questions that have come in.

01:04:14.000 --> 01:04:29.000
So, we had a question that talks about changing, trying to change from an advantage plan to a supplemental. And I think we've helped answer that question that a supplement is separate from an Advantage plan. Your choices are Medicare versus Medicare Advantage.

01:04:29.000 --> 01:04:45.000

And it's hard to go back to traditional Medicare after being on a Medicare Advantage plan and our other webinar covers that in detail. The exception, which is really important to pay attention to, as Kay said, is if your Medicare Advantage plan goes away for some reason.

01:04:45.000 --> 01:04:51.000
So we can, let me see if I can take care of any others while you're looking for your spot.

01:04:51.000 --> 01:04:54.000
Are you ready, Kay?

01:04:54.000 --> 01:05:03.000
I am just about ready. I think that on the Medicare supplement issue, it is really, really important…

01:05:03.000 --> 01:05:08.000
for people to make sure that they understand that if their plan…

01:05:08.000 --> 01:05:24.000
is no longer available, if their insurer is no longer operating in you know offering plans that that whole thing about not being able to switch is no longer true. And a lot of people don't know that.

01:05:24.000 --> 01:05:38.000
So, make sure you keep that in mind. And if you, you know, if you are unhappy with Medicare Advantage, and you look at, oh, no, my plan's not, I have to find a different plan, instead of thinking I have to find a different plan, it's a decision point.

01:05:38.000 --> 01:05:48.000
Do I want to go to Medicare fee-for-service with a supplement, or do I want to stay in Medicare Advantage? And you're going to want to kind of look at the costs of each of them.

01:05:48.000 --> 01:05:49.000
Okay, so.

01:05:49.000 --> 01:06:04.000
Yeah. And for people in transition and because we had a decent number of people not yet on Medicare, I do want to make note that watching that webinar on Medicare versus Medicare Advantage or listening to what we're saying today may help you understand why the financial…

01:06:04.000 --> 01:06:20.000

behind the scenes stuff that is going on and driving these issues is very different from your employer plan or an ACA plan versus when you transition onto Medicare. So, it's really important to understand that, yes, all these things that you may not have experienced before…

01:06:20.000 --> 01:06:24.000
Perhaps, will be new things you will experience going forward.

01:06:24.000 --> 01:06:30.000
Absolutely. Okay, so this is exciting because it's…

01:06:30.000 --> 01:06:40.000
one of the biggest changes in CLL over the past few years, and that's been the availability of fixed duration combination therapy. And what that means is…

01:06:40.000 --> 01:06:45.000
instead of having one BTK inhibitor…

01:06:45.000 --> 01:06:55.000
that you're going to be taking continuously until it's either no longer working or you'd no longer tolerate it, instead of that…

01:06:55.000 --> 01:06:58.000
you're going to get two...

01:06:58.000 --> 01:07:04.000
cancer drugs, a BTK inhibitor, and another drug, venetoclax, that…

01:07:04.000 --> 01:07:12.000
together will be given to you over a shorter period of time, and it's a fixed time, 12 to 14 months, approximately.

01:07:12.000 --> 01:07:20.000
So as much as it's exciting in that way, it also creates a different insurance experience.

01:07:20.000 --> 01:07:31.000
What we have now is that patients are excited. They like the idea of eventually stopping treatment instead of taking medication indefinitely.

01:07:31.000 --> 01:07:39.000
But the catch is that since there are two specialty drugs instead of one, there are two opportunities for insurance paperwork…

01:07:39.000 --> 01:07:43.000
and you can expect that you will be running into that.

01:07:43.000 --> 01:07:48.000
Insurance companies don't necessarily become simpler just because medications get better.

01:07:48.000 --> 01:07:56.000
What one of the biggest problems that we see is a logistics problem. And the question,..

01:07:56.000 --> 01:08:03.000
even though it's backed by guidelines, NCCN guidelines in particular,..

01:08:03.000 --> 01:08:05.000
you're going to have…

01:08:05.000 --> 01:08:13.000
a logistics problem and we can go through that if we move to the next slide.

01:08:13.000 --> 01:08:14.000
Okay.

01:08:14.000 --> 01:08:32.000
So, you're going to be seeing prior authorization on both drugs. And unfortunately, even though this combination has been in NCCN guidelines for a while, and now acalabrutinib plus venetoclax is on label,..

01:08:32.000 --> 01:08:53.000
a lot of insurers haven't really updated their claims processing systems. They see a claim for one drug, they put it through the rules for that drug. They see a claim for the other drug, they put it through the rules for that drug. So almost always you're going to end up with a prior authorization that is good for one year. Well, what if your treatment is 14 months? You have that…

01:08:53.000 --> 01:08:58.000
little period of time that you've got to make sure you reauthorize.

01:08:58.000 --> 01:09:06.000
There's also a ramp up on venetoclax. It starts low, steps up over a five week schedule..

01:09:06.000 --> 01:09:12.000
so your prescriber is going to be prescribing a certain amount and…

01:09:12.000 --> 01:09:19.000
Quality, quantity limits at the pharmacy can make it, you know, difficult for you to be able to…

01:09:19.000 --> 01:09:22.000
have that combo…

01:09:22.000 --> 01:09:25.000
aligned with the policies on the drug alone.

01:09:25.000 --> 01:09:34.000
One thing that is super important is remember that mid-treatment decisions are incredibly, incredibly…

01:09:34.000 --> 01:09:51.000
difficult to deal with. You don't want to wait until your treatment schedule to begin before asking whether both medications have been approved. Since this is a logistics problem, and you probably are going to need to get some blood work done,..

01:09:51.000 --> 01:09:54.000
various check-ins, etc, etc.,..

01:09:54.000 --> 01:10:02.000
talk to your doctor before you're scheduled to start on a combo therapy. Make sure that they have gotten,..

01:10:02.000 --> 01:10:09.000
you know, everything approved through the insurance company before you even start.

01:10:09.000 --> 01:10:12.000
And to me, that's…

01:10:12.000 --> 01:10:20.000
one of the very, very biggest things. Most of these problems can be prevented if you get this paperwork sorted out early.

01:10:20.000 --> 01:10:27.000
And then, if we want to move to the next slide.

01:10:27.000 --> 01:10:30.000
Okay, so…

01:10:30.000 --> 01:10:37.000

when I think about what is the big idea on this, it's to keep the treatment plan intact, right?

01:10:37.000 --> 01:10:42.000
Combination therapy is very carefully designed,…

01:10:42.000 --> 01:10:53.000
mid-course changes, delays, etc. It's not just inconvenience. They can disrupt the treatment strategy your physician selected. And that's one reason that…

01:10:53.000 --> 01:11:08.000
as we talk a little bit later, some of the newer Medicare protections are going to be especially important. Plans can't simply just say, oh, well, we're changing, we're not going to be offering acalabrutinib anymore.

01:11:08.000 --> 01:11:14.000
Right? Where instead we're going to have everyone start on zanu, you know “Z”.

01:11:14.000 --> 01:11:30.000
They can't do that without giving you particular rights. And I see you smiling on my use of the initial, Saira. But, and that's really important, and that's going to be important as we because right now, say you're starting a combo therapy, a fixed duration combination therapy…

01:11:30.000 --> 01:11:47.000
next week, right? We're looking at the end of, we can just call it August for practical purposes. You're going to be going into the next plan year. So, what if you change Part D plans? What if your plan is no longer available, et cetera, et cetera. These are things that you need to work out…

01:11:47.000 --> 01:12:02.000
well before. So, if you're going to be starting a fixed duration treatment this year, it's going to be going into the next year, make sure that if you switch plans, that all of those little things are worked out. Also, next year,..

01:12:02.000 --> 01:12:16.000
acalabrutinib is going to be one of the negotiated drugs. Your plan, as much as they like it better than “Z” this year, next year they may not. And they may want you to go switch to “Z”. Well,..

01:12:16.000 --> 01:12:31.000
you can't, that's not something that your doctor is going to want you to do. They don't want to work through the insurance denial process, take a month while you're mid-

treatment. So, make sure that anything, any of those things that happen are thought of in advance and dealt with before,..

01:12:31.000 --> 01:12:37.000
before you even get moving. And if that's done, then things should be pretty smooth.

01:12:37.000 --> 01:12:44.000
Basically, plans can't just make significant changes in the middle of the year either…

01:12:44.000 --> 01:12:53.000
without triggering formal patient protections. So, if something changes unexpectedly, you want to ask questions immediately.

01:12:53.000 --> 01:13:03.000
So, if we want to move to the next slide, we can talk about some of the new appeals protections.

01:13:03.000 --> 01:13:06.000
Okay.

01:13:06.000 --> 01:13:16.000
Lawyers get excited anytime you say appeal rights, right? And I know that that puts me in a fairly small club, but this really does matter.

01:13:16.000 --> 01:13:21.000
And as I said, if your plan makes mid-year coverage changes,..

01:13:21.000 --> 01:13:35.000
you want to alert, alert, alert. It can't just stop covering without giving you formal notice. So, open your mail that you get from your Part D plan.

01:13:35.000 --> 01:13:46.000
I know it can often you get the same thing all the time and you tend not to look at it. Make sure you look at it. That notice that you get will trigger very important appeal rights.

01:13:46.000 --> 01:13:54.000
And it doesn't guarantee you'll always win, but they do guarantee that you have a process. And that process matters.

01:13:54.000 --> 01:13:59.000
So, you're going to get faster dispute resolution, meaning…

01:13:59.000 --> 01:14:12.000
24 to 72 hours. You should be able to leverage that these are oncology drugs and get it on the shorter end of that with 24 hours.

01:14:12.000 --> 01:14:31.000
So, they have to give you that appeal right before they even deny something. If they made a change and you're on something or if it affects you, they have to give you that appeal right before you've run out of your medication, before they've denied anything. So, it's important to remember that.

01:14:31.000 --> 01:14:46.000
They have a kind of a bit of a support for grandfathering, right? It's not an absolute guarantee, but it makes it a lot harder for plans to just abruptly switch you to a different drug while you're already stabilized.

01:14:46.000 --> 01:15:02.000
And the NCCN guidelines saying that they're not interchangeable certainly gives you a lot of ammunition. And if plans are not honoring those NCCN guidelines, we would really like to hear about it.

01:15:02.000 --> 01:15:07.000
Unfortunately, CMS would object to it, but they don't really have a line of sight into it.

01:15:07.000 --> 01:15:11.000
And unless we see what's happening on the ground, we can't fix it.

01:15:11.000 --> 01:15:15.000
So, if we want to move to the next slide.

01:15:15.000 --> 01:15:18.000
Got some takeaways.

01:15:18.000 --> 01:15:23.000
Basically, I just want you to know, you don't need to become a Medicare expert.

01:15:23.000 --> 01:15:30.000
You just need to know what to do. And Saira talked about toolkits and everything and everything else. But with what you've…

01:15:30.000 --> 01:15:35.000
heard today, hopefully what you've learned today,..

01:15:35.000 --> 01:15:37.000

you can remember four things. First,...

01:15:37.000 --> 01:15:39.000
don't panic.

01:15:39.000 --> 01:15:51.000
Insurance patterns are often administrative problems. And administrative problems, paperwork problems are fixable, right? Second, let your oncology team know early.

01:15:51.000 --> 01:15:56.000
Small problems can become big problems when no one knows about them.

01:15:56.000 --> 01:16:05.000
Third, don't assume a denial is the final answer. I mean, we saw early in this presentation…

01:16:05.000 --> 01:16:18.000
the number of denials that are on expensive treatments. It's pretty high. Seventy percent are going to get prior authorization. A lot are going to get denials first time they're submitted.

01:16:18.000 --> 01:16:30.000
Don't think of it as alarming. Think of it as, oh, well, I guess I fall into the 70%, didn't make it into 30% this time. And understand that it's not the final answer.

01:16:30.000 --> 01:16:41.000
And remember that treatment decisions should be individualized. Your physician knows you, and that's why their voice and your voice really, really matters.

01:16:41.000 --> 01:16:53.000
So, you don't need to memorize the Medicare rules or the crazy words that insurance companies use to describe things. You just need to recognize when something doesn't seem right.

01:16:53.000 --> 01:16:59.000
And when you notice that something doesn't seem right, ask for help.

01:16:59.000 --> 01:17:17.000
That's really helpful, Kay. What a nice way to summarize that. And I will, for those of you who did ask for various terminology and what it all means, even though Kay said you don't have to worry about all of it, please do refer back to the initial slides that provided a glossary of terms…

01:17:17.000 --> 01:17:21.000
and that may also help you answer some of those questions.

01:17:21.000 --> 01:17:36.000
I also want to take a moment now to answer a few other questions that are fairly nuts and bolts type questions, and then we'll be able to…

01:17:36.000 --> 01:17:37.000
and…

01:17:37.000 --> 01:17:38.000
I think be able to get to most of your questions at this point, but if we haven't yet answered them,..

01:17:38.000 --> 01:17:39.000
please remember. Oh, sorry, Kay.

01:17:39.000 --> 01:17:43.000
I'm sorry. I have…

01:17:43.000 --> 01:17:52.000
two more advanced questions that I want to make sure that I answer, that we answer those as well.

01:17:52.000 --> 01:17:56.000
Okay.

01:17:56.000 --> 01:17:57.000
Absolutely.

01:17:57.000 --> 01:17:58.000
Okay, you go first then. Why don't you cover those since people were kind enough to submit them in advance, let's deal with those first.

01:17:58.000 --> 01:18:08.000
Yes, early bird gets the something, right? Okay, so a question is on using CHAMPVA…

01:18:08.000 --> 01:18:11.000
as a Medicare eligible person,..

01:18:11.000 --> 01:18:18.000
and, and how that kind of works. So, if you have, you recently got approved for CHAMPVA,..

01:18:18.000 --> 01:18:25.000
that's a veterans program, and when you're Medicare eligible, in order to maintain…

01:18:25.000 --> 01:18:31.000
the CHAMPVA benefits, you're going to need to enroll in Part A and Part B, right?

01:18:31.000 --> 01:18:47.000
Now, when you think about Medicare Advantage, your CHAMPVA is going to be like a supplement, so you have a supplement, okay? You don't have to worry about paying for supplement, so you don't want to say, oh, well, you know, the supplements are really expensive, you already have CHAMPVA.

01:18:47.000 --> 01:18:53.000
It will be a premium free supplement, right? And it covers out-of-pocket costs.

01:18:53.000 --> 01:19:04.000
So that's one thing that's super important. And what you'll end up having is, you know, the doctor's going to submit the bill to Medicare, Medicare is going to pay…

01:19:04.000 --> 01:19:20.000
if it's a drug, then that goes through the Part D. Any of the balances, any of the co-payments, they automatically forward those to CAHMPVA. And it kind of puts you into a very special club that's different from people who are in…

01:19:20.000 --> 01:19:35.000
the regular Medicare with a supplement because the CHAMPVA is going to work with your Part D or what would be your Part D. It's going to work across the board, right? And you can see any doctor that accepts Medicare,..

01:19:35.000 --> 01:19:43.000
any hospital or hospital-based providers that accept Medicare, they all have to accept CHAMPVA.

01:19:43.000 --> 01:19:48.000
So hopefully that answers some of that question.

01:19:48.000 --> 01:19:53.000
The other question was on fixed duration…

01:19:53.000 --> 01:20:04.000
and about what we are expecting. Are these going to go through as two separate drugs? I would love to get that fixed. I would love to see it go through as…

01:20:04.000 --> 01:20:12.000
a combination regimen treatment plan. For the most part, most insurers have not done that yet.

01:20:12.000 --> 01:20:27.000
For right now, it's going through as two separate drugs. You've got the dose escalation issue, you've got the treatment plan lasting beyond 12 months, potentially crossing over, you know, over plan years…

01:20:27.000 --> 01:20:36.000
and also over calendar years where you might be switching plans. So, all of those things make it a logistics problem.

01:20:36.000 --> 01:20:40.000
And the other thing is, it's interesting because if…

01:20:40.000 --> 01:20:53.000
I would think that to the extent that there is stability in a Medicare Advantage plan, for example, the fixed duration ends up saving money over time.

01:20:53.000 --> 01:20:57.000
But since people switch plants so often,..

01:20:57.000 --> 01:21:08.000
plans have, you know, insurers have learned to look at the short term, right? So, they're going to be saying, oh, well, how much is it costing us this year? Because if they're going to be paying all of it this year…

01:21:08.000 --> 01:21:20.000
and then the next insurer ends up getting a break, right? They're not paying for anything. So that's why, unfortunately, even though it's cost effective, plans aren't necessarily seeing it that way.

01:21:20.000 --> 01:21:23.000
So, Saira, if you want to go with your questions.

01:21:23.000 --> 01:21:31.000
Well, a question on the question you just answered. Can you define what CHAMPVA is?

01:21:31.000 --> 01:21:34.000
Yes, it is a,..

01:21:34.000 --> 01:21:40.000
it's out of the Department of Defense and Veterans Administration.

01:21:40.000 --> 01:21:41.000
Okay.

01:21:41.000 --> 01:21:43.000
So it's,..

01:21:43.000 --> 01:22:01.000
yeah, it's like it's a benefit for veterans - veterans, spouses, dependents.

01:22:01.000 --> 01:22:02.000
Yeah.

01:22:02.000 --> 01:22:03.000
And do we have any general information on whether VA healthcare pharmacies are better than Medicare Part D pharmacies? I'm not exactly sure that they don't, in fact, overlap quite a bit, but I'm not sure we know that.

01:22:03.000 --> 01:22:08.000
But one thing is that, and this one, you know, CHAMPVA is for it's…

01:22:08.000 --> 01:22:20.000
not veteran. Yes, it's through Veterans Administration, but it's for the spouses and dependents, right? So, with CHAMPVA, you're not necessarily, you know, you're not necessarily a veteran yourself.

01:22:20.000 --> 01:22:30.000
Just to make sure that that's clear. But, you know, from what I understand, they have far fewer prior authorization issues.

01:22:30.000 --> 01:22:42.000
And I would expect that they're going to be also be a lot happier with fixed duration, right? Because they envision covering the entire patient for the patient's entire life.

01:22:42.000 --> 01:22:47.000
Right, so saving money two years from now sounds like a good idea.

01:22:47.000 --> 01:22:57.000
More to them. So, I think that the problem is that a lot of clinicians don't really understand how to work with CHAMPVA.

01:22:57.000 --> 01:23:09.000
But that's kind of been a learning curve. But they are absolutely required if they accept Medicare, then they absolutely must take it.

01:23:09.000 --> 01:23:25.000
Great. We have a really interesting question from someone about the 70% that you've referred to a few times. The 70% denials likely to happen 70% of the time and not to take that as a final answer.

01:23:25.000 --> 01:23:42.000
The question relates to whether all those denials, in fact, end up raising the cost of healthcare in the United States, and is this sort of because of all the cost of the administrative work for the doctor to resubmit the claim, et cetera, et cetera.

01:23:42.000 --> 01:23:58.000
And I'll let you answer that question, but relatedly, the question asked whether this is something we can take to Congress to address. And that gives me a chance to make a plug for the CLL Society's program where we are pulling together…

01:23:58.000 --> 01:24:13.000
and training ambassadors from among the patients in the community or caregivers in the community, and we'll be starting a dialogue with members of Congress in the House and in the Senate at the federal level about a number of these issues.

01:24:13.000 --> 01:24:29.000
So, continuing to hear about your experiences helps inform the kind of conversation we have with members of Congress at the CLL Society, but also there's an opportunity. This is the second year for the program that is kicking off this year.

01:24:29.000 --> 01:24:46.000
The first year was very successful. We had great feedback from the participants, and so if you are at all interested, you'll find information about our virtual fly-in, it's called or ambassadors program on our website

01:24:46.000 --> 01:24:55.000
But with respect to the first half of the question, how does it, you know, how would you say it raises healthcare costs with all this administrative work for the doctors, Kay?

01:24:55.000 --> 01:24:57.000
Yeah, yeah, I,..

01:24:57.000 --> 01:25:06.000

I don't think we have enough time to really let me go on a full rant, so I'll abbreviate it a bit. Okay, first off,..

01:25:06.000 --> 01:25:14.000
when you're looking at these denials, this 70% is probably automatic denials because most claims go through,..

01:25:14.000 --> 01:25:30.000
you know, a computer basically, right? And the computer has a specific what they call edits. You know, you see this drug for this diagnosis in this patient deny, deny, deny, deny, right? And a lot of times those edits are really…

01:25:30.000 --> 01:25:32.000
comprehensive…

01:25:32.000 --> 01:25:33.000
and…

01:25:33.000 --> 01:25:46.000
it's frustrating because yes, it does, it absolutely does increase costs. And it also transfers costs, okay? So, let's look at it this way.

01:25:46.000 --> 01:25:48.000
Plans…

01:25:48.000 --> 01:26:03.000
have what they call PBMx, pharmacy benefit managers, and those are the entities that put together the formulary. They say, okay, here's what we are going to do to help you control drug costs, right? They do the formulary, the utilization management, etc, etc.

01:26:03.000 --> 01:26:08.000
There's a whole lot more scrutiny and potentially limits on…

01:26:08.000 --> 01:26:11.000
what kind of money they can get.

01:26:11.000 --> 01:26:26.000
Historically, they, what they've been, what they have been doing is kind of done their own back alley deals with manufacturers to say, hey, look, you know, we're working for Blue Cross Blue Shield. If you want us to put you…

01:26:26.000 --> 01:26:36.000

at the very top of the food chain on all these Blue Cross Blue Shield plans, you've got to grease our palm, right? You've got to give us a rebate, and they get that rebate, and they don't pass the whole thing on…

01:26:36.000 --> 01:26:48.000
to the insurer that they're working for. Now, since those kinds of things have been closed up a bit, and you're going to see them close up further once acalabrutinib has a negotiated price,..

01:26:48.000 --> 01:27:04.000
then, the PBMs don't want to say, oh, well, we don't make as much money. They're going to be saying, so how do we make that much money? And one of the answers is things that they get paid on a, for lack of a better term, per click, right? The per-click things are going to be prior authorizations,..

01:27:04.000 --> 01:27:09.000
medical review, peer-to-peer appeals, all of those things.

01:27:09.000 --> 01:27:21.000
They get paid a flat fee for each of those, each prior authorization that requires them to look over documents, et cetera, et cetera. So, when they put the denial through and the claim is put in for a reconsideration…

01:27:21.000 --> 01:27:23.000
with documentation,..

01:27:23.000 --> 01:27:28.000
that PBM that put that claim edit in there is getting paid.

01:27:28.000 --> 01:27:31.000
And who pays? Well.

01:27:31.000 --> 01:27:56.000
Who pays is your doctor in the form of paperwork burden. You, in the form of delays in care potentially. And the healthcare system to a large degree. So yeah, it's frustrating. There are some things in the works and Saira's talk about Congress is hugely important, and we all were potentially going to be seeing something on these PBMs…

01:27:56.000 --> 01:27:59.000
coming down the pike…

01:27:59.000 --> 01:28:01.000
as far as CMS kind of…

01:28:01.000 --> 01:28:06.000
making it a lot more transparent, and putting some…

01:28:06.000 --> 01:28:09.000
reins on what they can do. Is that helpful, Saira?

01:28:09.000 --> 01:28:12.000
That's very helpful. Thank you.

01:28:12.000 --> 01:28:22.000
So, we have a question about whether patients can self-pay for these medications before all this paperwork and all this utilization management works itself out.

01:28:22.000 --> 01:28:25.000
Is that a possibility?

01:28:25.000 --> 01:28:27.000
If you get a denial,..

01:28:27.000 --> 01:28:34.000
that's interesting. Okay. I'm assuming and I'm going to check on this.

01:28:34.000 --> 01:28:38.000
But I would assume if you get a denial…

01:28:38.000 --> 01:28:42.000
and you go ahead and you pay for it, you get your medication, and you appeal…

01:28:42.000 --> 01:28:45.000
then that's how you would do it.

01:28:45.000 --> 01:29:00.000
Yeah, I think the cautionary note would be that even though, yes, we think of all of these as problems to be solved, all these denials and prior authorizations and utilization management, one can't guarantee that in the end it is a no.

01:29:00.000 --> 01:29:16.000
And so if that happens, your ability to recoup the money you spent, assuming that it was just a paperwork hurdle, is at risk. So, with that cautionary note, I think, I think there's

01:29:16.000 --> 01:29:19.000
you know, value to your suggestion in the quest,to the suggestion in the question.

01:29:19.000 --> 01:29:26.000
And the better play to some extent would be to request..

01:29:26.000 --> 01:29:29.000
emergency…

01:29:29.000 --> 01:29:45.000
dispensing, right? And that's basically saying, hey, look, you know, I've got cancer. I need my treatment. I need my treatment now. I know you guys have things that you want to work out. We're pretty sure we're going to be successful. Look at the NCCN guidelines. Look at, you know, et cetera, et cetera.

01:29:45.000 --> 01:29:55.000
You need to dispense this medication to me for this period of time so that you can get it approved for…

01:29:55.000 --> 01:30:06.000
the full dosage, the full time period. And I think that can be very helpful. And always remember, not just appeal or reconsideration, but expedited…

01:30:06.000 --> 01:30:10.000
so that you get eyes on it quickly and get it resolved quickly.

01:30:10.000 --> 01:30:11.000
That's helpful.

01:30:11.000 --> 01:30:27.000
And also remember, and something that people may not think about is that, you know, say you pay out of pocket for it and you think, oh, well, I've already hit my out-of-pocket cap. You haven't. You haven't even touched it because unless it is covered, quote, covered, meaning that you're getting that drug…

01:30:27.000 --> 01:30:36.000
through your Part D plan and its coverage. It does not count as an out-of-pocket expense.

01:30:36.000 --> 01:30:51.000
And actually, while you're on the topic of out-of-pocket expenses, we have a question about if you start a drug in October, and you choose to divide the payments over a year, do you have to pay the whole $2,100 during the current year?

01:30:51.000 --> 01:30:52.000

It's…

01:30:52.000 --> 01:30:58.000
different plans have different plan years. So…

01:30:58.000 --> 01:30:59.000
assuming it's a calendar year, yeah…

01:30:59.000 --> 01:31:07.000
when you say October, I'm going to exactly at the end of your plan year. Okay, let's just call it end of the plan year, because I think that's really where the heart of the question is.

01:31:07.000 --> 01:31:13.000
And one of the things that we've seen is that because,..

01:31:13.000 --> 01:31:18.000
as of now, it cannot be spread across…

01:31:18.000 --> 01:31:20.000
years…

01:31:20.000 --> 01:31:27.000
that you're not going to want to do the payment plan if you know if you've, you know, kind of…

01:31:27.000 --> 01:31:29.000
started late because…

01:31:29.000 --> 01:31:34.000
it's pretty much the same as just, you know, the out-of-pocket.

01:31:34.000 --> 01:31:38.000
And that's a shame, and hopefully they will fix that.

01:31:38.000 --> 01:31:39.000
That's.

01:31:39.000 --> 01:31:54.000
Yeah, so essentially just to make sure we understand the amount you'll be asked to pay in October when you start in a year end, in a calendar year plan will be so high in order to recoup the cost during the course of those remaining two months…

01:31:54.000 --> 01:32:06.000
that there really is no point at that, you know, at that juncture to be starting a 12-month cycle plan, because they're going to front-load it all into the two months to make sure that they get their payment in full.

01:32:06.000 --> 01:32:07.000
Right.

01:32:07.000 --> 01:32:09.000
Thanks, Kay.

01:32:09.000 --> 01:32:21.000
Now, I'm not sure I'm going to pronounce the name of this drug correctly, but is there, a question is, is there any way to get MDC coverage for frontline zanubrutinib and sonrotoclax?

01:32:21.000 --> 01:32:26.000
And I'm not sure I know enough to answer that question, and we might have to…

01:32:26.000 --> 01:32:27.000
Yeah.

01:32:27.000 --> 01:32:28.000
do some digging to secure it.

01:32:28.000 --> 01:32:29.000
Thank you.

01:32:29.000 --> 01:32:30.000
Unless you happen to know?

01:32:30.000 --> 01:32:42.000
No, I mean, all of those things I hate to answer on the fly because, you know, it requires looking at what coverage policies are there, what NCCN guidelines say, what the labeled indications are, etc.

01:32:42.000 --> 01:32:48.000
Yeah, I think those are a little too specific for the CLL Society to tackle.

01:32:48.000 --> 01:32:49.000
Yeah, and we can look at it.

01:32:49.000 --> 01:32:54.000

So, we have done so we have done previous…

01:32:54.000 --> 01:33:10.000
webinars last year, and maybe the year before on both. So, we've referenced already Medicare versus Medicare Advantage. We tackled that topic a while back. PBM reform was another one we tackled, and Kay talked a little bit about the…

01:33:10.000 --> 01:33:26.000
charges PBMs have, which is what leads to 70% denials, as the questioner asked before. And then I think there's another one that deals with open enrollment and coming up to open enrollment that may address some of the questions we've had…

01:33:26.000 --> 01:33:29.000
in our Q&A as well

01:33:29.000 --> 01:33:48.000
There's two more questions at the very end here. One really relates to, will there be, the questioner asks, will there be a future update for the community on what is happening with pre-authorization programs being tested and planned to be instituted for traditional Medicare in the future?

01:33:48.000 --> 01:34:03.000
I think I would recommend that to the extent you all have topics that you are interested in learning more about and would like to have more information about, certainly a webinar is one approach. I know we try to,

01:34:03.000 --> 01:34:18.000
we space out the webinars we have throughout a year, but there is always other opportunities to learn about those things as well. So, I'll just say that to the extent we receive questions, your experience, your problems, and we learning, as we learn about those,..

01:34:18.000 --> 01:34:30.000
it really helps to inform the work we are doing throughout the year at the CLL Society's Policy Institute. So, as Kay mentioned, PBM reform will be coming up again.

01:34:30.000 --> 01:34:47.000
There will be a proposed rule later this year on it, we hear. And so it will give us a chance to comment substantively on what our community is facing, and same with any sort of pre-authorization plans, programs being tested and planned for.

01:34:47.000 --> 01:35:02.000

Right now, we're also expecting more on GLOBE and GUARD, which are negotiations for what treatments should cost if they're not one of the IRA negotiated drugs. So, you know, the Federal Government is,..

01:35:02.000 --> 01:35:18.000
keeps us quite busy with proposals and even legislation, proposed legislation, as well as proposed regulations. So, if you hear of things that you wish you knew more about, please do let the CLL Society know, because those definitely come down…

01:35:18.000 --> 01:35:21.000
to myself and to Kay, so we can…

01:35:21.000 --> 01:35:27.000
better understand the questions you all have and try to find ways to be responsive.

01:35:27.000 --> 01:35:31.000
Yeah, and I think Saira also,..

01:35:31.000 --> 01:35:45.000
patients should remember to be their own advocates, right? You and your care partner. When you go to your clinician and you know you talk to them about what the treatment…

01:35:45.000 --> 01:35:55.000
recommendations are. Hopefully you have an excellent relationship with your clinician and you can ask some of the harder questions,..

01:35:55.000 --> 01:35:59.000
like, you know how, how much is…

01:35:59.000 --> 01:36:05.000
my insurance driving what you think of as the treatment that I can receive?

01:36:05.000 --> 01:36:10.000
And we'll be sure to include that information in the toolkits we'll be providing later this year as well. So, let me…

01:36:10.000 --> 01:36:18.000
Yeah. And Saira, I think, oh, I was going to just say that if anybody encounters step therapy…

01:36:18.000 --> 01:36:26.000

If you feel you've, I mean, if your clinician says yes, you can't have this, I think it's something that we want to hear about.

01:36:26.000 --> 01:36:28.000
Right.

01:36:28.000 --> 01:36:32.000
Okay, let's go to the next slide.

01:36:32.000 --> 01:36:45.000
We don't want to forget to thank our donors for this program was made possible through their donations and through the grant support we received from AstraZeneca and BeOne.

01:36:45.000 --> 01:37:01.000
And then finally, I would like to say thank you for attending today. Because you attended today's webinar, you will receive a link to the access to treatment survey. This is the survey that Kay has been talking about throughout this webinar.

01:37:01.000 --> 01:37:18.000
If you're currently being treated for your CLL or have been in the last two years, please take a moment to complete this survey. The results of this survey will help inform the toolkits that we have been talking with you about so that we can help you be better advocates for yourself…

01:37:18.000 --> 01:37:25.000
as you receive, you know, if you were to receive one of those denials that we talked about earlier.

01:37:25.000 --> 01:37:38.000
So please do take a moment to fill out that survey. It really is a very important part of our quite extensive utilization management work we're doing this year on your behalf at the CLL Society.

01:37:38.000 --> 01:37:51.000
Separately, please complete the event survey you'll receive. That's a short one that you do that comes after every webinar. Provide your feedback. That always helps the CLL Society plan for future events.

01:37:51.000 --> 01:38:09.000
This webinar was recorded and will be made available on the website along with the slide deck and the transcript, and we'll be sure to request that links be provided to the

PBM webinar, as well as the Medicare versus Medicare Advantage webinar, and so on and so forth.

01:38:09.000 --> 01:38:22.000
If you have questions that were not answered today, I had said at the very outset, please remember your questions. You can send them in to support@cllsociety.org.

01:38:22.000 --> 01:38:32.000
Please join the CLL Society for their next webinar: Understanding the Numbers: Patients Guide to CLL Testing and Imaging on August 26th.

01:38:32.000 --> 01:38:50.000
Please remember, the CLL Society is invested in your long life and you can invest in the long life of the CLL Society by supporting their work. Thank you so much.