

Capping Out-of-Pocket Drug Costs for Medicare Beneficiaries

Access to medically necessary healthcare is critical for successful patient outcomes, yet access is often impeded or blocked entirely by cost sharing in the form of high deductibles, co-pays and coinsurance. Despite its value as a tool to limit discretionary healthcare spending, excessive cost sharing often creates insurmountable barriers between patients and medications, diagnostic tests, office visits, surgery and other needed services. There is significant concern that cost sharing limits access to medically necessary and appropriate treatment for seriously ill and economically vulnerable patients.

The Patient Access Network Foundation believes that cost sharing should not prevent anyone from obtaining medically necessary treatment.

PAN advocates for strategies that will increase access to medically necessary medications among economically vulnerable Medicare beneficiaries by reducing their out-of-pocket (OOP) drug costs:¹

- » Out-of-pocket costs for prescription medications should be capped through the use of monthly and/or annual limits.
- » All health conditions should have at least one highly-effective innovator drug on a fixed co-payment tier.
- » Out-of-pocket costs for prescription medications should be spread more evenly throughout the benefit calendar year.

This *Issue Brief* explores how the absence of a cap on annual OOP drug costs impacts Medicare beneficiaries' access to needed medications, as well as strategies to address this critical problem.

Do Medicare Beneficiaries Currently Have a Cap on Annual OOP Medication Expenses?

No. Medicare Part D drug plans are complex, and they can impose significant OOP costs on some beneficiaries. These OOP costs come from premiums, deductibles, as well as co-payments and

coinsurance.² Medicare beneficiaries represent the only group of insured people in the U.S. that is not protected by a cap on annual OOP costs.³

When Medicare beneficiaries who are enrolled in Part D drug plans meet their True Out-of-Pocket (TrOOP) threshold for the year—currently set at \$5,100 in OOP spending—they enter the “Catastrophic Coverage Phase,” and remain in this phase until the end of the calendar year. In this phase, beneficiaries pay 5 percent coinsurance (coinsurance is a percentage of the cost of a prescription medication) on their medications until the end of the year.⁴

Although the 5 percent coinsurance that is imposed during the Catastrophic Phase may seem small, because it is a percentage of the cost of a beneficiary’s prescription medications, this amount can balloon to many thousands of dollars for some patients because there is no annual cap during this coverage phase. OOP drug costs during the Catastrophic Phase are especially challenging for certain groups of Medicare beneficiaries. These include beneficiaries who need high-cost specialty medicines, and economically vulnerable patients who are not eligible for the Low-Income Subsidy (LIS), a program that helps people with limited incomes pay for their prescription medications. The absence of an annual OOP cap for prescription medications means that these beneficiaries face great uncertainty about whether they can afford to buy the drugs that have been prescribed for them by their doctors

How Many People Would Benefit from a Cap on Annual OOP Drug Costs?

One way to understand the potential benefit of an annual cap on OOP drug costs is to consider how many non-LIS Medicare beneficiaries reach the Catastrophic Coverage Phase. Research has shown that the number of non-LIS beneficiaries that is reaching this phase has increased substantially over time.^{5,6} This means that more beneficiaries have very high OOP drug costs because they are exposed to 5 percent coinsurance for the rest of the calendar year. These are the older adults who stand to benefit most from implementation of a cap on OOP drug costs, and data from the Kaiser Family Foundation (KFF) provide detail on the extent of this potential benefit.

KFF data show that in 2015, 3.6 million Medicare Part D enrollees reached the Catastrophic Phase and were exposed to 5 percent coinsurance for the rest of the year. Although these enrollees were only 2 percent of all people in Part D plans, they incurred 20 percent of Part D enrollees’ total OOP drug spending in 2015. Of the 3.6 million people who

FIGURE 1.
In 2015, 1 million Medicare Part D enrollees without low-income subsidies had high out-of-pocket drug costs—above the catastrophic coverage threshold—more than twice the number in 2007



reached the Catastrophic Phase, 1 million did not receive LIS subsidies to protect them against high OOP drug costs. KFF found that the number of these extremely economically vulnerable older adults more than doubled between 2007 and 2015 (Figure 1).

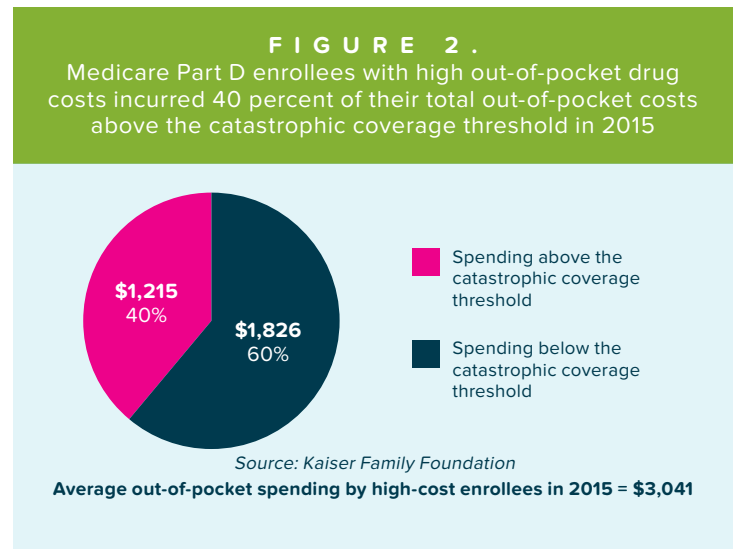
On average, the 1 million non-LIS Part D enrollees each spent more than \$3,000 OOP on their prescriptions in 2015, and 1 in 10 spent \$5,200 or more OOP for their drugs. This relatively small group of Part D enrollees spent a total of \$1.2 billion in OOP drug costs in 2015, with 40 percent of their total OOP drug spending happening after they reached the Catastrophic threshold (Figure 2). Other research has shown that the amount of spending that occurs during the Catastrophic Phase has also been increasing over time.⁷

These data provide a firm rationale for a cap on OOP drug spending:

- » Larger numbers of older adults are reaching the Catastrophic Phase, and these beneficiaries incur a disproportionate share of all OOP drug spending.
- » The number of Medicare beneficiaries impacted by the lack of an OOP cap on drug costs is growing rapidly, as is the OOP drug spending among these individuals.
- » Economically vulnerable older adults pay a large share of their OOP drug costs during the Catastrophic Phase despite a seemingly low coinsurance rate of 5 percent.
- » People who reach the Catastrophic Phase incur many thousands of dollars in OOP costs because there is no cap on these expenses.

What are the Practical Implications of Reaching the Catastrophic Coverage Phase?

Aside from substantial financial burdens, Medicare beneficiaries face other practical challenges when they reach the Catastrophic Coverage Phase because of the financial hardships that come with continued exposure to OOP drug costs.⁸ Research has shown that beneficiaries who are not shielded from high OOP drug costs are more likely to experience interruptions in treatment or to abandon treatment, consequences that are linked to less favorable clinical outcomes for these seniors.^{9,10,11,12,13}



These burdens are especially severe for older adults with cancer and those who need expensive medications. This is because the 5 percent coinsurance that is imposed during the Catastrophic Phase can translate into thousands of dollars in OOP costs for these patients.

Are There Ways to Cap OOP Drug Costs?

Yes. Several proposals suggest ways to cap OOP drug costs on an annual basis, a monthly basis or a per-prescription basis.

Annual Cap

A recent report⁶ that examined Medicare beneficiaries who reached the Catastrophic Coverage Phase in 2015 estimated the costs and benefits of implementing an annual OOP cap at the Catastrophic threshold. The results demonstrated that capping cost sharing at the Catastrophic threshold would increase Part D plans' spending, but that increases in premiums would likely cover these costs. Importantly, the researchers also noted that increased premiums would have a nominal impact on patients: premiums would rise by only \$0.40–\$1.31 per member per month (1 to 4 percent), with a lower cost if the policy applied to both LIS and non-LIS beneficiaries.

Not only would the increased premium be relatively small when spread across millions of beneficiaries, but it would also offer a high level of protection for non-LIS beneficiaries with high OOP drug costs, as well as added protection from high OOP drug spending for all Part D beneficiaries. The researchers illustrated the value of an annual OOP spending cap for the broader Part D population by showing that 16 percent of non-LIS beneficiaries who reached the Catastrophic Phase in 2015 got to this threshold with a single claim. An annual cap would therefore protect a substantial proportion of all Part D enrollees from the possibility of having to shoulder the costs of a single, very costly medication.

Monthly Cap

A monthly cap on OOP drug costs is another approach that has been proposed to help “smooth out” the high upfront OOP drug costs that many Part D enrollees experience at the beginning of the calendar year. The structure of Medicare Part D drug plans can result in an uneven distribution of OOP expenses during the year, with some beneficiaries paying very high OOP costs for their drugs in the early part of the year. This can place a particularly severe financial burden on patients in a relatively short period of time, enhancing the risk of treatment interruptions or abandonment.

Data on the “seasonality” of OOP drug costs showed that some beneficiaries incur many thousands of dollars in OOP drug costs in January alone, a pattern that forces these patients to have enough cash

on hand early in the year to access their prescription medications. Researchers found that for some beneficiaries, the first prescription that is filled at the beginning of the calendar year nearly equals or exceeds their monthly Social Security benefit. These patients are at increased risk of abandoning their treatment, something they might be less likely to do if their OOP costs were capped monthly and distributed more evenly throughout the year. Implementation of monthly and annual spending limits would help protect these patients from overwhelming costs in any one month by allowing them to spread the costs more evenly over the course of the year until they reached their annual spending cap. Such a policy would cost \$1.96 per non-LIS beneficiary per month, and presumably less if the policy were implemented for all Part D enrollees.¹⁴

Benefits for Younger Adults

Medicare Part D drug plans are not the only setting where OOP caps on prescription medications have been discussed. In fact, several states have implemented caps on OOP drug spending in “marketplace” health plans under the Affordable Care Act. Covered California—the health insurance marketplace for the state of California—is one state that has implemented these caps. In 2017, per-prescription cost-sharing caps were implemented for platinum, gold, silver and bronze plans. Under the new caps, cost sharing per 30-day period cannot exceed \$500 for bronze plans and \$250 for silver, gold and platinum plans. Other states—Delaware, Louisiana and Maryland—have limited cost sharing per 30-day supply of specialty medications; Maine and Vermont have capped annual OOP drug spending; and Colorado and Montana require some insurers to offer plans with co-pays of \$250 or less.¹⁵

Importantly, research on the early impact of California’s caps on prescription drugs has shown that Covered California insurers did not expect the cost-sharing cap to increase prescription drug spending beyond the increases in other states. This research also found that OOP drug spending caps would have a small impact (1.1 percent-1.3 percent) on premiums for the average member.¹⁵

The PAN Foundation

The PAN Foundation is an independent, national 501 (c)(3) organization dedicated to helping federally and commercially insured people living with life-threatening, chronic and rare diseases with the OOP costs for their prescribed medications. PAN provides the underinsured population access to the healthcare treatments they need to best manage their conditions and focus on improving their quality of life. Since its founding in 2004, PAN has provided nearly one million underinsured patients with over \$3 billion in financial assistance through close to 70 disease-specific programs.

For more information about this *Issue Brief*, contact Amy Niles, Vice President of External Relations, at aniles@panfoundation.org.



Supporting Literature

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