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PAN Foundation

Cost Sharing and Access to Prescription Medications

Overview

Access to medically necessary healthcare is critical for successful patient outcomes, yet access is often impeded or blocked entirely by cost sharing. Despite its value as a tool to limit discretionary healthcare spending, cost sharing can also create insurmountable barriers between patients and diagnostic tests, office visits, surgery and other needed services. There are significant concerns — especially among economically vulnerable patients and families — that cost sharing limits access to medically necessary treatment. This Issue Brief provides an overview and examples of the impact of cost sharing on access to prescription medications.

Position Statement

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

What is Cost Sharing?

Cost sharing refers to healthcare expenses that are not covered by an individual's insurance plan and must be paid out of pocket (OOP). These OOP expenses come from deductibles, co-payments and coinsurance. Cost sharing impacts Americans of all ages and income levels, including people under the age of 65 who have health insurance through exchanges created under the Affordable Care Act (ACA); those with employer-based health insurance; Medicare beneficiaries over the age of 65, as well Medicare beneficiaries under the age of 65 who have disabilities.[1]

What is the Rationale for Cost Sharing?

Cost sharing is designed to make health insurance affordable by lowering insurance premiums. That is, if policy holders share in a portion of the cost of the care they receive, then their premiums — the amount they pay for their insurance policies — will be lower. Cost sharing is designed to minimize "moral hazard" in insurance coverage. This is the tendency for people to use more and unnecessary products and services because they are protected from the cost. Cost sharing also encourages policy holders to "shop around" for the best price on the healthcare products and services that they use.

How is Cost Sharing Implemented for Prescription Medications?

There are a number of ways that cost sharing affects how much insured people pay OOP for their prescription medications. To illustrate how each cost sharing strategy works, consider a woman named Mary who has health insurance and $5,000 of healthcare expenses each year.

» DEDUCTIBLES

A deductible is the amount of money that Mary pays upfront, OOP each year for services that are covered under her plan before the plan begins to help cover the costs of these services. Prescription medications are among these covered services. Deductibles vary considerably among individuals who are insured under ACA exchanges, people with employer-based insurance and Medicare beneficiaries. Importantly, after Mary meets her deductible, other cost-sharing strategies — like co-pays and coinsurance — will apply.

Example: If Mary's plan has a $300 deductible, she must pay the first $300 of her $5,000 of healthcare expenses for the year OOP before the plan starts to help cover her healthcare costs.

Implications for access to prescription medications: Regardless of insurance type, people who require expensive prescription medications and those who require multiple medications will incur OOP prescription drug costs from their deductibles at a much faster rate than people who require less expensive medications and those with few or no health problems. This burden is compounded by trends showing that deductibles have been increasing over time, especially in employer-based plans.[2] These OOP costs can be particularly burdensome for low-income people who are unable to afford the high upfront OOP costs associated with their deductibles. This burden can force economically vulnerable people to forgo needed medications, or to skip doses or refills.

» CO-PAYMENTS (CO-PAYS)

A co-pay is the fixed fee that Mary pays each time she fills a prescription. These fees are tied to each prescription after her deductible has been met, and they have been increasing over time.[3] For patients who have multiple health conditions or conditions that require multiple medications, even modest co-pays can add up to significant OOP costs as the number of prescriptions rises. These costs present an obvious financial barrier to necessary treatment and disease management.[4]

Example: If Mary met her plan's deductible in February, she would have 10 more months in the year in which she would need to fill her prescriptions. If she took one prescription medication on a regular basis, she would need to fill 10 prescriptions, but if she took five medications on a regular basis, she would need to fill 50 prescriptions. If Mary's co-payment is $10 per prescription, she would have $100 in OOP co-payment expenses if she took one medication, but she would have $500 in OOP co-payment expenses if she took five medications.

Implications for access to prescription medications: Although a single prescription co-payment may not result in financial burden, these fees can add up quickly, especially for people who need multiple medications. As a result, people whose health is less favorable will incur higher OOP co-payment expenses. These expenses are especially burdensome for economically vulnerable people who are often driven to pursue similar strategies as people with high deductibles—forgoing needed medications, skipping doses or refilling less frequently.

» COINSURANCE

Coinsurance is a cost-sharing strategy in which patients pay a percentage of their medication costs, and this percentage can vary.[5] Covering the OOP costs of coinsurance is challenging for patients with health conditions that are best treated with high-cost medications, or medications for which there is no generic or low-cost equivalent.[6] The use of coinsurance as a cost sharing strategy has been increasing over time.[2,7]

Example: If Mary has a chronic condition that is treated with a medication that costs $400 each month after she meets her deductible, she would have a monthly OOP burden of $40 if her insurance plan stipulates 10% coinsurance for this medication. However, she would have $200 in OOP expenses each month for this medication if her plan applies 50% coinsurance.

Implications for access to prescription medications: Patients who require medically necessary treatment with drugs that have high coinsurance are disproportionately impacted by cost sharing. Coinsurance is especially challenging among economically vulnerable people who have health conditions for which medications with lower coinsurance are not available.

» SPECIALTY TIERS

Historically, prescription drug plans had two formulary tiers, one for brand-name medications and another for generics. Most insurers now have four or five tiers, with the highest tier being reserved for specialty (high-cost) medications. As the tiers rise, OOP costs also increase in the form of co-pays and coinsurance. Broadly implemented for the first time under Medicare Part D, specialty tiers are now standard features in both ACA exchange plans and commercial insurance.[8] Initiation and maintenance of specialty drugs is unfavorably impacted by cost sharing. This can include access to life-saving drugs for which there is no low-cost equivalent, as in the case of tyrosine kinase inhibitors (TKIs) for treatment of chronic myelogenous leukemia (CML).[4,9]

Example: Based on recently published data, if Mary is a Medicare beneficiary with CML and she does not have a low income subsidy, she will incur $2,600 in OOP expenses when she fills her first TKI prescription because this medication is in a specialty tier.

Implications for access to prescription medications: Placement of a lifesaving drug in a specialty tier results in overwhelming OOP prescription drug costs for economically vulnerable people, many of whom are elderly, disabled, unable to work or otherwise ill-equipped to handle these costs.

Unintended Consequences: Cost Sharing Reduces Access and Increases Health Disparities

In many cases — especially for economically vulnerable patients — OOP costs reduce or prevent access to prescribed medications, and this negatively impacts both quality of life and the course of disease.10 High OOP medication costs disproportionately impact the poor, with dramatic consequences for people who live on fixed incomes, including low-income seniors. Limited access to prescription medications excludes economically vulnerable patients from the benefits of new drugs, specialty drugs, high-cost generic medications, and other medically necessary, high-cost prescription medications that have proven benefits over conventional treatments. In many instances, even modest OOP costs associated with lower cost drugs can prevent access to medically necessary treatment.[1]

Cost sharing has far-reaching implications concerning the connection between access and health because delayed initiation of, or inability to remain on treatment due to OOP costs worsens outcomes, including increasing risk of mortality. Cost sharing creates a two-class system with respect to prescription medications. People who can afford their OOP drug costs can access the full spectrum of health benefits from recent advances in biotechnology and drug development, whereas those with insufficient resources to cover their OOP drug costs must settle for less-expensive medications that may be less effective than newer options, or they may skip doses, skip a refill or forgo the medications altogether. This dichotomy is not theoretical. New research unambiguously shows that cost sharing prevents Medicare Part D beneficiaries from initiating and adhering to a new, life-saving cancer treatment.[4]

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 more than 700,000 underinsured patients over $2.5 billion in financial assistance through more than 50 disease-specific programs.

Supporting Literature

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