

# Access to Prescription Medications Under Medicare Part D

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 create insurmountable barriers between patients and medications, diagnostic tests, office visits, surgery and other needed services. There are significant concerns that cost sharing limits access to medically necessary treatment for economically vulnerable patients and families.

## PAN'S POSITION ON COST SHARING AND ACCESS TO PRESCRIPTION MEDICATIONS

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

### How do People Access Medications Under Medicare?

Established in 1965, Medicare is a federal health insurance program that covers people over the age of 65, as well as people under 65 with long-term disabilities and end-stage renal disease. In January 2017, there were 57.6 million people enrolled in Medicare. Medicare covers a wide range of health services and supports, including prescription medications. Beneficiaries use prescription medications in a number of settings, and the setting in which prescription drugs are administered or acquired determines which part of the Medicare program covers their cost.<sup>1,2,3</sup>

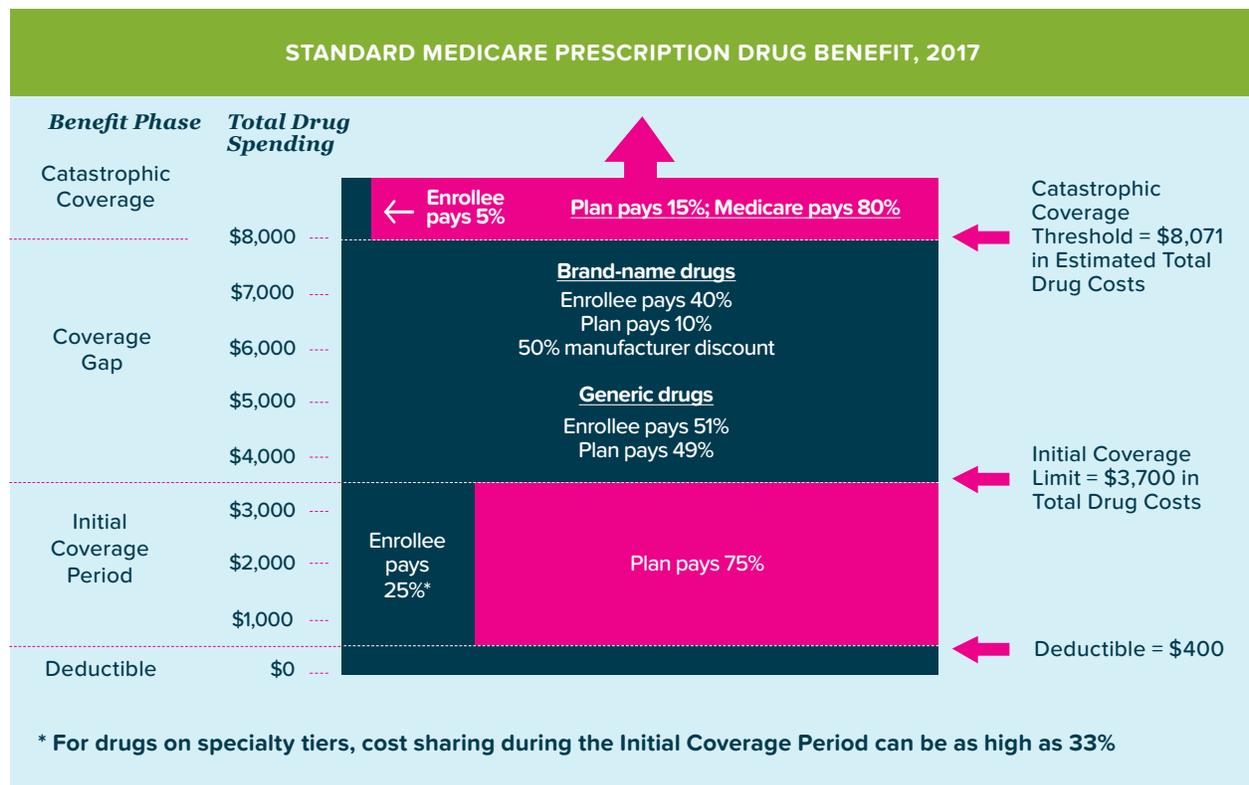
- » **PART A:** Covers drugs that are given during an inpatient hospital or skilled nursing facility stay.
- » **PART B:** Covers drugs that are administered in a doctor's office or outpatient hospital setting.
- » **PART C/MEDICARE ADVANTAGE:** Medicare Advantage plans cover Part A and Part B drugs, and may offer a benefit to cover Part D drugs. Beneficiaries enrolled in a Medicare plan can also purchase drug coverage separately under Part D.

» **PART D:** Covers drugs that are typically purchased at pharmacies.

This Issue Brief examines the impact of out-of-pocket (OOP) costs on access to prescription medications under Medicare Part D.

## Cost Sharing and Access to Prescription Medications

Cost sharing refers to healthcare expenses that insurers don't cover and must be paid OOP by the patient. These expenses include deductibles, co-pays and coinsurance. In Medicare Part D drug plans, the deductible is the amount of money that beneficiaries pay upfront before the Part D plan starts to cover their drug costs, co-payments are fixed fees that beneficiaries pay each time they fill a prescription (e.g., a \$15 co-pay for each prescription), and coinsurance is a fixed percentage of the cost of the medication (e.g., 30% of the cost of each prescription). Medicare Part D drug plans run on a January–December annual cycle. Although these plans can have different benefit structures, they are actuarially equivalent. The general structure of how Medicare Part D drug plans implemented cost sharing during the 2017 calendar year is shown in the below figure.<sup>4</sup>



After paying their \$400 Part D deductible, beneficiaries typically pay 25% of their drug costs during the “Initial Coverage Period.” After their drug costs reach \$3,700, beneficiaries enter the “Coverage Gap” phase, often termed “the donut hole.” In this phase, beneficiaries can incur considerable OOP drug costs (up to approximately \$8,000) until they reach the “Catastrophic Coverage Threshold,” at which point they pay 5% coinsurance for their drugs until the end of the calendar year. The cycle resets on January 1.

Several important points concerning the relatively complex structure of Medicare Part D drug plans warrant emphasis.

- » For some health conditions, a specialty medication, often placed on the highest specialty tier on a formulary, is the most appropriate treatment. In these cases, there is no lower cost or generic alternative that offers the same benefit on a less expensive formulary tier.
- » For Medicare beneficiaries who need specialty medications, cost sharing during the Initial Coverage Period can be as high as 33%,<sup>5</sup> and cost sharing is even higher during the Coverage Gap phase.
- » Although beneficiaries only pay 5% coinsurance during the Catastrophic Phase, there is no limit because there is no cap on OOP expenses. Patients can incur substantial OOP costs during this time, particularly if they need specialty medications.
- » The structure of Medicare Part D drug plans results in an uneven distribution of OOP expenses during the calendar year, with beneficiaries paying very high OOP costs for their drugs in the early part of the year.
- » Unlike people with commercial insurance, it is unlawful for Medicare beneficiaries to use the coupons offered by pharmaceutical companies to help offset their OOP drug costs.
- » To cover their OOP drug expenses, economically vulnerable older adults often turn to safety net organizations such as charitable foundations as payers of last resort.

### **Case Study: A Medicare Beneficiary With Chronic Myelogenous Leukemia (CML)<sup>5</sup>**

To understand the impact of OOP costs for prescription drugs under Medicare Part D, consider Ted, a beneficiary who has CML, a rare blood cancer, as well as diabetes and high blood pressure. His income is at 400% of the Federal Poverty Level, which makes him ineligible for Medicare’s low-income subsidy. CML guidelines call for treatment with drugs called tyrosine kinase inhibitors (TKIs), a relatively new

class of chemotherapeutic medications. Medicare beneficiaries who do not receive low-income subsidies have high coinsurance requirements for drugs like TKIs because they are often designated as specialty medications. Coinsurance payments vary widely because they are based on the cost of the medication. Further, under Part D, the coinsurance percentage for specialty drugs fluctuates across the coverage year, with the highest costs at the beginning of the year.

» **EVEN WITH PART D COVERAGE, TED CAN EXPECT TO ACCUMULATE CONSIDERABLE OOP EXPENSES DURING THE YEAR.**

The average Medicare patient with CML accumulated \$6,322 in OOP drug expenses for their health conditions. Of these OOP expenses, 95% were linked to their specialty medications.

» **MEDICARE BENEFICIARIES WHO NEED SPECIALTY MEDICATIONS ENTER THE CATASTROPHIC PHASE QUICKLY BECAUSE THEIR OOP COSTS PUSH THEM RAPIDLY THROUGH THE DEDUCTIBLE, INITIAL COVERAGE AND DONUT HOLE PHASES.**

Although Ted pays only 5% coinsurance once he enters the Catastrophic Coverage Phase, the high cost of his medication results in the accumulation of 56% of his total OOP costs during this phase. This is due in part to the absence of a spending cap during the Catastrophic Phase.

» **BENEFICIARIES WHO NEED SPECIALTY MEDICATIONS OFTEN INCUR VERY HIGH OOP COSTS EARLY IN THE CALENDAR YEAR.**

Of the \$6,322 in OOP drug expenses that Ted incurs during the year, he was responsible for \$2,456 in January alone. Of this amount, \$2,374 was linked to his specialty medications. Ted must therefore pay 40% of all of his OOP drug costs in the first month of the calendar year, with the vast majority of these unevenly distributed expenses being accounted for by his CML treatment.

## **Strategies to Increase Access to Medications Among Medicare Beneficiaries**

A number of stakeholders have proposed strategies to help improve Medicare beneficiaries' access to prescription medications. Some of these strategies include:

- » Putting a "hard cap" on OOP costs once beneficiaries reach Part D's catastrophic threshold.
- » Ensuring that health conditions have at least one effective drug that is not on a specialty tier.
- » Distributing OOP costs more evenly throughout the year.

Although it is unclear what strategies will ultimately provide a sustainable safety net for millions of Medicare beneficiaries who cannot afford their medications, there is no doubt about the pressing need for long-term solutions that ensure access to prescription medications for economically vulnerable older adults.

## 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.

For more information about this *Issue Brief*, contact Amy Niles, Vice President of External Affairs, at [aniles@panfoundation.org](mailto:aniles@panfoundation.org).

## Supporting Literature

<sup>1</sup><https://www.medicareresources.org/basic-medicare-information/brief-history-of-medicare/> (accessed August 23, 2016).

<sup>2</sup><http://pnhp.org/blog/2015/01/16/why-do-we-need-to-improve-medicare/> (accessed August 23, 2016).

<sup>3</sup><https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html> (accessed August 23, 2016).

<sup>4</sup><http://kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/> (accessed May 5, 2017).

<sup>5</sup><http://www.ajmc.com/journals/supplement/2017/beyond-charitable-assistance-sustainable-strategies-for-providing-access-to-critical-medications/reducing-out-of-pocket-cost-barriers-to-specialty-drug-use-under-medicare-part-d> (accessed April 21, 2017).