

Out-of-Pocket Drug Costs Among Medicare Beneficiaries

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

The Patient Access Network (PAN) Foundation advocates for strategies that will increase access to medically necessary medications among Medicare beneficiaries by reducing, redistributing and capping out-of-pocket (OOP) prescription drug costs. The PAN Foundation urges consideration of the following changes to the benefit structure of Medicare Part D prescription drug plans:

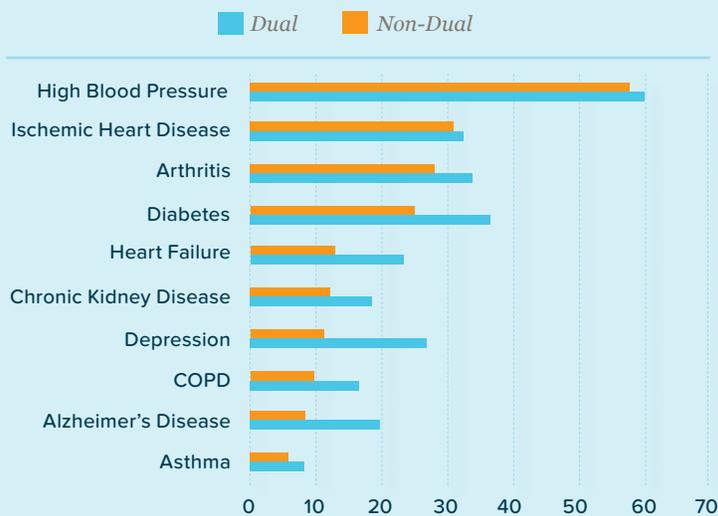
- » Put a “hard cap” on OOP costs once beneficiaries reach Part D’s catastrophic threshold.
- » Distribute OOP costs more evenly throughout the calendar year.
- » Ensure that health conditions have at least one effective drug that is not on a specialty tier.

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 seriously ill and economically vulnerable seniors and families.

STRATEGIES TO INCREASE ACCESS TO MEDICATIONS AMONG MEDICARE BENEFICIARIES

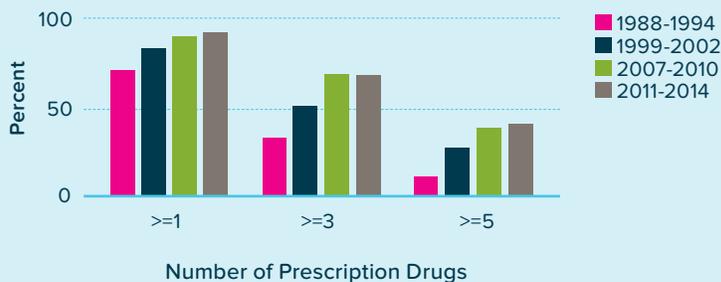
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FIGURE 1.
Percentage of Medicare Fee-For-Service Beneficiaries With Selected Chronic Conditions, by Dual Eligibility* Status



* "Dual eligibles" qualify for Medicare and Medicaid benefits

FIGURE 2.
Percentage of U.S. Population 65 and Above Who Take Prescription Medications, by Number of Medications and Year, 1998-2014⁸



This *Issue Brief* examines the intersection of chronic illness and OOP drug costs among Medicare beneficiaries, and trends that are driving increases in these costs over time.

The Medicare Population: Economic Insecurity and Heavy Disease Burden

In November of 2017, 58.9 million people were enrolled in Medicare, a federal insurance program primarily for adults over age 65.¹ Medicare beneficiaries represent about 17% of the total U.S. population, and their representation will continue to grow with the “aging of America.”^{2,3} Only 24% of the Medicare population is economically secure. Sixteen percent of this population lives in poverty, and 56% have income between 100%–400% of the Federal Poverty Level.⁴ A major source of economic insecurity

among Medicare beneficiaries is their need to cover expenses for health care.⁵ Overall, 25% of Medicare beneficiaries spent 20% or more of their income on health care in 2016, but 40% of beneficiaries who were below 200% of the Federal Poverty Level spent this amount on health care. Thus, Medicare beneficiaries with fewer financial resources are spending more on their health-related expenses.

More than 80% of people over the age of 65 have multiple chronic conditions, with 37% of Medicare beneficiaries having four or more health conditions.⁶ Although conditions related to cardiovascular

disease are highly represented among Medicare beneficiaries' 15 most common health conditions—58% have high blood pressure and 45% have high cholesterol—arthritis (29%) and cancer (8%) are also in the top 15.⁷ The prevalence of nearly all chronic conditions is higher among low-income beneficiaries—dual eligibles who also qualify for Medicaid benefits (Figure 1). This heavy disease burden is associated with high utilization of prescription medications, a trend that is increasing over time (Figure 2). Ninety percent of Americans over the age of 65 report taking at least one prescription medication in the past 30 days, 66.8% have taken three or more, and 40.7% have taken five or more medications in the past 30 days.⁸ Medicare beneficiaries' financial burdens increase as their health worsens, in part because their OOP drug costs increase in parallel with the number of prescription medications.⁵ There is little doubt that older Americans are taking more medications now, and this trend is likely to continue.

Medicare Coverage for Prescription Medications

Medicare offers coverage for prescription medications in two ways. Beneficiaries who select a Medicare Managed Care (“Medicare Advantage”) plan can access prescription medications by purchasing coverage through their plan. Beneficiaries with “traditional Medicare” can purchase prescription drug coverage through a “Part D” drug plan. In November of 2017, 43.1 million Medicare beneficiaries had prescription drug coverage. Of these, 25.4 million beneficiaries accessed drugs through Part D plans, and the remaining 17.7 million accessed them through Medicare Advantage drug plans.⁹

Medicare Part D prescription drug plans share the same general benefit structure.¹⁰

- » *Deductible:* Beneficiaries must pay a \$405 deductible before plan benefits kick in.
- » *Initial Coverage Period:* After the deductible is reached, beneficiaries pay 25% of the cost of their medications until they reach \$3,750 in total drug costs. Beneficiaries who take specialty medications pay a higher percentage during this period, and as a result, they can incur considerable OOP costs early in the calendar year.
- » *Coverage Gap:* After the \$3,750 limit is met, beneficiaries enter the Coverage Gap Phase, sometimes called the “donut hole.” During this phase, they pay a share of the cost of their medications based on whether drugs are generic or brand name. Beneficiaries remain in this phase until they reach the “catastrophic” threshold. This occurs after they have paid \$5,000 in OOP drug costs while in the Coverage Gap. Once again, beneficiaries who need expensive medications will incur high OOP drug costs in the early part of the year.

» *Catastrophic Phase:* After passing the \$5,000 OOP threshold in the Coverage Gap Phase, beneficiaries pay 5% of the cost of their medications in the Catastrophic Phase. Although 5% seems low, there is no cap on OOP drug costs during this period. As a result, beneficiaries who need expensive drugs continue to incur high OOP costs, even though they only have to cover 5% of the cost.

Medicare Beneficiaries Have Substantial Out-of-Pocket Costs for Prescription Drugs

Although Medicare drug plans have increased access to needed medications and reduced cost burdens for older adults overall,^{11,12} considerable research demonstrates that OOP costs for prescription medications remain a serious problem for large number of Medicare beneficiaries despite their prescription drug coverage. Beneficiaries' OOP drug costs result from the combined impact of high rates of chronic disease that require multiple medications,^{7,6} economic insecurity and the absence of a cap on OOP drug costs.^{4,13} Against this backdrop, even relatively small OOP drug costs can create significant barriers to older adults' ability to access needed medications. However, these burdens are especially acute for older adults with cancer and others who need specialty medications because the OOP costs for these drugs are particularly high.^{14,15,16,17,18}

High OOP drug costs are not unusual among older adults—millions of Medicare beneficiaries are affected. A report from the Kaiser Family Foundation showed that in 2015, 3.6 million Medicare beneficiaries with Part D coverage had OOP drug costs above the catastrophic threshold. Of these, more than 1 million did not have federal low-income subsidies to protect them from these costs, and the number of these individuals more than doubled since 2007. In 2015, these Medicare beneficiaries represented only 2% of all enrollees, but they incurred 20% (\$3 billion) of all OOP drug spending. On average, they spent more than \$3,000 OOP on their prescriptions in 2015, and one in 10 spent at least \$5,200.¹³

The Burden of OOP Healthcare Costs Is Increasing Rapidly for Medicare Beneficiaries

Overall OOP Healthcare Costs

Data from the Kaiser Family Foundation show that Medicare beneficiaries' OOP spending on healthcare—as a percentage both of Social Security income and total income—is increasing.¹⁹ For example, the report showed that as a share of per capita Social Security income, OOP healthcare spending will increase from 41% in 2013 to a projected 50% in 2030. These increases will hit hardest among beneficiaries over the age of 85, those with low incomes and among beneficiaries with multiple chronic conditions. By

2030, the Kaiser report projects that beneficiaries over the age of 85 will spend an additional \$4,400 on OOP healthcare expenses, and those aged 65–74 are projected to spend an additional \$2,000. Among Medicare beneficiaries with incomes below \$10,000, average OOP healthcare costs in 2030 are expected to *exceed* average Social Security income. Prescription medications are a significant part of older adults' overall OOP healthcare costs.

OOP Costs for Prescription Drugs

Although the Affordable Care Act resulted in a sharp drop in OOP drug costs between 2010 and 2011, these costs are once again on the rise, both in terms of absolute dollars and as a proportion of all OOP health expenses.²⁰ This impact extends to the Medicare population, as reflected in survey data from nearly 4,000 older adults that showed that even with prescription drug coverage, seniors reported increasing levels of financial hardship associated with medication purchases: 12%, 22% and 35% in 1998, 2001 and 2015, respectively.²¹

Research suggesting that Medicare beneficiaries' overall OOP drug costs have decreased in recent years²² masks an important distinction in the OOP impact of generic and brand name drugs. Between 2008 and 2016, generic drug prices declined while branded drug prices have almost doubled.²³ This trend is reflected in cost sharing among Medicare beneficiaries. A Kaiser Family Foundation report concluded that between 2006 and 2016, “Cost sharing in Part D plans for generic drugs has declined in recent years, while cost sharing for brands has generally increased.”²⁴ The report showed that median cost sharing for a preferred generic drug on a Medicare prescription drug plan was \$5 in 2006, and decreased to \$1 in 2016. By contrast, median cost sharing for preferred brand name drugs increased by 46% (\$28 to \$41) between 2006 and 2016.

Changes in the structure of these drug plans has also had a major impact on OOP drug costs. In 2009, only 3% of Medicare Part D prescription drug plan enrollees were in plans with five formulary tiers (two generic, two brand, one specialty), but this share increased to 98% in 2016. This shift is important because it impacts OOP costs for branded drugs and those on specialty tiers, ultimately increasing the number of Medicare beneficiaries who reach the catastrophic threshold, and how much OOP burden these beneficiaries need to manage after that point. In 2013, Medicare part D enrollees who were above the catastrophic threshold spent an average of \$2,789 OOP for their medications, and these costs rose to \$2,870 in 2014, and \$3,041 in 2015. In many cases, enrollees with extremely high OOP drug costs are older adults with health conditions that are optimally treated with drugs that are on specialty tiers.¹³

The impact of high OOP costs on initiation and maintenance of treatment is not theoretical. Research has shown that Medicare beneficiaries who are not shielded from high OOP costs for specialty medications are less likely to initiate expensive treatments, more likely to delay initiation of treatment and more likely to experience interruptions in treatment, all outcomes that generate less favorable clinical outcomes for these seniors.^{14,15,16,17,25}

OOP Drugs Costs Are Part of a Larger Problem Facing Economically Vulnerable Seniors

Although OOP costs for prescription medications present an increasing burden for economically vulnerable Medicare beneficiaries, these costs are part of a larger problem facing these older adults. Only half of Medicare beneficiaries who live in poverty, and less than 25% of those with incomes between 100% and 150% of the Federal Poverty Level, have full Medicaid coverage that protects them from high OOP healthcare costs. These expenses include cost sharing for other covered services such as inpatient and emergency medical care, as well as OOP costs for services that are not covered under Medicare such as glasses, eye exams, most dental care and hearing aids. As noted earlier, millions of low-income Medicare beneficiaries are exposed to these OOP costs and the number of these vulnerable seniors are projected to increase over time.

Current sources of financial assistance are unable to meet the needs of these seniors now, and the sources of support will become increasingly inadequate to meet their needs in the future. The long-term solution to ensuring Medicare beneficiaries' access to medically necessary prescription medications lies in promoting thoughtful and sustainable policy-based solutions.

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 1 million underinsured patients over \$3 billion in financial assistance through over 60 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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