

POSITION STATEMENTS

IMPROVING PATIENT ACCESS TO HEALTHCARE

The inability to pay for essential medical care is a significant problem for people who have health insurance, but are underinsured. Rising deductibles, premiums, co-pays and coinsurance prevent many people from being able to afford the critical treatment they need.

The PAN Foundation's mission is to help underinsured people with life-threatening, chronic and rare diseases get the medications and treatments they need by assisting with their out-of-pocket costs and advocating for improved access and affordability. The following position puts patients first in our complex healthcare system, and can help them access treatment at a price they can afford.

1

Out-of-pocket costs should not prevent individuals with life-threatening, chronic and rare diseases from obtaining their prescribed medications.

High out-of-pocket medication costs frequently prevent patients from accessing their prescribed and essential medications. Research demonstrates that patients with serious health conditions who are exposed to high out-of-pocket drug costs are less likely to fill their prescriptions, take longer to start their treatment, and experience increased interruptions and gaps in treatment.^{1,2}

In addition, multiple studies have shown that even with a co-pay as low as \$40 for a medication, many patients will choose to not fill their prescriptions.^{3,4} PAN advocates for policies to ensure that high out-of-pocket costs do not impede access to medically necessary treatments.

2

Within today's healthcare delivery system, charitable patient assistance programs provide a critical safety net for ensuring access to medically necessary treatment.

Charitable foundations are a lifeline for patients who have nowhere else to turn for help to cover their out-of-pocket medication expenses. Older adults depend primarily on Medicare to cover their health expenses, but more than a quarter of Medicare beneficiaries are underinsured and spend a large share of their income on healthcare expenses, including prescription medications.⁵

Out-of-pocket medication expenses increase with the number of chronic illnesses. For millions of older adults, living with multiple health conditions is the norm. In fact, 36 percent of Medicare beneficiaries have four or more health conditions and 15.3 percent have six or more.⁶ Rising out-of-pocket healthcare costs prevent seniors from accessing needed medical treatments, exacerbating the widespread economic insecurity among our nation's older adults.⁷

High out-of-pocket medication costs also underscore why many older adults are unable to access and stay on needed medications, especially newer, innovative medications that tend to be more expensive.^{1,2}

Until policies ensure our country's most vulnerable patients can access medically-necessary treatments, charitable assistance programs will continue to play a critical role in the healthcare safety net.

3

Out-of-pocket costs for prescription medications should be spread more evenly throughout the benefit year.

The structure of Medicare Part D prescription drug plans front-loads out-of-pocket medication costs early in the benefit year. This can have a devastating impact on patients who face high cost sharing for their medications.

A recent study showed that among Medicare beneficiaries with rheumatoid arthritis, multiple sclerosis and chronic myelogenous leukemia, more than half of all out-of-pocket medication costs were incurred in the first three months of the year. For many patients, paying thousands of dollars at the beginning of the year is an enormous hardship.⁸

Commercially-insured people enrolled in high-deductible health plans also experience high out-of-pocket costs that can limit access to needed treatment.^{9,10}

Policymakers, insurers and other stakeholders must identify ways to modify the structure of insurance plans so that out-of-pocket costs for prescription medications can be spread more evenly during the year, and economically vulnerable patients can access and remain on the treatments they need.

4

Out-of-pocket costs for prescription medications should be capped through the use of monthly and/or annual limits.

Medicare beneficiaries are the only group of insured people in the U.S. that is not protected by a cap on annual out-of-pocket costs, forcing many to make difficult trade-offs or to forgo treatment altogether.¹¹ Some beneficiaries who require expensive medications can incur many thousands of dollars out-of-pocket for their prescriptions in January alone, a pattern that requires them to have enough money early in the year to access their treatment.⁸

A monthly cap on out-of-pocket drug costs would help these patients better anticipate, and plan for their medication expenses throughout the year. An annual cap is another way to protect millions of low-income seniors from high out-of-pocket costs.

In 2016 alone, 5.2 million Medicare beneficiaries reached the Part D coverage gap, paying nearly \$1,600 out-of-pocket for their medications by the time they get there.¹²

The same year, one million patients with Medicare Part D progressed through the coverage gap and entered the “Catastrophic Coverage Phase,” where they continue to pay the out-of-pocket costs for their needed treatment. The number of beneficiaries in this phase has increased rapidly—more than doubling between 2007 and 2015.^{13,14}

PAN agrees with the Institute of Medicine and the Congressional Budget Office, which both advocate for limits on out-of-pocket drug spending for Medicare beneficiaries.^{15,16}

¹⁷ A cap would facilitate access to needed treatments by lowering out-of-pocket costs and helping beneficiaries predict and plan for these costs throughout the year.



5

Value-based insurance designs (VBID) that increase access to treatment for individuals living with life-threatening, chronic and rare diseases should be encouraged.

Value-based insurance design (VBID) promotes patients’ use of high-value care options by changing the cost sharing consumers must pay for different care options. Under a VBID approach, treatments that provide high clinical value have reduced or no cost sharing.

The American Medical Association believes that health insurance must provide access to affordable, ongoing care for patients at high risk for serious disease and/or the progression of an existing disease, and it has long supported VBID to align incentives around high-value services.¹⁸

The Centers for Medicare and Medicaid Services also support VBID, and this is reflected in its implementation of the Medicare Advantage VBID Model. This model offers supplemental benefits or reduced cost sharing to enrollees with certain chronic conditions and focuses on services of highest clinical value to patients. The model will be expanded to all 50 states by January 1, 2020.¹⁹

6

All conditions should have at least one highly-effective innovator drug on a fixed co-payment tier.

VBID is not only beneficial for patients with common conditions—its principles hold true for all patients, regardless of their health conditions.

The University of Michigan Center for Value-Based Insurance Design advocates for “precision medicine” when it is medically indicated. “By enhancing access to effective therapies when indicated, the application of clinically-nuanced cost sharing commits to established policies that encourage first-line therapies and supports precision medicine initiatives.”²⁰

When a therapy—even an expensive one—is medically indicated and offers high value, VBID benefit designs should facilitate access to treatment for patients.

Specialty medications typically offer major treatment advances for patients with life-threatening, chronic and rare diseases, reduce the risk of disease progression and costly complications, and improve survival for life-threatening conditions.¹¹

For many patients who are prescribed specialty medications, a generic or less-costly alternative is not available. However, specialty medications are often placed on the highest formulary tiers of drug plans, requiring patients to pay coinsurance—a percentage of the drug’s cost—which can be as high as 50 percent. High cost sharing for specialty medications delays initiation of treatment² and increases abandonment of established treatment regimens²¹, delays between refills²² and interruptions in treatment.¹ Moreover, cost sharing for specialty medications has a disproportionate impact on low-income patients and creates a treatment landscape where the most economically vulnerable patients have the least access to innovative treatments.

Ensuring that all conditions have at least one highly-effective, innovative medication placed on a fixed co-pay formulary tier is one way to increase access to these treatments.

7

High front-end deductibles create barriers that can prevent access to treatment for many individuals with life-threatening, chronic and rare diseases.

Although deductibles have long been part of the benefit structure of most commercial insurance plans, dramatic increases in these deductibles have prevented many people from accessing and staying on needed treatment.

To control healthcare costs, employers have increasingly turned to high-deductible health plans. People with these plans must pay thousands of dollars in out-of-pocket expenses before their insurance provides coverage. Between 2006 and 2016, the enrollment in high-deductible plans quadrupled from 11.4 to 46.5 percent. In 2017, 13 percent of employers offered these plans as their only option for health insurance.^{9,23}

Additional research has found that deductibles are much higher in firms with low-wage workers, a trend that places a greater financial burden on people who can least afford it.²⁴ High-deductible plans are particularly challenging for people who need newer or innovative medications for which there are no generic or less expensive alternatives. To remain on their medication, these patients must pay most or all of their deductible at the beginning of the year. Many people are unable to handle these upfront costs, choosing instead to abandon their treatment.

The challenges to accessing and remaining on treatment are not unique to people with commercial insurance. For patients who require expensive medications, the Medicare Part D benefit structure also concentrates out-of-pocket drug costs at the beginning of the year, a feature of these plans that has been shown to increase treatment abandonment, delay and interruption.^{1,2,8}

Policymakers and insurers must take steps to mitigate the impact that high, upfront out-of-pocket expenses have on the ability of patients to access and remain on their prescription medications.



Co-pay accumulators or similar programs lead to greater out-of-pocket costs for individuals with life-threatening, chronic and rare diseases and should be prohibited.



LEARN MORE AT
[PANFOUNDATION.ORG/ADVOCACY](https://panfoundation.org/advocacy)

PAN Foundation

Drug manufacturer co-pay cards help underinsured patients with commercial insurance afford their prescription medications. Patients use these cards to pay for their deductibles, co-pays or coinsurance, reducing their total out-of-pocket drug costs. Since deductibles and coinsurance have increased dramatically in recent years, these cards have become even more important for economically vulnerable patients. Between 2006 and 2016, deductibles for commercial insurance grew by 300 percent—increasing from an average of \$303 to \$1,200, and far outpacing wage growth.²⁴ There has also been a marked increase in the proportion of employees enrolled in high-deductible health plans. In 2006, only 11.4 percent of enrollees were in high-deductible plans. By 2016, 46.5 percent of employees were enrolled in one.²³

Co-pay accumulator programs prevent patients from using co-pay cards to pay down their deductibles and other out-of-pocket drug costs, resulting in a much larger financial burden for their medications. These programs are especially challenging for lower-income patients who require expensive medications and those enrolled in high-deductible health plans.

Prohibiting co-pay accumulator programs allows patients to use manufacturer co-pay cards in a manner that helps protect them from out-of-pocket medication costs. ●

REFERENCES

¹Doshi JA, Hu T, Li P, Pettit AR, Yu X, Blum M. Specialty Tier-Level Cost Sharing and Biologic Agent Use in the Medicare Part D Initial Coverage Period Among Beneficiaries With Rheumatoid Arthritis. *Arthritis Care Res (Hoboken)*. 2016 Nov;68(11):1624-1630.

²Doshi JA, Li P, Huo H, Pettit AR, Kumar R, Weiss BM, Huntington SF. High Cost Sharing and Specialty Drug Initiation Under Medicare Part D: A Case Study in Patients with Newly Diagnosed Chronic Myeloid Leukemia. *Am J Manag Care*. 2016 Mar;22(4 Suppl):s78-86.

³IQVIA. Patient Affordability Part Two. Implications for Patient Behavior and Therapy Consumption. Available at:

⁴Shrank WH, Choudhry NK, Fischer MA, Avorn J, Powell M, Schneeweiss S, Liberman JN, Dollear T, Brennan TA, Brookhart MA. The epidemiology of prescriptions abandoned at the pharmacy. *Ann Intern Med*. 2010;153(10):633-40.

⁵Schoen C, Solis-Roman C. On Medicare But At Risk: A State-Level Analysis of Beneficiaries Who Are Underinsured or Facing High Total Cost Burdens. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2016/may/medicare-risk-state-level-analysis-beneficiaries-who-are>.

⁶Centers for Medicare and Medicaid Services. Multiple Chronic Conditions. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/MCC_Main.html.

⁷National Council on Aging. Economic Security for Older Adults. Available at: <https://www.ncoa.org/news/resources-for-reporters/get-the-facts/economic-security-facts/>.

⁸Doshi JA, Li P, Pettit AR, Dougherty JS, Flint A, Ladage VP. Reducing Out-of-Pocket Cost Barriers to Specialty Drug Use Under Medicare Part D: Addressing the Problem of “Too Much Too Soon”. *Am J Manag Care*. 2017;23(3 Suppl):S39-S45.

⁹Miller GE, Vistnes JP, Rohde F, Keenan PS. High-Deductible Health Plan Enrollment Increased From 2006 To 2016, Employer-Funded Accounts Grew In Largest Firms. *Health Affairs*. 2018;37(8): 1231-1237.

¹⁰Agarwal R, Mazurenko O, Menachemi N. High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services. *Health Affairs*. 2017;36(10): 1762-1768.

¹¹Doshi JA, Pettit AR, Li P. Addressing Out-Of-Pocket Specialty Drug Costs In Medicare Part D: The Good, The Bad, The Ugly, And The Ignored. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20180724.734269/full/>.

¹²Cubanski J, Neuman T. Closing the Medicare Part D Coverage Gap: Trends, Recent Changes, and What's Ahead. Kaiser Family Foundation. Available at: <https://www.kff.org/medicare/issue-brief/closing-the-medicare-part-d-coverage-gap-trends-recent-changes-and-whats-ahead/>.

¹³Cubanski J, Neuman T, Orgera K, Damico A. No Limit: Medicare Part D Enrollees Exposed to High Out-of-Pocket Drug Costs Without a Hard Cap on Spending. Available at: <http://files.kff.org/attachment/Issue-Brief-No-Limit-Medicare-Part-D-Enrollees-Exposed-to-High-Out-of-Pocket-Drug-Costs-Without-a-Hard-Cap-on-Spending>.

¹⁴Trish E, Xu J, Joyce G. Growing Number Of Unsubsidized Part D Beneficiaries With Catastrophic Spending Suggests Need For An Out-Of-Pocket Cap. *Health Affairs* 2018;(37)7:1048-1056.

¹⁵Kaiser Family Foundation. What's in the Administration's 5-Part Plan for Medicare Part D and What Would it Mean for Beneficiaries and Program Savings? Available at: <https://www.kff.org/medicare/issue-brief/whats-in-the-administrations-5-part-plan-for-medicare-part-d-and-what-would-it-mean-for-beneficiaries-and-program-savings/>.

¹⁶Institute of Medicine. Making Medicines Affordable: A National Imperative. Available at: <http://www.nationalacademies.org/hmd/Reports/2017/making-medicines-affordable-a-national-imperative.aspx>

¹⁷Congressional Budget Office. Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2019 Budget. Available at: <https://www.cbo.gov/system/files?file=115th-congress-2017-2018/dataandtechnicalinformation/53906-medicare.pdf>.

¹⁸American Medical Association. Aligning Clinical And Financial Incentives For High-Value Care. Available at: <https://www.ama-assn.org/system/files/2018-12/i18-cms-csaph-joint-report.pdf>.

¹⁹Centers for Medicare and Medicaid Services. Medicare Advantage Value-Based Insurance Design Model. Available at: <https://innovation.cms.gov/initiatives/vbid/>.

²⁰Michigan Center for Value-Based Insurance Design. Precision Medicine Needs Precision Benefit Design. Available at: <http://vbidcenter.org/initiatives/precision-medicine/>.

²¹Doshi JA, Li P, Huo H, Pettit AR, Armstrong KA. Association of Patient Out-of-Pocket Costs With Prescription Abandonment and Delay in Fills of Novel Oral Anticancer Agents. *Journal of Clinical Oncology* 2018;(36)5:476-482.

²²Olszewski AJ, Dusetzina SB, Eaton CB, Davidoff AJ, Trivedi AN. Subsidies for Oral Chemotherapy and Use of Immunomodulatory Drugs Among Medicare Beneficiaries With Myeloma. *Journal of Clinical Oncology* 2017;35(29): 3306-3314.

²³Claxton G, Rae M, Long M, Damico A, Foster G, Whitmore H. Employer Health Benefits 2017 Annual Survey. Available at: <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017>.

²⁴Claxton G, Rae M, Long M, Damico A, Foster G, Whitmore H. Employer Health Benefits 2017 Annual Survey. Available at: <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017>.