

An Advocate's Guide to Patient Out-of-Pocket Costs for Prescription Medications

Thanks to innovative new treatments, some diseases that were once fatal are now being treated as manageable chronic conditions. For other diseases, new treatments have greatly increased average life expectancy. But the high out-of-pocket cost of accessing these breakthrough treatments make them out of reach for many patients.

Background and Issue Overview

Patients routinely pay for a portion of the cost for each of the health care services and treatments they receive. This “cost-sharing” between a patient and their health plan simply means that you and your insurer each pay a portion of your health care costs. In addition to a premium (the amount that a policyholder and/or his employer must pay for health insurance), most health care plans also include a deductible. A deductible is the amount you owe for health care services before your health insurance plan begins to contribute to the cost. Once a patient meets their health plan deductible, cost-sharing for prescription drugs generally falls into one of two categories:

Copay: The patient pays a fixed dollar amount for each prescription, and the health plan pays for the remainder of the cost.

Coinsurance: The patient pays a percentage of the total cost of the prescription, and the health plan pays for the remainder of the cost.

Health plans use tiered lists of drugs, called formularies, to communicate to patients what drugs are covered by the plan as well as what type and level of cost-sharing will be applied to each of the medications they have been prescribed. It is common, for example, for a higher copay to be charged for a name-brand drug than for a generic drug. Health insurers have historically used this tiered approach to cost-sharing in order to encourage patients and health care providers to make use of lower-cost medications whenever possible.

While the use of tiered formularies is an important tool for controlling drug spending, some diseases require treatments for which there is no available lower-cost therapy. And some patients do not respond medically to an available lower cost treatment. Yet, increasingly, insurers are placing treatments like oral anti-cancer drugs on the highest tiers of their formularies – often referred to as “specialty tiers” – where patients must pay coinsurance instead of a copay. For patients with serious illnesses – including blood cancer – this can mean that they are facing out-of-pocket costs of hundreds or thousands of dollars each month until they have reached their health plan’s annual out-of-pocket maximum. In 2015, out-of-pocket maximums can be as high as \$6,600 for an individual plan and \$13,200 for family coverage.

Devastatingly high out-of-pocket costs can make it impossible for cancer patients to afford their treatments. They are faced with the impossible choice of skipping their prescription drug regimens or going into extreme debt just to follow their doctors’ orders. When patients can’t afford their medications, they are forced to abandon their treatment, getting sicker and losing their ability to function as their disease worsens.

According to an article that appeared in the Journal of the American Medical Association (JAMA), non-adherence to medication regimens contributes an annual cost of \$100 billion to the U.S. health care system -- with indirect costs exceeding \$1.5 billion annually in lost patient earnings and \$50 billion in lost productivityⁱ

The Impact on Patients

Because of the way that health insurance benefit plans are currently designed, many blood cancer patients must pay thousands of dollars in out-of-pocket costs – especially in the beginning of their health plan year – to access the treatments their health care providers have prescribed.

The use of coinsurance for “specialty tier” drugs is commonly applied to medications used to treat not only cancer, but also HIV/AIDS, arthritis, multiple sclerosis and other debilitating and life-threatening diseases. This creates a financial strain for patients who are already facing enormous health care challenges.

For example: imatinib is a medication used to treat chronic myeloid leukemia (CML). Many CML patients must take this medication daily, for the rest of their lives. Given the price for an average monthly supplyⁱⁱ of imatinib, a cost-share of even just 20% generates an out-of-pocket expense of at least \$1,200 per month until the patient has reached his or her out-of-pocket maximum.

When cost becomes a barrier to access, patients may not use their medications appropriately, skipping doses in order to save money or abandoning a treatment all together. According to several studies, prescription abandonment rates increase significantly when patients have to pay more than \$100 for a prescription.ⁱⁱⁱ

Our Proposed Solution

The Leukemia & Lymphoma Society (LLS) seeks to ensure that all blood cancer patients have access to quality and affordable treatment. LLS advocates for implementation of policies at both the state and federal level that place limits on the out-of-pocket costs that patients are required to pay for each prescription medication.

Is This Feasible?

Two recent studies – one focused on federally regulated health plans^{iv} and another focused on state regulated health plans^v – analyzed the feasibility of imposing limits on the out-of-pocket costs patients pay for prescription drugs. Both analyses found that limited patient out-of-pocket prescription drug costs would dramatically improve affordability for patients and could be implemented with minimal impact on health insurance premiums.

ⁱ Goldman D.P., et al. (2004). Pharmacy benefits and the use of drugs by the chronically ill. JAMA., 291(19): 2344-2350

ⁱⁱ Imatinib carries a retail price in the \$6,000 to \$7,500 range for an average monthly supply.

ⁱⁱⁱ Streeter, S.B., Schwartzberg, L., Husain, N., Johnsrud, M. “Patient and plan characteristics affecting abandonment of oral oncolytic prescriptions.” *American Journal of Managed Care*. 2011. 175 (5 Spec No.): SP38-SP44.

^{iv} Estimated Impact of Patients’ Access to Treatments Act of 2013. A report of Avalere Health prepared for the Coalition for Accessible Treatments. August 30, 2013.

^v Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations. March 2015. A report by Milliman, Inc. commissioned by the Leukemia & Lymphoma Society.