

# Making Medicines More Affordable for Commercially Insured Patients and Medicare Beneficiaries

Patients continue to face challenges accessing the medicines they need despite a dramatic slowdown in medicine prices and spending. In fact, average net prices for brand medicines actually declined by 2.9% in 2020.<sup>i</sup> But it often doesn't feel that way for many of the sickest patients with complex and chronic health conditions who are burdened with most of the costs. That is because insurers and middlemen known as pharmacy benefit managers (PBMs) have shifted more health care costs to patients through the use of deductibles and coinsurance, which are typically based on the undiscounted list price of a medicine rather than the negotiated price the insurer or PBM receives. Prescriptions filled in the deductible or with coinsurance now account for more than half of total patient out-of-pocket spending.<sup>ii</sup> Today, patients are paying more for their insurance and getting less.

Biopharmaceutical manufacturers have stepped up to help patients who are struggling to afford their medicines through the [Medicine Assistance Tool](#) (MAT). MAT matches patients with resources and cost-sharing programs that may help patients with their out-of-pocket costs regardless of insurance status. But to truly fix the system and address patient affordability challenges, we need long-term solutions to make insurance work like it ought to, including by lowering patient cost sharing, making out-of-pocket costs more predictable throughout the year, passing along savings from negotiated rebates directly to patients at the pharmacy counter, and modernizing the Medicare program to work better for seniors and those with disabilities.

## Making Insurance Work Like Insurance

Insurance needs to work like insurance—it needs to spread costs broadly across all who are insured and pay for care when people are sick. Patients need lower out-of-pocket costs without reducing health care choice, quality or access. The following reforms can help to improve affordability and access for patients in the commercial market:

**Cover More Medicines from Day One.** Insurers are increasingly requiring people to pay high deductibles before receiving coverage of their medicines.<sup>iii</sup> This can lead to people rationing their medicine or not taking it at all and suffering devastating consequences to their health. People managing chronic health conditions should have at least some of their medicines covered by their insurance from day one.

**Make Cost Sharing More Predictable.** Insurers' increasing use of coinsurance—where patients are typically charged a percentage of the full list price of a medicine—can leave patients with sticker shock at the pharmacy counter. One potential solution is to encourage the use of fixed-dollar copays instead of coinsurance. Placing a limit on the maximum amount a patient will be asked to pay per prescription, per month and/or annually would also help.

**Make Coupons Count.** Due to high out-of-pocket costs, patients are increasingly turning to manufacturer cost sharing assistance to help them afford their medicines.<sup>iv</sup> In some cases, health insurance companies do not allow the assistance manufacturers provide to patients to count toward deductibles or other out-of-pocket limits, meaning people could be paying thousands more at the pharmacy than they should be. We need to end this practice and ensure that people get the full benefit of the programs meant to help them afford their medicines.

**Share the Savings.** Rebates and discounts that pharmaceutical companies pay to health insurance companies, PBMs, the government and others reduce the list prices of brand medicines by 44%, on average.<sup>v</sup> In 2020 alone, rebates, discounts and other price concessions reached \$187 billion. And although rebates and discounts have more than doubled in size since 2012, it does not feel that way to many insured patients with complex and chronic health conditions. But too often, these rebates and discounts are not used to directly lower costs at the pharmacy counter. If insurance companies and middlemen don't pay the full price for medicines, patients shouldn't either. More of these rebates and discounts should be shared directly with patients at the pharmacy counter.

**Standardize Health Plans.** The U.S. Department of Health and Human Services has noted that consumers have difficulty navigating the “complex tradeoffs among cost-sharing differences among a large number of plans.”<sup>vi</sup> Without standardized health plans, enrollees often purchase health plans primarily based on premiums, and do not focus on cost-sharing parameters while shopping. Requiring health plans to offer at least some standardized health plans on federal and state Exchanges can simplify the process of obtaining health insurance coverage by streamlining plan choices in a consumer-friendly manner. This is especially true when the standardized plan contains patient-friendly cost-sharing parameters such as low deductibles and fixed-dollar copayments.

## Improving Affordability in Medicare Part D

Even though market forces are working to hold down prices and spending for medicines, many Medicare Part D beneficiaries who are not eligible for low-income subsidies (LIS) face multiple affordability challenges today due, in part, to the way the benefit is structured and how cost sharing is calculated. These challenges include high-cost sharing, the lack of an out-of-pocket cap, and an uneven distribution of out-of-pocket costs throughout the year.

More costs are being shifted onto seniors and people with disabilities through the substantial increase in the use of coinsurance and complex multi-tiered formularies in Medicare Part D, which provides coverage for medicines at retail or mail order pharmacies. As a result, 62% of all medicines covered by Part D plans are now on a coinsurance tier and 92% of total Part D beneficiary out-of-pocket spending is tied to the undiscounted list price.<sup>vi,viii</sup>

Part D could work better and be made fairer by improving affordability and predictability for beneficiaries who face high out-of-pocket costs for their medicines. Improvements to Part D must be done the right way, with targeted and measured reforms.

**Cap Annual Out-of-pocket Costs.** Most patients with commercial insurance coverage already benefit from an annual limit on out-of-pocket costs. But this is not the case for seniors and those with disabilities in Part D. We need to cap annual out-of-pocket costs in Part D.

**Lower Cost Sharing and Make it More Predictable.** We should lower the amount of cost sharing seniors and people with disabilities have to pay in Part D and allow them to spread out their cost sharing payments over the year to give more predictability and peace of mind about what they'll pay each month at the pharmacy.

**Share Savings at the Pharmacy Counter.** Similar to the commercial market, the rebates and discounts pharmaceutical manufacturers negotiate with Part D health insurance plans often are not directly used to lower beneficiary out-of-pocket costs. We must ensure these savings are passed on to seniors and people with disabilities at the pharmacy counter.

## Reducing Costs in Medicare Part B

Part B covers a wide range of advanced, physician administered therapies, such as complex biologics, that have played a major role in transforming the outlook for patients with serious and life-threatening diseases like cancer, rheumatoid arthritis, hemophilia, macular degeneration and rare genetic disorders. The market-based system used to reimburse providers for the medicines they administer (called the average sales price – or ASP – methodology) has successfully managed costs and assured robust and timely access to these medicines for beneficiaries. However, we believe more can be done to strengthen this system.

We support reforms that enable Medicare and Medicare beneficiaries to benefit more from the lower prices negotiated by large commercial purchasers in the market, while protecting physician care quality and patient access. Under this approach, manufacturers would provide a price concession to Medicare, called a “market-based adjustment,” based on prices that fall below the ASP. This reform would achieve savings for the government and beneficiaries while protecting access to medicines and provider reimbursement, with significant savings for the approximately 10% of seniors and people with disabilities on Medicare who lack supplemental insurance and are responsible for 20% of the costs of their care – including medicines covered under Part B.<sup>ix</sup> For these beneficiaries, it could lower their out-of-pocket costs by hundreds or even thousands of dollars a year.



i IQVIA. [Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2025](#), May 2021.

ii IQVIA. [Medicine Spending and Affordability in the U.S.](#), August 2020.

iii Ibid.

iv IQVIA. [Faced with High Cost Sharing for Brand Medicines, Commercially Insured Patients with Chronic Conditions Increasingly Use Manufacturer Cost-Sharing Assistance](#), 2020.

v IQVIA. [Use of Medicines in the U.S.: Spending and Usage Trends and Outlook to 2025](#), May 2021.

vi HHS Notice of Benefit and Payment Parameters for 2017 proposed rule, 80 CFR 75487.

vii Avalere Health. 2021 Medicare Part D Formularies: An Initial Analysis. December 2020.

viii PhRMA. Trends in Out-of-Pocket Spending for Brand Medicines in Medicare Part D. <https://www.phrma.org/Report/Trends-in-Out-of-Pocket-Spending-for-Brand-Medicines-in-Medicare-Part-D>

ix J Cubanski et al., [Sources of Supplemental Coverage Among Medicare Beneficiaries in 2016](#), KFF, November 2018.