Cost shifting may make arthritis medications too expensive for medicare beneficiaries

June 1 2009

Biologic disease-modifying antirheumatic drugs (DMARDs) such as adalimumab, etanercept and infliximab are effective at reducing symptoms and slowing progression of rheumatoid arthritis (RA). These drugs act more quickly, require less laboratory monitoring, and are better tolerated than nonbiologic DMARDs, but they are also up to 100 times more expensive. Insurance plans differ greatly in their coverage of and cost sharing for biologic DMARDs, sometimes shifting a large portion of the cost of patients. A new study examined the cost-sharing structures for biologic DMARDs in Part D plans and the resulting cost burden to patients. The study was published in the June issue of *Arthritis Care & Research*.

In 2003, Congress created the Medicare Replacement Drug Demonstration (MRDD) to provide temporary drug insurance until the start of Medicare Part D in 2006. The MRDD, which ran September 2004 - December 2005, targeted low-income vulnerable Medicare patients with select conditions, including RA, who did not have comprehensive drug insurance coverage. This program had similar cost-sharing arrangements to Medicare Part D and evaluations showed that it reduced financial barriers and improved health outcomes. However, unlike the MRDD, Part D plans could place high-cost items such as biologic DMARDs in a specialty tier, where they are subject to higher patient cost sharing. There is concern that specialty tiering imposes a heavy financial burden on RA patients.

Led by Jennifer M. Polinski of Brigham and Women's Hospital in

Boston, researchers followed almost 15,000 vulnerable, low-income patients who were enrolled in the MRDD as they transitioned into Part D in 2006. They grouped patients into one of three drug coverage options: enrollment in a Part D plan further stratified by a Medicare Advantage or stand-alone plan, other creditable coverage or unknown coverage. They examined the benefit design of each plan, as well as potential differences in beneficiaries' annual out-of-pocket costs for biologic DMARDs under three coverage scenarios.

They found that 81 percent of poor and disabled Medicare beneficiaries with RA who participated in the MRDD program had enrolled in Part D plans by July 2006. Compared with stand-alone Part D plans, Medicare Advantage plans offered lower deductibles, lower premiums, and were more likely to require copayments (which are fixed), rather than coinsurance (typically a percentage paid by the insured person pays after an insurance deductible has been exceeded). They also placed significantly fewer restrictions on biologic DMARD reimbursement. "In spite of the greater generosity and lesser restrictions of Medicare Advantage plans, the most sick and most financially needy patients enrolled in these plans less often than they did in stand-alone plans," the authors note.

Most patients enrolled in plans that placed biologic DMARDs on high-cost specialty tiers and used coinsurance proportions as high as 75 percent. The specialty tier was created to ensure that beneficiaries receiving high-cost biologic agents were not discriminated against in terms of cost sharing, but there is concern about the financial impact of this structure, especially the widespread use of high coinsurance. The study found that Part D plans that require coinsurance instead of copayments shift the financial burden of these high-cost medications from the plan to the patient and to Medicare. In plans where cost sharing is high (e.g. plans with high coinsurance), patients may delay or not even begin therapy due to the high cost; in plans with cost sharing that is steep

but manageable (e.g. plans with high copayments) patients may begin therapy but then discontinue it when faced with paying the full cost of the medication out of pocket. "Neither scenario is optimal for patients who may benefit from biologic DMARDs," the authors point out.

Specialty tier and coinsurance resulted in estimated annual expenditures for patients that exceeded $4,000 despite drug insurance coverage and more Part D plans have adopted specialty tiering over time. In 2006, 60 percent of the national stand-alone plans used this system but by 2008, 87 percent were using it. Similarly, between 2006 and 2008 the number of plans charging 33 percent coinsurance increased more than five-fold. "Patients assume up to 28 percent and Medicare assumes more than 58 percent of the costs of biologic DMARDs in our scenarios, yet neither is in a position to sustain such financial burden," the authors conclude. "As more biologic DMARDs are approved and used for RA and more plans use the specialty tier system, both beneficiaries and Medicare face costs they may be increasingly unable to afford."

More information: "Impact of Medicare Part D on Access to and Cost Sharing for Specialty Biologic Medications for Beneficiaries with Rheumatoid Arthritis," Jennifer M. Polinski, Penny E. Mohr, Lorraine Johnson, Arthritis & Rheumatism (Arthritis Care & Research), June 2009. http://www3.interscience.wiley.com/journal/77005015/home

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