October 18, 2018

Rheumatoid Arthritis Patients Could Face Access Barriers Under Proposal to Address Drug Prices

New research from Avalere finds that Medicare patients with rheumatoid arthritis (RA) may face higher out-of-pocket costs under a proposal to move Medicare Part B drugs into Part D, absent additional policy change to lower cost sharing in the Part D program. Avalere's study finds that seniors often pay more out-of-pocket for RA drugs covered under Medicare Part D compared to those covered in fee-for-service (FFS) Medicare under the Part B benefit.

In 2016, the average annual out-of-pocket costs for Part B-covered RA drugs was $1,380, compared to $1,990 for drugs covered by Part D. These figures represent average costs across patients, including those with supplementary coverage or low-income subsidies (LIS).

A variety of specialty drugs are used in the treatment of RA—some are primarily used to ease disease symptoms, while others are indicated for slowing or stopping disease progression. Currently, Medicare covers RA biologics either under Part B or Part D, depending on whether the drugs are self-administered by a patient or administered within a provider's office. As part of its blueprint to reduce drug prices in the US, the Trump administration is evaluating the merits of consolidating coverage for some therapies under Part D.

"Without benefit design changes, shifting rheumatoid arthritis drugs from Part B into Part D may lead to higher out-of-pocket costs for many Medicare patients," said Matt Brow, president at Avalere. "The impact on individuals may vary based on the medication they take or the Part D plan they choose."

Out-of-pocket costs for Medicare patients are determined by many factors, such as income, health status, type of coverage, formulary design, and price of prescribed therapies. Due to the differing benefit designs of Part B and Part D, a patient's out-of-pocket costs for RA therapies can vary substantially between the two programs.

In Part B FFS beneficiaries typically pay 20% of the total cost of medical services – also known as coinsurance – including for medicines administered in a provider's office. Supplemental plans (e.g., Medigap, employer coverage) are available to Part B FFS beneficiaries to cover costs such as deductibles, coinsurance, and copayments, but they are not permissible under Part D. Medicare Part D covers only self-administered prescription medicines and has a more complex structure that requires some degree of out-of-pocket spending for beneficiaries who do not qualify for low-income subsidies. Avalere's analysis shows that Prescription Drug Plans (PDPs) subject all Part D-covered RA therapies to coinsurance, rather than copayments (i.e., fixed dollar amounts), most frequently in the range of 25-33% (Figure 1).

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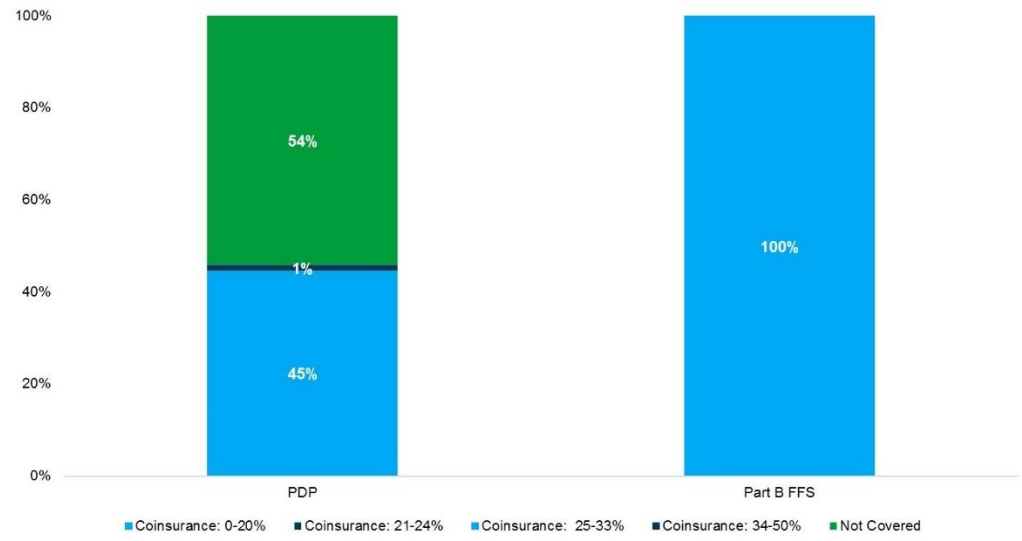
Figure 1. Cost-sharing Levels for Rheumatoid Arthritis Medicines, Medicare Part D Prescription Drug Plans and Part B FFS, 2016

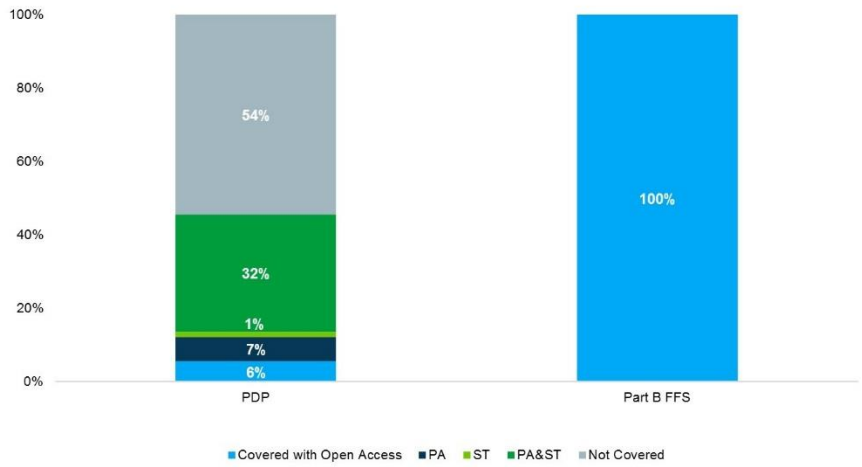


Source: Avalere Health PlanScape®, a proprietary analysis of prescription drug formularies, July 2018. This analysis is based on data collected by Managed Markets Insight & Technology, LLC, representing formulary coverage in July 2016.

As a result of the different benefit structures of Part B and Part D, Avalere's analysis finds that in 2016, patients receiving Part-D covered therapies on average paid $610 more per year compared to those taking RA therapies covered by Part B. The impact on individual patients would vary based on their income level and their access to Low Income Subsidies (LIS) under Part D or supplemental health insurance in Part B.

Avalere's analysis also finds that Part D plans cover RA drugs without any utilization management, such as prior authorization and step therapy, only 6% of the time (Figure 2). Under Medicare FFS, Part B drugs are not subject to prospective utilization management, thus allowing physicians to choose from the full range of clinical options for their patients.

Figure 2. Utilization Management for RA Therapies, Medicare Part D Plans and Part B FFS, 2016



Source: Avalere Health PlanScape®, a proprietary analysis of prescription drug formularies, July 2018. This analysis is based on data collected by Managed Markets Insight & Technology, LLC, representing formulary coverage in July 2016.

"The proposal to move drugs from Part B into Part D may subject more patients to utilization management for rheumatoid arthritis medications," said Richard Kane, senior director at Avalere. "As a result, beneficiaries may find it more difficult to access care."

This analysis of benefit design and out-of-pocket costs does not include Medicare Advantage (MA) plans, which currently represent about 32% of beneficiaries. Recently, the administration released guidance that allows MA plans to apply utilization management, in particular step therapy, across both Part B and Part D drugs, which could raise similar questions about access and out-of-pocket costs.

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Methodology

Avalere analyzed prescription drug event (PDE) data and Medicare Part B FFS claims for 2016 under a CMS research data use agreement. We analyzed a cohort of patients representing less than 20% of total beneficiaries; this cohort included beneficiaries we identified as receiving rheumatoid arthritis (RA) treatments during 2016. We defined RA therapies to include one or more of the following drugs: adalimumab, anakinra, certolizumab pegol, etanercept, hydroxychloroquine sulfate, leflunomide, sarilumab, sulfasalazine, tofacitinib citrate, abatacept,

azathioprine, golimumab, infliximab, infliximab-abda, infliximab-dyyb, rituximab, and tocilizumab when accompanied by a diagnosis of M05.xxx and MO6.xxx.

We classified patients as receiving a Part D-covered RA therapy if they had two or more PDE events for a drug in 2016, a Part B evaluation and management (E&M) visit with a diagnosis for RA during the year, and a medical claim (Part A or Part B) with an RA diagnosis occurring less than 60 days prior to the PDE event. We classified patients as receiving a Part B-covered RA therapy if they had two or more Part B claims for a drug with a diagnosis for RA.

We used the PDE data to estimate the amount patients paid out-of-pocket for Part D therapies. We used FFS claims data to estimate the beneficiary liability for Part B therapies, and then assumed the share of patients without supplemental coverage was similar for this group of patients as for all Medicare Part B enrollees.

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