GoodRx Health

How Affordability Impacts Medication Adherence


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Key takeaways:

- An estimated 1 out of 4 prescriptions in the U.S. are never filled, and, in approximately half of all cases, patients do not take treatment as prescribed.
- Affordability is a major cause of medication nonadherence — particularly for the uninsured, the underinsured, and those with Medicare.
- Using assistance programs unique to each patient group can help mitigate affordability challenges.

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Medication adherence — often defined as taking 80% or more of prescribed doses — continues to be a challenge in the U.S. In fact, medication nonadherence can lead to increased healthcare costs and is associated with hospitalization and mortality.

One study estimated that about 1 out of every 4 prescriptions are never filled, and patients with chronic conditions are estimated to adhere to only about 50% to 60% of prescribed medications.

While numerous factors affect adherence, affordability remains a significant barrier, and, here, we'll explore the effects of affordability on adherence. We'll also look at ways to help patients overcome financial barriers.

Patients most vulnerable to the impacts of medication costs

Even medications we might consider affordable can be a struggle for others, who may be choosing between paying for food, electricity, rent, or medication. One study found higher copays to be a strong predictor of treatment failure.

The National Health Interview Survey, investigating strategies that patients used to lower their drug costs and the effects of cost on adherence, found that almost 8% of U.S. adults did not take medicine as prescribed in order to save money, and an additional 15.1% asked their doctor for a lower-cost medication.

Below, we explore the problem among three distinct patient groups.

The uninsured

Uninsured patients are especially vulnerable to high medication costs. According to the National Health Interview Survey, they are the most likely patient group to struggle with medication adherence, to ask their doctor for cheaper medications, and to buy medications from other countries. In fact, data as recent as 2018 found the top 5% annual out-of-pocket spending among the uninsured topped $1,620.

Medicaid Medically Needy

Medicaid "share of cost," also called Medically Needy programs, insures those whose income is above Medicaid requirements. It is challenging because a patient must "spend down" their income every month until they meet Medicaid eligibility requirements in order for the coverage to be activated. A total of 36 states and the District of Columbia currently have Medically Needy programs. Florida provides an overview of how this program works.

If the patient's annual gross household income is $12,000 above the eligibility requirement for Medicaid, for example, then every month they must spend or be billed $1,000 in healthcare expenses before Medicaid is activated.

The bills must be submitted to the state each month, which is a significant burden for both the patient and the provider. To further complicate matters, after the bills are submitted, there is a waiting period for the state to process the bills and activate Medicaid. Sometimes this runs into the next month, and the patient is forced to start over. In the interim, patients don't qualify for many other programs because they, at least on paper, have insurance via Medicaid.

Adherence data on Medically Needy programs are scarce, but even those with full Medicaid and thus little to no cost sharing were second most likely, behind the uninsured, to be nonadherent or ask their doctor for a different medication, according to the National Health Interview Survey.

Medicare Part D

Medicare Part D patients struggle with adherence due to the structure of the program, which consists of four phases (dollar amounts listed are for 2022 plans):

- **The deductible phase:** The initial deductible — a maximum of $480 — must be paid by the patient before the plan pays anything.
- **The initial coverage phase:** During this phase, the patient will only be required to pay their usual copays. Many branded drugs have a copay of around $47.
- **The "donut-hole," or coverage gap phase:** After the patient and the plan have spent $4,430 on drugs, the patient must pay up to 25% of medication costs until they reach catastrophic coverage.
- **Catastrophic coverage:** Once the patient has spent $7,050 out of pocket, they reach catastrophic coverage, where drugs are either completely covered or only require a small copay.

Because of the deductible period and the donut hole, Medicare patients — unlike Medicaid patients — can face high copays even if the medication is on formulary. Yet, unlike privately insured patients, they do not qualify for manufacturer copay cards, because the cards are considered a kickback.

A recent study found Medicare Part D patients, without any supplement, to be more likely to switch, stop, or delay their cardiovascular medications during the donut hole compared to beneficiaries with coverage throughout the donut hole. This is consistent with previous data investigating the relationship between the donut hole and adherence.

Addressing affordability concerns

Affordability is a challenge, but there are programs out there to help.

Uninsured patients

Dispensary of Hope is a nonprofit drug distributor that enrolls member pharmacies that dispense medications at no cost to eligible patients. Currently, patients must be under 300% of the federal poverty guidelines and have no prescription drug insurance.

The Department of Health also offers programs for specific conditions, like HIV or diabetes, and often offer related medications at either no cost or on a sliding scale.

Patient assistance programs are available for many branded medications. Once approved, the manufacturer will mail the patient the medication at no cost to them.

Medicaid Medically Needy program

Ensuring that bills are faxed to the Medicaid office as soon as possible will shorten the time it takes to activate coverage. Keep in mind that the patient is not required to have paid the bill — only to have incurred it — so consider creating a process in the office to automatically fax them.

While bills can be faxed by either the patient or the provider's office, the provider is in the best position to do so because of access to medical and billing records as well as to a fax machine.

Medicare Part D

The Medicare Find a Plan site is a great tool during open enrollment, when patients can choose a new plan. After entering ZIP code and medication regimen, a list of plans in the area will populate, along with estimated total cost, monthly expenses, premiums, and plan satisfaction ratings. It will estimate when the patient will enter and exit the donut hole and list out-of-pocket costs during that period.

Some Medicare patients might qualify for Extra Help, which offers assistance for copays, premiums, and deductibles. This help is estimated at around $5,100 per year, and patients must have limited resources, as defined by the Social Security Administration, although patients with both Medicare and Medicaid automatically qualify.

The bottom line

Medication adherence is a significant barrier to optimal health outcomes in the U.S., and affordability remains a challenge for many Americans. Groups most vulnerable to nonadherence due to affordability include the uninsured, those enrolled in Medicaid Medically Needy, and Medicare patients. However, there are programs out there to help, and provider offices are in an ideal position to help patients find the resources they need to ensure they can stay adherent.

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