

The Impact of Medication Cost on Dialysis Patients

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Background

Americans spend more money on prescription drugs than any other nation in the world. In 2018, spending on medicines, including over-the-counter drugs, in the United States was \$1229 per person. This cost really sets us apart from most other countries (1).

In Europe, the second-largest pharmaceutical market after the United States, governments negotiate with the drug companies directly, limiting what their health systems pay. The US free market economy, however, does not allow for direct negotiation with drug companies. Instead, the compensation of numerous stakeholders (from insurance companies to pharmacy benefit managers) is negotiated throughout the pharmacy supply chain, adding considerably to the final cost of medications (2).

The result of these drug cost disparities is that people in the United States are far more likely to do without medications due to cost concerns. One in five US adults (11% of all patients) said they failed to complete a prescribed course of medicine because of cost.

Effect of Medication Cost on Patients on Dialysis

People with CKD and ESKD are even more profoundly affected by medication costs. Among patients enrolled on Medicare, per person per year out-of-pocket costs for Medicare Part D covered drugs in 2018 were \$440 for all patients with ESKD, \$381 for those on hemodialysis, and \$569 for those on peritoneal dialysis (3).

Between 2009 and 2018, total Medicare Part D spending, in inflation-adjusted dollars, rose by approximately 80% in those with ESKD (from US\$1.9 billion to US\$3.4 billion) and by approximately 50% in those without ESKD (from US\$44.0 billion to US\$67.3 billion). This increase is due to both the increased numbers of patients with CKD and ESKD, and to higher drug costs.

Early access to treatment such as cost-effective blood pressure medications can prevent or delay the onset of higher-cost treatments, such as dialysis and kidney transplant, yet high out-of-pocket costs often keep patients with CKD from taking their prescribed medications. This nonadherence can lead to far higher medical costs, including those related to strokes and heart attack. Low-income households and the uninsured are the worst affected (4).

How much someone pays for drugs depends on many things, including what drugs they are prescribed, their income, and where they get their drug coverage.

There are a number of resources that can help pay for drugs:

- For people with Part D coverage and limited income and resources/assets, there is Part D extra help. For those receiving Medicare's low-income subsidy, out-of-pocket costs were only 1%–2%, whereas patients who did not receive the subsidy paid 28%–32%.
- Some drug companies have patient-assistance programs, and some foundations/charities (https://www.medicarerights.org/fliers/Help-With-Drug-Costs/copay_charities.pdf) help people pay for drugs if they meet income guidelines, have certain diagnoses, and/or have (or do not have) certain types of drug coverage.
- Some states have prescription-assistance programs that pay a portion of drug costs.
- Drug discount cards, and websites such as GoodRx.com, provide discounts and coupons on prescription drugs.

Effect of Medication Management

The complexity of dialysis places patients at risk for medication-related problems. Patients on dialysis typically have 10–12 prescription medications, resulting in an average burden of 19 pills per day, and these medications are prescribed by an average of 4–5 different providers (5). Complex medication regimens place patients on dialysis at risk for drug interactions and other medication-related problems. Improving medication management in this vulnerable population is an increasing concern.

Medication management—including medication reconciliation, safety programs, and medication therapy management for patients at high risk for medication-related problems, adverse drug interactions, and hospitalization—may result in improved outcomes and lower costs.

Current approaches to medication management, designed for the broader patient population, may not be well suited to the needs of patients with kidney disease. Given the complexity of medication regimens used by patients on dialysis, a national initiative has been created to include pharmacists as an integral part of the care team for patients with CKD/ESKD (6). Although this strategy may be viewed as costly by some, and has not yet been widely deployed, its costs may be offset by reductions in hospital admissions

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and readmissions, and through reduced medication costs. There is evidence supporting the idea that active medication management can improve medication adherence and reduce medication-related problems.

The dialysis facility is a logical coordination center for medication management services for patients with ESKD. A dialysis clinic is often the first health care facility visited by a patient with ESKD after hospitalization. A clinic-based pharmacist could provide consistent, high-quality medication management services. The use of medication reconciliation and management services to identify and resolve medication-related problems would be likely to improve outcomes for patients with ESKD and reduce total cost of care consistently and systematically (7).

Beginning in 2022, the Centers for Medicare and Medicaid Services will require dialysis facilities to report on a new Quality Incentive Program measure with respect to medication reconciliation. This measure will describe the percentage of patient-months in a dialysis facility for which a medication reconciliation was performed and documented by an eligible professional (5).

What Patients Are Saying

Anecdotally, I asked members of several dialysis support groups (8,9) how they have been affected by medication costs. The majority had Medicare and/or private insurance or a supplement plan and paid very little overall, but the discrepancies can be huge, even among those taking the same drug. Patients with Medicare primary and a secondary payor seem to fare best, with annual drug expenditures of anywhere from US\$0 to US\$4000:

I have private insurance and I only have to pay copays in January, so I spend about US\$500.00 for my wife and me in January. After that, my dialysis cost has eaten up my deductible, so I then have US\$0.00 copay for generic drugs.

I had a combination of Medicare and private insurance and I did not pay anything out of pocket for my dialysis meds.

We use (discount chain) pharmacy, so even when he just had Medicare, meds weren't too expensive. (He's also not on a lot of meds though.) Now that he's back on Medicaid, the most we pay is US\$3 per prescription.

My husband spent US\$2534.99 out of pocket last year for prescription drugs. This past year he had an issue with his foot—surgery, intravenous antibiotic at home, ointments, etc. The other major expense was insulin.

Finding affordable medications has been a struggle for me since I lost my union plan and had to get the Medicare D plan ... I find it extremely hard when I'm in the "donut hole" for Medicare (who thinks this stuff up?). First, I stockpiled my insulin when I switched to Medicare, then I stopped eating so I wouldn't use up all my insulin, and then I stopped taking insulin altogether because I was in a donut hole and insulin was going to cost US\$1000 each month for 3 months ... ugh ... Recently I was hospitalized with blood clots TWICE because I couldn't afford my blood thinners ... I have had doctors switch my binders because of cost ... Even at US\$30–US\$50, if you are on a fixed income your money

is earmarked and some months you just don't have it ... or you don't pay something or buy food ... I cry sometimes because I cannot afford to buy my medicine or if I did my rent didn't get paid that month ... and with my health issues (lupus, ESKD) you cannot do that and stay well.

In conclusion, it appears that people with CKD and ESRD have a heavier and costlier pill burden, but many can find drug plans and supplemental programs to help offset costs. Even so, the disparities, especially in patients with a low income, are widespread. This vulnerable population could greatly benefit from a program of medication management and cost containment.

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Author Contributions

N. Gedney wrote the original draft.

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