

Low-Income Subsidies: Impact on Disparities, Anticancer Treatment Use, and Spending Among Medicare Beneficiaries with Multiple Myeloma

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Abstract

Significant out-of-pocket costs have contributed to the suboptimal use of orally-administered antimyeloma medication and exacerbated racial/ethnic disparities in access to necessary therapy. The low-income subsidy (LIS) program reduces cost-sharing for Medicare Part D beneficiaries with limited incomes and thus, may improve access to high-cost antimyeloma therapies and narrow racial/ethnic disparities in antimyeloma care.

To test these hypotheses, we used 2006-2016 Surveillance, Epidemiology, and End Results (SEER)-Medicare linked data. We used Cox proportional hazards models and modified Poisson regression to assess the relationship between LIS program participation and (1) initiation of and adherence to antimyeloma therapy; and (2) racial/ethnic disparities in initiation of and adherence to antimyeloma treatment. We also used log-binomial models and generalized linear models to examine the association between subsidies and (1) hospitalizations and emergency department (ED) visits and (2) total and component Medicare spending, respectively.

LIS program participation was not associated with earlier initiation of or improved adherence to orally-administered antimyeloma therapy. However, LIS enrollees were 22% more likely to experience earlier treatment discontinuation than non-subsidized patients. In terms of healthcare use and spending in the 12 months following diagnosis, LIS enrollees had an increased risk of ED visits and hospital admissions, as well as higher total Medicare expenditures compared to non-LIS enrollees. Receipt of full subsidies did not appear to minimize racial/ethnic disparities in antimyeloma treatment use. Black LIS and non-LIS enrollees were less likely than their non-Hispanic/Latino White counterparts to ever-initiate therapy (LIS: adjusted hazard ratio [aHR] 0.86, 95% CI 0.73-1.02; non-LIS: aHR 0.86, 95% CI 0.74-0.99).

Cost-sharing subsidies alone are insufficient to improve the use of or reduce racial/ethnic disparities in antimyeloma care. Healthcare providers and policymakers should address known barriers to access (e.g., implicit bias, social determinants of health, patient education) to ensure uptake of and equitable use of high-cost antimyeloma treatment.

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