Article

How Patient Support Can Ease Transitions to the Part D Redesign in 2025

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Imagine planning a hike through Yosemite National Park. To prepare, you acquire a detailed trail map and compass, and research the terrain, including the changing foliage and the potential for icy conditions. These precautions are key to staying safe and on course. Otherwise, you could face challenges that delay the journey or leave you stranded.

Since Medicare Part D's introduction in 2006, many beneficiaries have felt like they were hiking in Yosemite without a map or compass. The infamous "donut hole" created uncertainty and strained budgets — forcing choices between paying for medications or other vital necessities. Some patients resorted to using credit, accumulating debt just to stay healthy.[1] These financial burdens led to cost-related non-adherence, where patients skipped doses or stopped taking medications altogether because they simply couldn't afford them.[2]

A new year, a new era in Medicare Part D

January 1, 2025, will bring more than a new year; it will also ring in provisions of the Inflation Reduction Act (IRA) of 2022 that affect Medicare Part D. So, what's going to change? First, annual out-of-pocket (OOP) expenses will be capped at $2,000, **making medication more affordable**. Second, through the Medicare Prescription Payment Plan (M3P), patients who are taking high-cost specialty drugs will have the **opportunity to exert greater control over when they pay for their prescriptions**. Rather than frontloading costs in the first few months of 2025, patients will be able to spread the expenses throughout the year.

These changes prompt several crucial questions about the broader implications on patient behavior and health outcomes. How will the $2,000 OOP cap and M3P drive patients' ability to use their benefits and maintain therapy? With the previous coverage gap removed, how will patient behavior evolve — and how should manufacturers' patient assistance program strategies shift to support the Medicare population, including the most vulnerable seniors?

To address these questions, pharma leaders should consider such factors as their patients' health literacy, access to healthcare services, and socioeconomic statuses. By understanding these factors, companies can better understand and anticipate changes in utilization rates and trends by therapeutic area. For example, our U.S. Market Access Strategy Consulting analysis across all cancer types found an average 12% decrease in patient use of third-party support from the beginning of 2023 to 2024. We would assume a further decrease in 2025 with the patient affordability incentives.

[1] Does Medicare Part D still have a donut hole? What you need to know | Fortune Well
[2] 3 big changes coming to Medicare in 2025 — and what they'll mean for you | Fortune Well

This may be an opportunity for a re-evaluation across all patient programs for oncology franchise leaders, with changes to foundation partnerships, patient assistance programs, and commercial program support based on higher Medicare utilization rates.

Looking back to plan ahead

Nearly two decades ago, the Medicare Modernization Act (MMA) of 2003 provided for the creation and implementation of the Medicare Part D benefit on January 1, 2006. This was landmark policy legislation. **Yet policy change is just the first step in advancing patient access; implementing policy represents another significant challenge.**

At that time, the Bush Administration and the CMS Administrator relied heavily on healthcare.gov to educate enrollees about Part D plan options. When the website failed, patients and caregivers were left confused and searching for help.

Industry-sponsored patient support programs emerged as a surprising source of information and education. Such programs were hit with a surge in demand — including an increase in the volume, length, and complexity of interactions with patients and healthcare providers.

What's more, this surge occurred at the height of reverification season. For a hiker in Yosemite, it was the equivalent of encountering unexpectedly rough terrain — in the middle of a snow squall.

We believe a similar scenario is now taking shape.

Patient support teams: Start preparing now

Recent history has shown that the start of any calendar year can bring increased demand for patient support services. For example, the technology provider, Infinitus, has reported that call volumes among access hubs increased 2.2 times in January 2024 compared to January 2023. Similarly, the length of time on interactive voice response systems increased by 78% in 2024 compared to 2023. Meanwhile, payer conversations increased by 100% in 2024 compared to 2023. In short, access hurdles, payer controls, and obesity drug launches drove up staffing requirements at the beginning of 2024.[3]

Add in Medicare Part D changes for 2025, and the odds are high that access and customer service teams will be inundated with outbound and inbound calls. Based on that hypothesis, now is the time to begin creating your patient support services insurance plan.

With the year-end approaching quickly, consider these three steps:

1. Analyze the potential expected call volume based on your brands' Medicare Part D population and potential for new enrollees, or those patients previously covered by a patient assistance program.
2. Model capacity, hire, and train for staffing needs.
3. Finalize your FAQs and call guides.

At IQVIA, we've given a lot of thought to the impacts — and opportunities — inherent in the redesign of Medicare Part D. We invite you to seize this moment and begin transforming patient support from reactive and financially oriented, to more connected and personalized. To help kickstart the process, we've created a checklist for preparing sales teams, educating healthcare providers and patients, and shoring up data and operations.

[3]Benefit verification call length, IVRs, and hold times are increasing: What we learned from reverification season — Infinitus

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