ORIGINAL RESEARCH

A Descriptive Study of Patients Receiving Foundational Financial Assistance Through Local Specialty Pharmacies

Julia Zhu, MPH, MS; Randall Odebralski, MBA; Safia Boghani, MPH; Clorinda Walley; Frank Koen, RPh; Chad Conley; and Heather S. Kirkham, PhD, MPH

ABSTRACT

OBJECTIVES: To describe the population of patients who received financial assistance from the Good Days Foundation (GDF) as facilitated by Walgreens local specialty pharmacies (LSPs).

STUDY DESIGN: This was a retrospective descriptive study.

METHODS: This study used a joint foundational and pharmacy claim database between January 1, 2014, and December 31, 2016.

RESULTS: Among 1572 eligible patients who received GDF financial assistance as facilitated by Walgreens LSPs, 1524 had disease state information and 14 of these patients receveived financial assistance for 2 disease states (patient count denominator, 1538). The top 3 disease states by patient count were oncology (1403; 91.2%), multiple sclerosis (49; 3.2%), and hepatitis C (39; 2.5%). Of the 777 patients who had complete data and disease state information, 2 received finanical assistance for 2 disease states (denominator, 779); oncology remained the disease with the highest patient count (724; 92.9%). The mean annual financial assistance per patient was highest for hepatitis C ($4156), followed by oncology ($3603) and miscellaneous/rare disease ($1829), which covered 98.8%, 99.3%, and 99.6% of these patients' total co-pay requirements, respectively. In addition to prescription co-pay assistance, 21 patients received travel assistance of $554 per year per patient from GDF. The mean persistence of oncology patients was 170.7 days without a 30-day gap over 1 year of observation time.

CONCLUSIONS: The facilitation of treatment by GDF and Walgreens LSPs may be the key to many patients receiving their treatment and maintaining medication persistence. GDF co-pay assistance helped cover most out-of-pocket costs associated with medications and aided with travel expenses for patients, especially in the area of oncology. For many patients, this meant reducing the significant financial barriers to accessing care and facilitating the necessary treatment for their chronic or life-altering disease. Without this assistance, many patients would simply not have been able to meet the expected medication persistence and thus would have received suboptimal treatment.

Am J Manag Care. 2018;24(5 Suppl):S80-S84

Numerous studies have demonstrated that higher co-pay, coinsurance, and out-of-pocket (OOP) costs can lead to medication underuse and lower adherence.[1-8] This lack of adherence is associated with poor clinical outcomes and greater cost of care.[9-13] The rates of cost-related medication underuse tend to be greater among patients with lower incomes, higher OOP prescription drug costs, and less generous prescription benefits.[4,14-20]

Specialty medications are typically more expensive than other medications, potentially making cost a barrier to patient adherence.[21] In 2015, specialty drugs accounted for 36% of the $428.8 billion total spending on medicine and 75% of new drug spending growth.[22] The high costs of these medicines are known to be related to medication nonadherence among patients,[21,23] which could eventually lead to more significant burden to the healthcare system.

Given that medication underuse or nonadherence could lead to serious health consequences, some researchers and policy makers have suggested that selectively lowering patients' prescription costs might improve adherence and decrease the overall cost of their care.[24,25] For example, first-dollar coverage of angiotensin-converting enzyme inhibitors appeared to reduce costs for Medicare beneficiaries with diabetes and extend their lives.[26] Lowering OOP drug costs for people with chronic diseases could save money for patients and third-party payers directly and reduce medication costs indirectly by achieving better clinical outcomes for patients. A prospective cohort study by Schoen et al[27] examined the impact of a financial assistance program on clinical outcomes and drug adherence among uninsured or underinsured indigent patients with cardiovascular disease. After receiving 6 months of financial assistance, the study found an increased mean international normalized ratio among patients receiving warfarin, a lower mean diastolic blood pressure among patients with hypertension, and decreased mean low-density lipoprotein level among patients receiving free lipid-lowering drugs. The program was also shown to reduce hospitalization events and improve drug adherence.[28]

The high cost burden of drugs could be reduced if patients are able to take advantage of financial assistance programs offered

by nonprofit organizations, foundations, and pharmaceutical companies.[11,29-32] Unfortunately, study findings have shown that only a small percentage of patients reporting cost-related adherence problems were given information from their clinicians about such programs.[15,33]

Walgreens local specialty pharmacies (LSPs) have collaborated with multiple assistance providers, such as the Good Days Foundation (GDF), to help overcome financial barriers to medication use for patients.[34] Key steps taken by Walgreens LSPs included identifying those patients who were at risk of not filling their prescriptions due to financial barriers, evaluating patient eligibility, coordinating with assistance providers like GDF, and matching patients to the appropriate sources of financial assistance.

TAKEAWAY POINTS

A collaboration between the Good Days Foundation and Walgreens local specialty pharmacies may have been crucial in saving lives, preventing financial ruin, and supporting patient medication persistence. For patients dealing with chronic or life-altering diseases, the assistance and support provided through this collaboration included:

- Providing hope when it was needed the most.
- Extending life and allowing more time with loved ones.
- A viable option for dealing with the reality that insurance, including Medicare, does not always cover everything related to treatment needs.
- An alternative to reduce rising out-of-pocket costs and improve the ability to afford both treatments and the necessities of everyday living.

Since 2003, GDF has provided financial assistance to eligible patients who cannot afford their medications and established individual funds for more than 30 disease states. In addition to co-pay assistance, GDF also offers programs to provide premium and travel assistance for patients in need. Based on donations received, the premium assistance program provides assistance to cover the monthly insurance premium of eligible patients with any of the following conditions: chronic granulomatous disease, nephropathic cystinosis, severe malignant osteopetrosis, and urea cycle disorder. Premium assistance is also offered to the patient's dependents when applicable (eg, if the patient is a minor, it is offered to the patient's guardian as part of a family plan). The travel assistance program provides assistance to eligible patients who need help with their travel-related expenses for diagnosis-related treatments. These expenses include public transportation (eg, bus, taxi, or train), parking, gas, tolls, rental cars, hotels, airfare, and meals, when applicable. GDF also makes all travel arrangements and stays in contact with the patient, physician, and/or hub case manager (ie, an individual who helps patients navigate payer access and patient assistance services) throughout the course of the patient's therapy.

Based on the previous discussion and aforementioned gaps in the literature, we identified 3 key study objectives: characterizing the study population overall and by disease category, estimating OOP cost savings of the study population overall and by disease category, and describing medication persistence.

METHODS

This was a retrospective cohort study using joint administrative data from both Walgreens and GDF from January 1, 2014, to December 31, 2016. Our study sample included patients who were 18 years or older, had filled at least 1 medication, and had received financial assistance from GDF as facilitated by Walgreens LSPs. The GDF approval process is shown in the **eAppendix Figure** (eAppendices available at **ajmc.com**). To qualify for financial assistance from GDF, the following criteria must be met: patient must be diagnosed with a covered disease and program must be accepting enrollments; patient must have a valid Social Security number to apply for assistance and receive treatment in the United States; patient must have valid medical insurance with at least 50% coverage of the costs of treatment, excluding deductibles; patient must be seeking assistance for a prescribed medication that is approved by the FDA to treat the covered diagnosis; and patient income level must be at or below 500% of the federal poverty level (FPL) based on household size.

Outcome Measures

Financial benefits/savings. Several types of financial benefits were measured for the 3-year period by disease state: mean annual original OOP costs, mean assistance amount received per patient, mean annual OOP costs after foundational co-pay assistance, mean annual co-pay assistance received as a percentage of mean annual original co-pay cost (OOP cost plus insurer cost was calculated), and mean annual amount of other types of assistance (ie, travel or premium assistance) during the study period.

Drug persistence. Persistence was defined as "the duration of time from initiation to the discontinuation of therapy"[35] and was measured by time in days. Patients were considered to have discontinued the adequate regimens if a gap in therapy of 30 days or more occurred. Patients were included in the persistence analysis if they were in possession of adequate regimens for 30 days or more or if they had at least 30 observation days.

Statistical Analyses

All statistical analyses were performed using SAS Enterprise Guide 7.1 (SAS Institute Inc; Cary, North Carolina).

RESULTS

Table 1 summarizes the demographic characteristics of 1572 eligible LSP patients who received GDF assistance. Per eligibility requirements, all patients had an income at or below 500% of the FPL

TABLE 1. Baseline Characteristics of Walgreens LSP Patients Who Received Financial Assistance From GDF During the Study Period

Variables	Joint Patients Between Walgreens and GDF Databases[a]	Patients With Complete Data[a]
Patients (n)	1572	777
Age, years (mean ± SD)	72.9 ± 10.0	72.9 ± 10.5
Age group (years)		
18-49	43 (2.7%)	23 (3.0%)
50-64	201 (12.8%)	102 (13.1%)
≥65	1328 (84.5%)	652 (83.9%)
Female	801 (51.0%)	373 (48.0%)
Plan type (n of patients)	1559[b]	617[c]
Medicare Part D	1163 (74.6%)	467 (75.7%)
Medicare Part B and D	260 (16.7%)	96 (15.6%)
Medicare Part B	9 (0.6%)	4 (0.6%)
Commercial	108 (6.9%)	43 (7.0%)
Medicaid	10 (0.6%)	5 (0.8%)
Other	9 (0.6%)	2 (0.3%)
Number of comorbidities (n of patients)	1295[b]	617[c]
1	68 (5.3%)	27 (4.4%)
2	4 (0.3%)	3 (0.5%)
≥3	2 (0.2%)	1 (0.2%)
Per capita income (mean ± SD)	$19,159 ± $17,156	$20,145 ± $13,138
Diseases/conditions (n of patients)	1524[d]	777[e]
Oncology	1403 (91.2%)	724 (92.9%)
Multiple myeloma	724 (51.6%)	313 (43.2%)
Liver cancer	182 (13.0%)	140 (19.3%)
Non–small cell lung cancer	158 (11.3%)	91 (12.6%)
Multiple sclerosis	49 (3.2%)	10 (1.3%)
Hepatitis C	39 (2.5%)	29 (3.7%)
Miscellaneous/rare	31 (2.0%)	14 (1.8%)
Nonspecialty	14 (0.9%)	2 (0.3%)
Organ transplant	2 (0.1%)	0 (0%)
Cost outcomes (n of patients)	1524[d]	777[e]
Mean original co-pay amount, $ (mean ± SD)	728 ± 808	889 ± 974
Mean co-pay assistance amount, $ (mean ± SD)	722 ± 806	882 ± 973
Mean out-of-pocket amount, $ (mean ± SD)	6 ± 38	7 ± 20

GDF indicates Good Days Foundation; LSP, local specialty pharmacy.
[a]Data are n (%) unless otherwise noted.
[b]There were 74 patients with multiple diseases.
[c]There were 31 patients with multiple diseases.
[d]There were 14 patients who received financial assistance for 2 diseases/conditions.
[e]There were 2 patients who received financial assistance for 2 diseases/conditions.

based on household size. The mean annual per capita income was $19,159 (SD = $17,156). The majority of patients were 65 years or older (85%), and half of them were female (51%). Among the 1559 patients with insurance information available, most (92%) had Medicare Part B or D. Most patients (91%) were receiving assistance for oncology medications. Across patients, the average initial co-pay of $728 per patient per year was reduced by an average of $722 in financial assistance to yield an average final co-pay of $6. Due to the complexity of the data captured in 2 systems (Walgreens and GDF), approximately half of these patients (777) had consistent cost data between data systems (see the second column of Table 1). Characteristics of this subset of patients were similar to the larger sample.

Table 2 provides the average co-pay before and after financial assistance, as well as the proportion of costs covered by financial assistance for the subset of patients with consistent cost data between data systems. The top 3 disease categories by patient count were oncology (93%), hepatitis C (4%), and miscellaneous/rare diseases (2%). Among the oncology patients, the top 3 cancers were multiple myeloma (43.2%), liver cancer (19.3%), and non–small cell lung cancer (12.6%). The mean financial assistance per patient was highest for hepatitis C ($4156), followed by oncology ($3603), miscellaneous/rare disease ($1829), and multiple sclerosis ($1439), which covered between 99% and 100% of total co-pay requirements. After receiving financial assistance from GDF, the mean patient co-pay ranged from $0 to $51 per patient per year.

In addition to this prescription assistance, some patients received other types of financial aid from GDF, such as premium or travel assistance. Within the study population, 21 received travel assistance, averaging $554 per patient per year. None of the patients in this study population received premium assistance. Furthermore, oncology patients persisted, on average, 170.7 days without a 30-day gap over 1 year of observation time.

DISCUSSION

Our study results indicate that, without assistance programs, the financial burden of

TABLE 2. Financial Assistance Provided During the Study Period, by Disease State (N = 777)[a]

Disease State	Patients (n)	Annual Original Co-Pay Sum	Annual Original Co-Pay Mean	Annual OOP Sum	Annual OOP Mean	Annual Assistance Sum	Annual Assistance Mean	% Co-Pay Covered by Assistance
Oncology	724	$2,628,279	$3630	$19,593	$27	$2,608,686	$3603	99.3%
Hepatitis C	29	$121,993	$4207	$1468	$51	$120,525	$4156	98.8%
Miscellaneous/rare	14	$25,713	$1837	$105	$8	$25,608	$1829	99.6%
Multiple sclerosis	10	$14,394	$1439	$0	$0	$14,394	$1439	100.0%
Nonspecialty	2	$21	$11	$0	$0	$21	$11	100.0%

OOP indicates out-of-pocket costs.
[a]There were 777 unique patients, with 2 patients receiving financial assistance for 2 disease states; therefore, the patient count by disease state was 779.

medications for complex diseases like oncology and hepatitis C was very high among individuals who were underinsured, especially the Medicare population. Our findings show that a high proportion of this financial burden in our study population was covered by co-pay assistance, leading to lower OOP costs for patients.

Of note, the majority of our study population in this analysis had cancer and were Medicare beneficiaries with low family incomes. According to findings of a study conducted by Narang and Nicholas from 2002 to 2012, the mean annual OOP costs of cancer therapies ranged from $2116 to $8115 among Medicare beneficiaries[36]; other reports indicated that the median income of the Medicare population was less than $24,150.[37,38] As such, the burden of OOP spending relative to patient income was very high, which is consistent with the findings of this study.

This financial burden can lead to patient noncompliance with therapy.[1-8] According to the findings of a study by Starner et al,[39] an OOP expense of $250 was considered the point at which patients were much more likely to abandon costly therapies, including biologic anti-inflammatory drugs and drugs for multiple sclerosis ($P = .09$ compared with the reference group, $0-$50), in the majority of cases. A significantly higher abandonment rate was detected when monthly OOP expenses were $500 or more ($P < .001$). Co-pay assistance programs have been developed to address this and help patients overcome financial burdens. In our study, co-pay assistance covered most OOP patient costs; the mean annual patient OOP cost decreased to $0 to $51 with the foundational co-pay as facilitated by Walgreens LSPs, which might have helped decrease the medication abandonment rate.

Limitations

As is the case with other observational studies using administrative data, this study had some limitations. First, data were limited to 1 pharmacy chain. If a patient visited another pharmacy, it would not be reflected in Walgreens' pharmacy claims; thus, persistence rates in this study may be underestimated. Second, the results of this study were descriptive because we could not compare eligible patients who received financial assistance with those who did not. Third, physician discontinuation of a drug regimen might have been misclassified as nonpersistence. Finally, the administrative data were not collected for research purposes, resulting in data inconsistencies that hampered a complete analysis dataset.

CONCLUSIONS

Financial assistance through the collaboration between Walgreens LSPs and GDF contributed to dramatic reductions in patients' co-pay burden. As of late 2016, the total underinsured population in the United States had doubled since 2003 to 41 million individuals.[40,41] This partnership between LSPs and foundational financial assistance organizations might provide a safety net for those with multiple complex, chronic, and rare conditions within the underinsured population to prevent these patients and their loved ones from bankruptcy or other significant financial impacts affecting everyday life. The facilitation of treatment by foundational assistance organizations and LSPs might be the key to a patient receiving their treatment and maintaining medication persistence. GDF co-pay assistance helped cover nearly all of the OOP costs associated with medications and aided with travel expenses for patients, especially in the area of oncology. For many patients, this meant reducing significant financial barriers that may have affected their access to care and allowing them to receive the necessary treatment for their chronic or life-altering diseases. Without the elimination of these financial barriers, many patients would not have been able to meet the expected medication persistence required for proper treatment. However, this was only a preliminary descriptive study. Future research should be conducted to further examine and expand the relationship between adherence and/or persistence and co-pay assistance. ■

Acknowledgments

The authors would like to thank Charles Moorman and Roger Hagedorn for their technical support. They would also like to thank Edward Witt for his constructive advice.

Author Affiliations: Walgreen Co (JZ, SB, FK, CC, HSK), Deerfield, IL; Good Days Foundation (RO, CW), Plato, TX.

Source of Funding: This study is sponsored by Walgreen Co and Good Days Foundation.

Author Disclosures: Ms Zhu, Mr Conley, and Dr Kirkham are employed by the study sponsor, Walgreen Co, and own Walgreen stock. Mr Odebralski and Ms Walley are employed by the Good Days Foundation. Ms Boghani is employed by Walgreen Co. The remaining author reports no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (JZ, RO, CW, FK, CC, HSK); acquisition of data (JZ, RO, CW, FK, CC); analysis and interpretation of data (JZ, RO, CW, CC, HSK); drafting of the manuscript (JZ, RO, SB, CW); critical revision of the manuscript for important intellectual content (JZ, RO, SB, CW, FK, HSK); statistical analysis (JZ); administrative, technical, or logistic support (JZ, SB, FK, CC, HSK); and supervision (JZ, HSK).

Address Correspondence to: Heather S. Kirkham, PhD, MPH, Walgreen Co, 102 Wilmot Rd, 5th Fl, Mailstop 125D, Deerfield, IL 60015. Email: heather.kirkham@walgreens.com.

REFERENCES

1. Piette JD, Heisler M, Wagner TH. Problems paying out-of-pocket medication costs among older adults with diabetes. *Diabetes Care.* 2004;27(2):384-391.
2. Paris W, Dunham S, Sebastian A, Jacobs C, Nour B. Medication nonadherence and its relation to financial restriction. *J Transpl Coord.* 1999;9(3):149-152.
3. Piette JD. Medication cost-sharing: helping chronically ill patients cope. *Med Care.* 2005;43(10):947-950.
4. Piette JD, Heisler M, Wagner TH. Medication characteristics beyond cost alone influence decisions to underuse pharmacotherapy in response to financial pressures. *J Clin Epidemiol.* 2006;59(7):739-746. doi: 10.1016/j.jclinepi.2005.11.023.
5. Kripalani S, Henderson LE, Jacobson TA, Vaccarino V. Medication use among inner-city patients after hospital discharge: patient-reported barriers and solutions. *Mayo Clin Proc.* 2008;83(5):529-535. doi: 10.4065/83.5.529.
6. Shrank WH, Choudhry NK, Solomon DH, et al. Rationale and design of the Study Assessing the Effect of Cardiovascular Medications Provided as Low-cost, Evidence-based Generic Samples (SAMPLES) trial. *Am Heart J.* 2009;157(4):613-619. doi: 10.1016/j.ahj.2008.12.006.
7. Zullig LL, Peppercorn JM, Schrag D, et al. Financial distress, use of cost-coping strategies, and adherence to prescription medication among patients with cancer. *J Oncol Pract.* 2013;9(6 suppl):S60-S63. doi: 10.1200/JOP.2013.000971.
8. Steinman MA, Sands LP, Covinsky KE. Self-restriction of medications due to cost in seniors without prescription coverage. *J Gen Intern Med.* 2001;16(12):793-799.
9. Offord S, Lin J, Mirski D, Wong B. Impact of early nonadherence to oral antipsychotics on clinical and economic outcomes among patients with schizophrenia. *Adv Ther.* 2013;30(3):286-297. doi: 10.1007/s12325-013-0016-5.
10. Lindenmayer JP, Liu-Seifert H, Kulkarni PM, et al. Medication nonadherence and treatment outcome in patients with schizophrenia or schizoaffective disorder with suboptimal prior response. *J Clin Psychiatry.* 2009;70(7):990-996. doi: 10.4088/JCP.08m04221.
11. Garner JB. Problems of nonadherence in cardiology and proposals to improve outcomes. *Am J Cardiol.* 2010;105(10):1495-1501. doi: 10.1016/j.amjcard.2009.12.077.
12. Heisler M, Choi H, Rosen AB, et al. Hospitalizations and deaths among adults with cardiovascular disease who underuse medications because of cost: a longitudinal analysis. *Med Care.* 2010;48(2):87-94. doi: 10.1097/MLR.0b013e3181c12e53.
13. Eaddy MT, Cook CL, O'Day K, Burch SP, Cantrell CR. How patient cost-sharing trends affect adherence and outcomes. *P T.* 2012;37(1):45-55.
14. Tamblyn R, Laprise R, Hanley JA, et al. Adverse events associated with prescription drug cost-sharing among poor and elderly persons. *JAMA.* 2001;285(4):421-429. doi: 10.1001/jama.285.4.421.
15. Piette JD, Heisler M, Wagner TH. Cost-related medication underuse: do patients with chronic illnesses tell their doctors? *Arch Intern Med.* 2004;164(16):1749-1755. doi: 10.1001/archinte.164.16.1749.
16. Lynch T. Medication costs as a primary cause of nonadherence in the elderly. *Consult Pharm.* 2006;21(2):143-146.
17. Tseng CW, Tierney EF, Gerzoff RB, et al. Race/ethnicity and economic differences in cost-related medication underuse among insured adults with diabetes: the Translating Research Into Action for Diabetes Study. *Diabetes Care.* 2008;31(2):261-266. doi: 10.2337/dc07-1341.
18. Piette JD, Heisler M, Harand A, Juip M. Beliefs about prescription medications among patients with diabetes: variation across racial groups and influences on cost-related medication underuse. *J Health Care Poor Underserved.* 2010;21(1):349-361. doi: 10.1353/hpu.0.0247.
19. Piette JD, Rosland AM, Silveira MJ, Hayward R, McHorney CA. Medication cost problems among chronically ill adults in the US: did the financial crisis make a bad situation even worse? *Patient Prefer Adherence.* 2011;5:187-194. doi: 10.2147/PPA.S17363.
20. Polinski JM, Shrank WH, Huskamp HA, Glynn RJ, Liberman JN, Schneeweiss S. Changes in drug utilization during a gap in insurance coverage: an examination of the Medicare Part D coverage gap. *PLoS Med.* 2011;8(8):e1001075. doi: 10.1371/journal.pmed.1001075.
21. Stern D, Reissman D. Specialty pharmacy cost management strategies of private health care payers. *J Manag Care Pharm.* 2006;12(9):736-744. doi: 10.18553/jmcp.2006.12.9.736.
22. IMS Institute for Healthcare Informatics. Medicines use and spending in the US: a review of 2015 and outlook to 2020. Morning Consult website. morningconsult.com/wp-content/uploads/2016/04/IMS-Institute-US-Drug-Spending-2015.pdf. Published April 2016. Accessed December 21, 2017.
23. Gleason PP, Starner CI, Gunderson BW, Schafer JA, Sarran HS. Association of prescription abandonment with cost share for high-cost specialty pharmacy medications. *J Manag Care Pharm.* 2009;15(8):648-658. doi: 10.18553/jmcp.2009.15.8.648.
24. Talley S, Ramos T. Use of patient assistance programs to improve adherence. *J Am Psychiatr Nurses Assoc.* 2000;6(5):152-157. doi: 10.1067/mpn.2000.110004.
25. Lewis JH, Schonlau M, Muñoz JA, et al. Compliance among pharmacies in California with a prescription-drug discount program for Medicare beneficiaries. *N Engl J Med.* 2002;346(11):830-835. doi: 10.1056/NEJMsa122601.
26. Rosen AB, Hamel MB, Weinstein MC, Cutler DM, Fendrick AM, Vijan S. Cost-effectiveness of full Medicare coverage of angiotensin-converting enzyme inhibitors for beneficiaries with diabetes. *Ann Intern Med.* 2005;143(2):89-99. doi: 10.7326/0003-4819-143-2-200507190-00007.
27. Schoen MD, DiDomenico RJ, Connor SE, Dischler JE, Bauman JL. Impact of the cost of prescription drugs on clinical outcomes in indigent patients with heart disease. *Pharmacotherapy.* 2001;21(12):1455-1463.
28. Conley CS, Hughes PJ. Medication adherence of patient assistance program recipients: a pilot study. *Inov Pharm.* 2012;3(3):1-11. conservancy.umn.edu/bitstream/handle/11299/137107/(12-114)%20Medication%20Adherence%20formatted%2010.1.12_article%2085.pdf.
29. Duke KS, Raube K, Lipton HL. Patient-assistance programs: assessment of and use by safety-net clinics. *Am J Health Syst Pharm.* 2005;62(7):726-731.
30. Stey AM, Fei K, Franco R, Mendelson A, Bickell NA. Cost of comprehensive patient assistance program in early breast cancer patients. *Springerplus.* 2013;2(1):173. doi: 10.1186/2193-1801-2-173.
31. Wei II, Lloyd JT, Shrank WH. The relationship between the low-income subsidy and cost-related nonadherence to drug therapies in Medicare Part D. *J Am Geriatr Soc.* 2013;61(8):1315-1323. doi: 10.1111/jgs.12364.
32. Zafar SY, Peppercorn JM, Schrag D, et al. The financial toxicity of cancer treatment: a pilot study assessing out-of-pocket expenses and the insured cancer patient's experience. *Oncologist.* 2013;18(4):381-390. doi: 10.1634/theoncologist.2012-0279.
33. Piette JD, Heisler M, Krein S, Kerr EA. The role of patient–physician trust in moderating medication nonadherence due to cost pressures. *Arch Intern Med.* 2005;165(15):1749-1755. doi: 10.1001/archinte.165.15.1749.
34. Specialty pharmacy. Walgreens website. walgreens.com/pharmacy/specialtypharmacy.jsp. Published 2013. Accessed December 21, 2017.
35. Cramer JA, Roy A, Burrell A, et al. Medication compliance and persistence: terminology and definitions. *Value Health.* 2008;11(1):44-47. doi: 10.1111/j.1524-4733.2007.00213.x.
36. Narang AK, Nicholas LH. Out-of-pocket spending and financial burden among Medicare beneficiaries with cancer. *JAMA Oncol.* 2017;3(6):757-765. doi: 10.1001/jamaoncol.2016.4865.
37. Smith K, Jacobson G, Huang J, Neuman J. Projecting income and assets: what might the future hold for the next generation of Medicare beneficiaries? Kaiser Family Foundation website. kff.org/medicare/report/projecting-income-and-assets-what-might-the-future-hold-for-the-next-generation-of-medicare-beneficiaries. Published May 30, 2011. Accessed December 21, 2017.
38. Jacobson G, Huang J, Neuman T, Smith KE. Income and assets of Medicare beneficiaries, 2013-2030. Kaiser Family Foundation website. kaiserfamilyfoundation.files.wordpress.com/2014/01/8540-income-and-assets-of-medicare-beneficiaries-2013-e28093-2030.pdf. Published January 2014. Accessed December 21, 2017.
39. Starner CI, Alexander GC, Bowen K, Qiu Y, Wickersham PJ, Gleason PP. Specialty drug coupons lower out-of-pocket costs and may improve adherence at the risk of increasing premiums. *Health Aff (Millwood).* 2014;33(10):1761-1769. doi: 10.1377/hlthaff.2014.0497.
40. Collins SR, Rasmussen PW, Beutel S, Doty MM. The problem of underinsurance and how rising deductibles will make it worse. *Issue Brief (Commonw Fund).* 2015;13:1-20.
41. Collins SR, Gunja MZ, Doty MM. How well does insurance coverage protect consumers from health care costs? The Commonwealth Fund website. commonwealthfund.org/publications/issue-briefs/2017/oct/insurance-coverage-consumers-health-care-costs. Published October 18, 2017. Accessed December 21, 2017.

Full text and PDF at **www.ajmc.com**

eAppendix Figure. Good Days Foundation Approval Process