# Copay $ubsidies

Payers are struggling to find an appropriate way to respond to copayment subsidies. Aggressive tactics to counteract them run the risk of keeping drugs from people who need them.

**BY JOHN CARROLL,** *Senior Contributing Editor*

The first time Eileen Wood heard about the new copayment subsidies that pharmaceutical companies were offering, they sounded like a pretty good idea.

If this could be a replacement for handing out drug samples at doctors' offices, coupons that cover the first round of copayments for new drugs could be "a really good thing," thought Wood, vice president of pharmacy and health quality programs for the not-for-profit Capital District Physicians' Health Plan, in Albany, N.Y. After all, she couldn't track who got a sample or why, so the coupons could take the initial sting out of an individual's cost without leaving the insurer blind to what was going on.

"But then we started seeing these were a charge-card kind of thing with a renewable copay discount," adds Wood. Members who would otherwise face a rising scale of copayments for generics, preferred, and nonpreferred brands could either greatly reduce their out-of-pocket costs or eliminate them altogether.

"We started investigating that, and we found them everywhere," says Wood. Ads were showing up in popular magazines. A viral message made its way around the Internet, pointing consumers down the trail of web sites like «www.internet-drugcoupons.com». Another website includes offers for more than 300 therapies. Such offers range across the board, but the underlying theme, to Wood, looked like an obvious attempt to scuttle copayments and much of what they are designed to do.

"It's a game changer for sure," she says. And that didn't seem like a good idea at all.

## WHAT'S THE PURPOSE?

"On the one hand, the drug companies want to sell more drugs that are more costly, and they're helping people do that by providing these cards," says Paul Fronstin, PhD. a senior research associate with the Employee Benefit Research Institute. "On the other hand, employers and insurance companies argue that the generic drug is as medically effective as the brand name, so why can't we give the generic and call it a win-win? There's a real tension between the two."

Pfizer, which recently merged with Wyeth in a $68 billion corporate marriage, says that its primary motive in offering copayment discount cards has to do with consumer health. Now more than ever, says the world's largest pharma company, the recession forces patients to choose drugs based on what they can afford, and a higher copayment could spur them to make the wrong decision.

"In today's challenging economic environment, patients may be more sensitive to copay costs and may ask their physicians about cheaper medications, and in some cases, this may compromise care," Pfizer said in a statement to BIOTECHNOLOGY HEALTHCARE. "The availability of the Lipitor Co-Pay Card is a direct way to address this cost sensitivity so that eligible patients who are prescribed Lipitor have better access to it and decisions about treatment are made based on what the physician thinks medically is best for the patient and not just patient cost."

Pfizer went on to note in its statement that "Pfizer runs the largest

and most extensive family of patient assistance programs in the United States."

But it's not just the megablockbuster atorvastatin (Lipitor) — which already faces steep competition from rosuvastatin (Crestor) and will face an avalanche of direct generic competition in 2011 — that's involved here. Copayment cards are also available for popular biologics like Amgen's etanercept (Enbrel) and Genentech's erlotinib (Tarceva). A patient can go online and get a card for erlotinib that covers $4,000 of the copayment. There's also $500 off the copay due on certolizumab (Cimzia), which UCB sells for the treatment of Crohn's disease.

## FERARRI OR HONDA?

Nobody in healthcare, from Wood on, is opposed to any kind of pharma-sponsored drug subsidies that help patients who don't have the income to pay for a therapy they need. Where Wood and others draw the line, though, is when the subsidy scuttles the purpose of copayments: Steer patients away from costly therapies and toward less-expensive, clinically equivalent or superior alternatives that can save the healthcare system billions of dollars, while still providing members with quality care.

"There have always been programs that manufacturers support for people who can't afford drugs," says Sean Karbowicz, PharmD, clinical pharmacy manager for RegenceRx, the pharmaceutical benefit manager for Regence BlueCross BlueShield, the largest insurer in the Pacific Northwest. "What seems to be on the rise now is that some of these programs, irrespective of a patient's income, are based more out of the marketing department of the pharmaceutical companies. We're definitely seeing them for new medications, seeing them for some of the biologics, or brand new medications, particularly when there is competition in the market. We're not talking about treatments where there are no other options."

But when subsidies are used to reduce or eliminate copayments, he says, that can throw a monkey wrench into the most finely tuned pharmacy benefit programs now available.

"One of the key drivers [behind copayments], is the disconnect between price and value," adds Karbowicz. "Cost sharing or paying a percentage can inform people on the true cost of medications. If you went car shopping and got any car you wanted, and it cost you $5, what would you get? A Ferrari or a Honda Accord?"

"We do our best to manage copays or coinsurance depending on the plan so that it does not prove to be a burden to people," says Edmund Pezalla, MD, MPH, national medical director and chief clinical officer at Aetna Pharmacy Management. "When it gets to a very expensive medicine, though, the bill can be pretty high. If someone has an assistance program to help them stay on their medication, one of their preferred medications on our formulary, then that's great. If it helps them out, that's terrific. We're not against programs to help people stay on medications they're stabilized on.

"We do have copay differences

**One fear is that** copayment subsidies may steer patients toward costly therapies and away from less-expensive, but clinically equivalent or superior alternatives, says Eileen Wood, at Capital District Physicians' Health Plans.

on different tiers and products, and these are intended to help promote and maintain access to therapies that are clinically appropriate, based on safety and evidence-based guidelines, and cost-effective. We would prefer that folks not be in programs that circumvent those sorts of management tools."

Like a lot of insurers, Aetna has not adopted any programs designed specifically to counter subsidies that thwart copayments that are there to help tamp down expenses or direct members to the best therapy for their condition.

## THE $2 FEE

What's particularly troubling to Wood is that she generally cannot tell what's going on or who's using a copayment card. When one is offered at a pharmacy, payment is provided through a separate clearinghouse, and all she knows is that the copayment has been covered.

"To me, it looks like the claim was paid regularly," says Wood. "If there's a third-tier, $40 copay subsidy, I don't see that. It doesn't go to the pharmacy benefits manager's switch."

The only time the subsidy appears on her PBM radar is when she sees a mystifying spike in claims for a therapy in the second or third tier of the plan's formulary. That happened about a year ago when claims for minocycline (Solodyn), a branded acne therapy from Medicis, shot up suddenly. And she countered it by instituting a step therapy provision that now requires members to first try generic minocycline before moving to the more expensive drug.

For anyone who ultimately prefers the branded form of extended-release minocycline, though, there's still a copayment subsidy available.

**"One of things that we have seen** — and we think this is a very reasonable approach — is that manufacturers who have some expensive medications are capping the overall cost of the medication on an annual basis," notes Edmund Pezalla, MD, MPH, with Aetna Pharmacy Management.

Eric Durban, PharmD, a pharmacist in Sugarcreek, Ohio, says the programs "leave the pharmacist and pharmacy staff in the middle." And the middle position doesn't pay very well.

"We're the ones doing all the legwork to get the discounts to the patients," he wrote in a recent issue of *Modern Medicine*. "After listening to the patients complain about the high cost of medications (over which we have no control), we process the discount cards/coupons and receive maybe two dollars for our trouble."

Generally a $15 price differential is enough to get a member to shift drugs, says Wood. "You have a significant number of really good generics," she adds. "Zocor used to be branded, and now it's generic simvastin. We have it at a $10 copayment. We feel that price differential speaks to the member." And what the health plan hears, she says, is, "Let me try the generic first."

But the manufacturer gets in the way of that silent, budget-minded conversation when it offers a $200-a-year subsidy on a competing drug that lost out during formulary negotiations with PBMs and wound up on a tier with a steeper copay-

ment than its competitors. To get around that, says Wood, all a manufacturer has to do is figure out what it costs to provide a consumer subsidy and advertise that offer, and then it can set the retail price, leaving the payer on the hook for the higher amount. If enough manufacturers do that, then any concentrated push to gain a greater use of generics or lower-cost drugs and to contain drug costs goes awry.

As copayment subsidy programs for biologics begin to proliferate, the dollars at stake will rise exponentionally.

Wood says she is tempted to find all the drugs that come with copayment subsidies and stick them all on a new fourth tier in the formulary, but the state won't allow it — New York State law allows only three drug tiers.

## WHAT'S THE PROBLEM?

The overall formulary trend on drug copayments for 2010 is clear, says Randall Abbott, a senior healthcare consultant for Watson Wyatt, a consulting firm. His Fortune 1000 clients are typically cutting the cost of a generic drug to a single digit — as low as $4 for a month's supply — while higher tiers are moving up in price, often with a jump of at least $15 from one tier to the next. "And we are increasingly seeing a move for specialty drugs to a fourth tier with a higher copayment which, if it exists, will be in the range of about $50."

But most of his clients don't count copayment subsidies as a cause for concern.

"I guess, potentially, a subsidy could interfere with the whole formulary process, which is structured for a certain reason," says John Malley, national practice leader for pharmacy benefits at Watson Wyatt. "But I don't think this has gotten enough traction in the marketplace to make that kind of impact."

As for many employers who are shifting costs to employees through higher copayments, if their workers can find some way to pay their share without taking it out of the employer's pockets, adds Malley, then that's not an issue.

*Payers struggle to respond to copayment subsidies appropriately. It is difficult to evaluate the impact of these programs on a drug-by-drug basis.*

"Eighty-five percent of these companies are familiar with the programs and are not concerned," he says. "To the extent employees find a means to pay their share, that's fine. It doesn't affect their bottom lines."

Pezalla stresses that manufacturers also are using other strategies to keep specialty medications within the budgets of the people who need them.

"One of the things that we have seen — and we think this is a very reasonable approach — is that manufacturers who have some expensive medications are capping the overall cost of a medication on an annual basis," adds Pezalla. "It's not just a copay subsidy; past a certain point, there's no charge for the medication. It helps you control your cost, and that seems fair. Most people are in a plan where risk is being shared, so it's good to share the benefits."

A lot of payers are struggling to respond to copayment subsidies appropriately, says George Van Antwerp, MBA, who is general manager for pharmacy solutions at Silverlink, a company that helps health plans and PBMs communicate with consumers. With patients picking up copayment cards and coupons on the Internet, in doctors' offices, or from magazines, it's hard to come up with a response on a "drug-by-drug" level.

"How do I respond to this at a drug level without disadvantaging someone who may not have access to the coupon?" he asks. "You don't want to come out with an aggressive program when you don't know the impact it will have."

But at Capital District, Wood wants to do more to rein in the use of copayment cards. She wants consumers to understand the significant price difference between drugs, which the tiered copay system attempts to impart.

There are ways to stop copayment subsidies, says Wood — come up with a new regulation that prohibits it, for instance, though politically that's probably a nonstarter — or move away from copayments to coinsurance, where members pay a share of the overall cost. Wood is not enthusiastic about the coinsurance route.

"If you're sick, you don't want to worry about price shopping," she says. "We want members to know that if they pay their set copay, they can get the medication they need, get well, and avoid hospitalization." So in the end, says Wood, it all might come down to more step therapy requirements.

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