

Article from **The Healthcare Savings Chronicle** (http://www.imakenews.com/seroper/e_article000859090.cfm?x=b11,0,w)

July 12, 2007

Healthier, More Cost-Effective Alternatives to High Copayments

www.psgconsults.com

by Jeff Hawes, PharmD
Pharmacy Benefit Consultant
Pharmaceutical Strategies Group

It is often thought that simply increasing the copayment for chronic-condition drugs will result in better overall savings for plan sponsors. Recent evidence, however, suggests otherwise. Studies are showing that, as plans increase member copayments, there is a decrease in member's therapeutic compliance resulting in higher long-term treatment expenses. Conversely, making medications more affordable for specific chronic disease states results in substantial overall savings.



Take diabetics for example. Patients not following careful medication protocols are at a higher risk for co-morbid conditions (e.g., heart disease, dental disease, stroke, blindness, kidney disease, nerve system disease, etc.). In turn, plans sponsoring such patients risk an increase in spending not only for further treatments, but for disability leave and absenteeism. When a plan sponsor chooses to increase copayments to try and recoup costs, they are putting pressure on lower-income patients to make an economic decision. If the member chooses to try and save money by trimming back on their pharmaceutical therapy, they become a higher risk for complications down the road, which is both bad for them and more costly to the plan sponsor. Other common disease states that have similar issues are asthma and hypertension.

The most popular three-tier structure is \$10 for generics, \$20 for brands, and \$35 for non-preferred brands. Now, consider that the Federal minimum wage is \$5.15 and that, even for those who earn more, many are still paid at a level that challenges their ability to afford medications with copays greater than around \$20. For a patient with a chronic condition, he or she will often have several prescriptions to fill on a monthly basis—all of which are required to minimize the possibility of future medical complications. Financial concerns are already evident by studies showing that if medications are available in a more-affordable generic form, there is a higher likelihood that the member will remain in compliance (e.g., a 2006 study in the *Archives of Internal Medicine* shows that patients who were prescribed a generic drug had a 62% higher therapy adherence rate than those prescribed a non-preferred brand. Those taking a preferred-brand drug had a 30 % better adherence rate).

However, there are classes of medications that do not have generics available. Thus, the employee is faced with paying either a second- or third-tier copayment. In data examined from 1997 to 2000 (during which time copayments doubled), there was a significant decrease in the use of prescription medications. According to the May 2004 edition of the *Journal of the American Medical Association*, utilization of diabetes drugs dropped by 23%. This is quite alarming considering that when diabetics fail to take their medications consistently, it often progresses to additional medical problems.

Before taking the cost-saving shortcut of increasing member copayments, more cost-effective alternatives should be considered that take into account *overall* healthcare savings. In the long run, better patient adherence to drug regimens is more cost-effective than simply cost shifting to the member since resting negative medical events is much more expensive. According to the *Washington Times* (October 3, 2006), consumer spending in 2005 on hospitalization, physician visits, home health agencies, and ambulance utilization increased dramatically. Meanwhile, most prescription drug plans were increasing their member copayments. A 2003 working paper by the *National Bureau of Economic Research* found that this inevitably affects patients' therapeutic adherence. On one NBER model, the copayment for diabetes medications was

adjusted from \$6 to \$10. Analysts then predicted that such cost shifting would save U.S. companies \$177 million in immediate drug costs, but would eventually wind up costing them \$433.5 million in latent medical complications. This illustrates how raising pharmacy copays even a small amount can have a major impact on total healthcare costs.

This data should speak volumes to plan sponsors. And, indeed, it has for some. An excellent real-life case study in implementing a more effective coverage model comes from a program launched in 1997 by the city government of Asheville, North Carolina. Recognizing that healthcare costs continue rising even though more and more costs are being shifted to employees, the "Asheville Project" began a diabetes management program that *eliminated* copays for diabetic medications. Instead, employees would be required to meet with a pharmacist on a monthly basis from whom they would receive education and monitoring. At first, healthcare expenses seemed to grow (the *immediate* effect). However, inpatient claims eventually decreased dramatically (within one year). The *Journal of the American Pharmacists Association* (2003; 43, pp 173-94) indicates that the Asheville Project soon reduced the city's total mean medical costs by \$1200 per-patient per-year. Missed work hours were reduced by 50% and not a single diabetic went on dialysis for eight years. An estimate by the *American Journal of Managed Care* (Jan 2006, 12:1, pp 22-28) indicates the program ultimately realized more than \$6 million in total health cost savings.

The Asheville Project also saw cost savings with asthma patients through decreased ER visits, hospitalizations, and missed work hours. On average, there was a decrease in total healthcare costs for asthmatics by \$725 per patient per year. Positive results were also realized for patients being treated for hypertension.

Using the Asheville Project as a model, we readily see there are better ways to decrease costs and *improve member's health* without the need for an increase in member spending. It is now safe to say that it is an empirically-proven equation that Affordable Medications = Higher Patient Compliance = Improved Patient Health = Lower Overall Health Costs for both the patient and the plan sponsor.

Unfortunately, quick-turnaround "expected savings" models deceptively dissuade plan sponsors from considering this model which centers around a low- to-zero copayment strategy. But the most current studies reveal there is a better course that results better cost containment and more favorable health outcomes. Better managing a patient's disease and therapy is more important in controlling healthcare costs than realizing quick savings through higher member copays.

Dr. Jeff Hawes is a Pharmacy Benefit Consultant with Pharmaceutical Strategies Group (www.psgconsults.com). He can be reached at jhawes@psgconsults.com.

Published by [Coalition America, Inc.](#)
Copyright © 2009 Coalition America, Inc. All rights reserved.
All Rights Reserved - 2008

Powered by [IMN](#)