

## Benefit-based Co-pays:

### Paying Less for a Prescription When You Need It More

*When drug benefit programs change, expert say, so do patients' drug spending and utilization behaviors. Confused by multi-tiered drug formularies and priced out of higher co-pays for certain drugs, some patients forego filling their prescriptions altogether, a decision that adversely affects outcomes and utilization costs. That's why support is growing around the idea of benefit-based co-payments (BBCs)—reducing or eliminating prescription co-pays for the sickest patients. This payment structure, first advocated in 2001 by Mark Fendrick, M.D., professor of internal medicine at the University of Michigan Medical School, links improvements in clinical outcomes with lowered out-of-pocket costs for patients. Simply put, the higher a drug's clinical benefit to a patient, the lower that patient's co-pay. In extreme cases, when drug adherence is critical to treatment, some patients may even be paid to take their medicine.*

### Industry Weighs BBC Benefits

In its September online survey, the Healthcare Intelligence Network (HIN) asked respondents to document their experience with BBC plans. Nearly 13 percent of the 47 survey respondents have already implemented BBCs, and another 10 percent plan to launch a BBC effort in 2006. About one-third of this month's survey responses come from health plans, 20 percent from employers and nine percent from disease management companies. The remaining responses came from hospitals, providers, pharmaceutical companies and industry consultants.

With a quarter of respondents either on board with BBCs or ready to launch a program in coming months, they are a snapshot of an industry watching this developing trend with interest.

Clinical support for BBCs builds daily. Case in point: a team of University of Michigan researchers recently proposed that a group of drugs known as ACE inhibitors be available at no cost to the eight million Americans over age 65 who have diabetes. These drugs are so beneficial for patients, the researchers said, that even *giving them away* ultimately would save the Medicare system and society large amounts of money by preventing heart attacks, strokes and kidney failure. The team's findings appeared in the July 19, 2005 *Annals of Internal Medicine* and were based on a sophisticated computer analysis.



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## BBC Formulary Based on Drug's Effectiveness, Not Cost

Ideally, BBCs would only be applied when the benefit of a drug changes according to the patient's severity of illness. For example, lower medication co-pays would be established for diabetes patients who have either been hospitalized or visited the emergency room because of their illness.

The goal of BBCs is to increase drug compliance, thereby improving outcomes and reducing utilization. As Medicare prepares to pick up part of the tab for prescriptions for this population, industry observers expect that drug adherence among this group will increase as out-of-pocket costs decrease.

## EBM's Role in the Debate

Before buying in to BBCs, health plans and employers need access to robust clinical data to determine their medically neediest patients and associated co-pays. The best source for this data is still a major issue in the BBC debate. To create their new formularies, BBC players who responded to the HIN survey are experimenting with evidence-based medical (EBM) guidelines and other novel clinical approaches. Some will ultimately create their own, tapping claims data and provider expertise. "Input from network physicians and clinical pharmacists together produce an effective formulary," said an employer.

One health plan reports using "clinical research and presenting to contracted physicians for input." This respondent relies on evidence-based guidelines for hypertension, diabetes and depression that incorporate formulary medication management. Another health plan said they currently track chronic care cases, affordability (by looking at percentage of prescriptions filled) and outcomes.

Others are reducing or eliminating co-pays for members and employees who agree—in writing—to cooperate with nurses and health coaches in managing their care and changing lifestyles to improve their health. Some respondents are asking disease management (DM) and pharmacy benefit management (PBM) companies to provide clinical evidence. "We need the cooperation of a nimble PBM with a clinically driven formulary," writes one employer.

"We have done some investigation into predictive modeling as a way to review (quantify) risk using prescription-filling data," said a representative from a PBM firm.

Technology will play an increasing role in the proliferation of BBC plans. As more physicians gain access to computerized prescription systems and the clinical evidence they provide, caregivers will be more likely to prescribe drugs that will work best for each patient.

## Generics, Tiered Co-Pays Shot in Industry Arm

Many employers and health plans rely on a combination of generic drugs (unless brand drugs are medically necessary) and tiered co-pays as an effective antidote to rising benefits costs. They shared some of the lessons they are learning:

"If generics are available, they are substituted unless medically necessary for brand," said a disease management company.

“You can’t look at (or control) prescription costs as long as they are in a separate ‘silo’ from the rest of the plan. It’s not Rx costs—it’s total healthcare costs. And it’s not really costs. Some of these should be seen as investments if employee behavior can really be impacted over the long-term, because such investments will pay big dividends to the organization.”

*Employer, in response to HIN survey*

affordable, yet largest drug benefit to our Medicare members. Clearly affordability is linked to generic prescribing and to plan attractiveness.”

Another health plan has learned to use generics whenever possible. “Some of the red tape that you have to go through to get a newer prescription approved is really not a cost-saving measure most of the time. It just wastes more healthcare dollars than putting the person on the medication to begin with.”

Two disease management firms report they support tablet-splitting---breaking higher-dose, higher-cost tablets in half---whenever this poses no risk to the patient, even reimbursing co-pays as an incentive for this option. David Parra, a clinical pharmacist at the West Palm Beach VA Medical Center, found that splitting one popular cholesterol-lowering drug alone could save a patient more than \$850 a year. He presented his findings at the 2004 annual meeting of the American Heart Association.

To offset the cost of maintenance drugs for the chronically ill, one health plan has implemented a mandatory mail order program, while a third-party plan administrator (TPA) said they will likely use a DM firm to review maintenance situations for conditions such as hypertension, etc. If a member agrees to participate in a DM program, they’ll eliminate the co-pays for as long as the member works with a nurse or health coach.

## Participation, Tracking Vital to BBC’s Success

While drug costs are still going up, even with a myriad of cost-saving measures in place, the road to BBCs may a long one. Member/patient education and buy-in is critical, respondents say. “Waiving co-pays for participation in disease management programs is a good perk, but (the program) needs to be pushed for participation to increase,” said a TPA. “With participation from members comes benefits for all,” concurs a DM vendor.

The idea seems to be sinking into the collective member/employee consciousness. Health plans and employers are receiving more requests for generic drugs, particularly among the Medicare population.

The benefit level of one employer is determined by tier: “Tier 1 is generic, Tier 2 is preferred brand, Tier 3 is non-preferred brand.” Another employer concurred, fearful that without tiers, “patients/doctors will gravitate to brands.” A third employer credits a tiered approach to driving down costs.”

By using a \$0 deductible for unlimited generics, one health plan has cut its brand prescribing to less than 35 percent of scripts. “This enables us to offer the most

“(The BBC process) must be carefully tracked to keep it in check, (including) careful review of drug costs by brand and efficacy. We need to quickly ID high cost drugs with lower cost alternatives, and limit dispensing of the higher cost drugs only to patients where lower cost alternatives are impractical or not effective.”

*Health plan, in response to HIN survey*

### Related Resource

As this brief look at the BBC debate indicates, payers and PBMs are feeling more pressure than ever to control drug costs. They are responding with creative new strategies — including some simple ideas that can have immediate impact. *Health Plan Strategies for Pharmacy Benefits* brings you clear explanations and examples of these strategies. In this all-new book updated in 2005, you’ll learn the latest thinking on the best ways to:

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