Current Issue
Archive
Subscribe
Advertise

THE LEADER BOARD BLOG

Web Exclusive Content
Home
HR News Analysis
Features
Columnists
People
Resources and Tools
Technology Center
Legal Clinic
HRE Conferences
HRE Rankings
Webinars
RSS
Career Center
HRE Information
Subscription Center
Advertiser Information
About Us
Contact Us

Coupon Overdose

Employers are starting to combat co-pay drug coupons that drive up pharmacy-benefit costs.

By Carol Patton

Write to the Editor Reprints

In 2009, Eric Noll watched the cost of his employer's medical and pharmaceutical benefits for more than 800 employees jump by nearly 28 percent. As director of HR at Union College in Schenectady, N.Y., he noticed that most of the increase was on the pharmacy side. Not only was he puzzled; he was also concerned, since these benefits often serve as magnets for recruiting and retaining quality employees.

The private college supports three medical plans, two of which are self-funded. Capital District Physicians' Health Plan, based in Albany, N.Y., covers the school's estimated 720 union workers and the majority of its 110 retirees.

Not surprisingly, CDPHP also received a wake-up call when its 2008 costs in just one drug classification soared by more than $600,000.

Capital District soon identified the culprit: offset programs and co-payment coupons or cards introduced by pharmaceutical companies in recent years.

These marketing tools cover high patient co-pays for expensive drugs, increasing patient access to brand-name products. A good example is Lipitor, a popular cholesterol-reducing drug that will turn generic this fall. With a coupon, employees can purchase the drug for a $4 co-pay, which is in direct competition with Walmart's $4 generic form.

While it's beneficial to offer patients therapeutic alternatives, such as generics, some health plans and employers believe the real intent behind these programs or coupons is to drive patients away from inexpensive generic drugs and toward higher-priced products, dumping more dollars into the vaults of pharmaceutical companies.

After researching soaring pharmacy expenses over the past year or two, some employers are now pointing to drug co-pay coupons as the culprit and have started fighting back, implementing a variety of policies that promote the use of generic drugs to control costs while still ensuring quality patient care.

Taking Back Control

The health plan discovered that some employees began using co-pay coupons in 2007 for a new drug called Solodyn, a tier-three prescription drug that treats

acne. The coupons were up to $50 off a month's supply, eliminating the patient's co-pay.

Beforehand, CDPHP spent roughly $500,000 each year for this class of antibiotic drugs. But by the first quarter in 2008, less than six months after the coupon was introduced, costs soared to $1.2 million, says Eileen Wood, vice president of pharmacy and quality programs at the plan.

CDPHP's cost for a one-month's supply of Solodyn, she says, was $500 with a $50 co-pay, compared to $40 a month with a $10 co-pay for the generic version -- which fewer people used because of the coupon.

"So the employee's [co-pay] was either $10 or $50," Wood says. "Then, the coupon comes along and now the choice is [pay] $10 or zero. Most people will take zero."

CDPHP notified Union College about its findings and offered two solutions: Introduce a mandatory mail-order pharmacy program, which won't accept co-pay coupons, and a step-therapy program, requiring employees to first try lower-cost generics. If unsuccessful, then employees could work their way up toward a higher tier drug such as Solodyn, which would now require prior authorization.

"[Both programs] took us back down, to below $500,000 a year by the end of 2009," says Wood, adding that employees received a 90-day notice of the step-therapy plan. "When you have the same scenario repeated for all brand drugs, you're talking double-digit inflation every year on pharmacy benefits if we don't manage it."

Employees can also suffer from coupon overload. Wood recalls one employee (not at the college) with a $2,000 annual pharmacy benefit who used the Solodyn coupons to fill monthly prescriptions for his teen-age son. On his fifth trip to the pharmacy, Wood says, he was shocked to learn that he had exhausted his pharmacy benefits for the year.

"The member was irate, off the wall, because he was never told this is what the drug costs," she recalls, adding that the drug's monthly cost has since jumped to $700. "The rest of his family didn't have a drug benefit because he spent $2,000 on an acne drug."

Back at Union College, Noll says, HR introduced the mail-order pharmacy program in January 2010 with a unique twist: Employees could also use any CVS pharmacy as their mail-order pharmacy, so they could walk into the store to fill their scripts and access local pharmacists.

That year, pharmacy-benefit costs dropped by $75,000. Then, last January, the college introduced the step-therapy program for drugs that fall into the two highest-use categories -- high cholesterol and acid reflux. HR hopes to slash 2011 drug expenses by another $160,000.

Approximately 59 employees at the college fill scripts for cholesterol drugs, another 50 take acid-reflux medicine and 12 employees use both. At this time, Noll says, only a handful of employees are appealing, asking permission to use brand drugs versus generics.

The college's success, says Noll, has to do with the fact that its HR department stepped up communication efforts, sending employees a letter explaining how the program worked and how it would save money. For example, CDPHP pays a monthly average of $26 per employee for generic drugs, compared to $230 for brand-name drugs. While its generic dispensing rate is 75 percent, 75 percent of its pharmacy costs come from brand-name drugs.

Meanwhile, HR may expand the step-therapy approach to other drug

classifications, says Noll. However, it will carefully evaluate its impact on patients with life-threatening conditions to ensure they have convenient access to the most effective drugs. Noll believes coupons providing drug options are fine, but not when they drive employees to "inappropriately" use brand-name drugs.

"They're problematic because they do increase costs, which carries over, not only to the employer, but to the employee as well," he adds. "Employees will end up paying a higher premium than they need to and the plan ends up paying a much higher cost. In the long run, everybody loses."

Behind the Scenes

The number of drug-rebate or offset programs has escalated over the past decade, says Scott Hinds, research analyst at Sector & Sovereign Research in Stamford, Conn., which analyzed co-pay coupons last year.

After examining the top-selling 109 drugs sold in the United States in 2009, it found roughly half offered some type of rebate. "The [pharmacy benefit managers] turn bright red when this issue comes up because it's really frustrating for them," Hinds says, adding that they don't really know if or when co-pay cards will be used. "Customers don't care if it's a tier-three or tier-two drug if somebody subsidizes their out-of-pocket costs. If PBMs are unable to rein this in, higher plan costs or premiums will certainly be a potential outcome."

The offset programs buy access to PBM enrollees, he says, and are very effective at leveling the playing field between drugs in the same class or tier.

While employees are happy because it saves them money, their health plan and employer, especially if self-funded, are feeling the pain.

Generics typically cost just several dollars for a month's supply, whereas brand-name drugs can be much more expensive. According to Sector & Sovereign's research, the average retail price for a month's supply of Lipitor was $161; Nexium, a popular acid-reflux drug, was $203; Diovan, a hypertension drug, was $91; and Actos, a diabetic drug, was $275.

"It's a brilliant move by pharma companies," says Hinds, explaining that co-pay coupons are also improving the public image of pharmaceuticals since they save people money. "PBMs have to articulate that, overall, [coupons] are undercutting their ability to negotiate lower costs -- which, in the long run, will increase total healthcare costs."

As HR professionals continue struggling with rising healthcare costs, there are other effective approaches they can use to minimize pharmacy benefit expenses.

Listed below are four additional strategies, as suggested by Adam Fein, who writes an **educational blog** about pharmacy economic issues and is also founder and president of Pembroke Consulting in Philadelphia.

* Enlarge the co-pay amounts between drug tiers. (The four common tiers are: Tier 1, generics; Tier 2, preferred brand-name drugs; Tier 3, non-preferred brand-name drugs; and Tier 4, specialty drugs.) Fein says the average difference between tiers two and three is roughly $25 but jumps to $40 to $50 between generic drugs and tier three. By increasing the difference, employers eliminate the financial incentive for employees to use co-pay coupons or participate in offset programs.

* Increase the formulary rebates requested from drug manufacturers. "Try to encourage them to offer more to you as a direct price discount via your PBM versus allowing the manufacturer to bypass the PBM and go directly to the

consumer," he says. "This will help maintain the integrity of the formulary design."

* Implement utilization management, which requires a pharmacist to take extra steps when reviewing particular scripts. He says some plans now use this approach for drugs with co-pay programs. Pharmacists actually intervene by presenting generic alternatives to consumers at the pharmacy counter.

* Create a closed formulary, which is the most extreme measure, but offer options. This removes certain drugs from a formulary, requiring employees to pay full retail price for these drugs. However, many benefit managers and employers are reluctant to do so, especially since physicians see value in prescribing different drugs for different patients.

"It's a complex situation," Fein says, adding that government programs such as Medicare Part D or Medicaid do not participate in offset programs. "The use of these programs can, in some situations, raise the total cost for the payer. It's always a wise decision to evaluate whether something is actually affecting you or not before you start to take action."

June 2, 2011