Health Care Chutzpah vs. Health Plan Literacy

When patients complain that their prescription medicines are "too expensive," what they generally mean is that their co-pay and co-insurance rates are too high.[i] In order to reduce the out of pocket burden for patients at the pharmacy counter, 21st century health care reform should embrace and advance policies that either prohibit or discourage players in the health care ecosystem from retaining compensation based on a percentage of the list price of the drug.

Let's deal with reality. It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own interest.[ii] Payers have always hated copay cards because payers love restrictive formularies and hate patient choice.

In the United States, nearly $15 of every $100 spent on brand-name drugs goes to PBMs, which claim they lower drug costs. However, the share of annual drug price increases that PBMs pocket – as opposed to pass on to consumers – has soared from 5 percent in 2011 to 62 percent in 2016. Three large PBMs control 78 percent of the market and use this market power to control what medicines people can use, what they pay, and where they get their prescriptions filled.[iii]

While it may be true that copay assistance programs for some brand name drugs with generic competition provides an "end run" around legitimate PBM cost-reduction strategies, it is completely untrue for most specialty drugs. – The uniform elimination of copay assistance as a method of meeting "accumulator" requirements does not appropriately recognize this not-so-subtle difference.

Copay accumulator policies leave patients financially exposed and prone to noncompliance. But it's good for the PBM bottom line. Perhaps a better term for "copay accumulator" is "PBM bottom line enhancer." Sometimes it's worthwhile to call something by its proper name.

Besides addressing rebates, smart reform should eliminate opportunities for middlemen to receive fees for services based on a percentage of the list price of a drug. Government reforms that support a move away from supply chain payment based on a percentage of list price could

also push more of the rebate through to the plan sponsors. Plan sponsors should then use those savings to pass through a share of the rebate and devote some of the remaining money towards lower prescription drug cost-sharing more generally.

Copay accumulators, a tool to ensure that the value of a copay card or coupon doesn't count toward a patient's out-of-pocket maximum expense, allows pharmacy benefit managers to further pad their pockets — but harms both patients and the public health by making life-saving medicines unaffordable. And to make matters worse, these programs are being sold to patients as a "benefit." The health care chutzpah of the PBM industry is astounding.

In the United States, nearly three-quarters of all prescription claims are handled by the top three companies: Express Scripts, CVS Caremark and OptumRx. Total profits for the three exceed $17 billion.[iv] A Health Affairs study estimates an additional $22.6 billion in gross profits for all of the remaining PBMs.[v] Much of this profit is made on the backs of patients.

Over the last five years, according to the Department of Health and Human Services, pharmaceutical spending has increased by 38 percent, while the average individual health insurance premium has increased by 107 percent.[vi] Rebates, discounts and fees haven't slowed precipitous premium increases. Copay accumulator programs will only accelerate this dangerous trend.

Until recently, manufacturer couponing programs limited or eliminated patients' out-of-pocket costs until their insurance deductible was met. These coupons are particularly crucial for patients suffering from multiple sclerosis, various cancers, rheumatoid arthritis, Crohn's disease, pulmonary arterial hypertension, psoriasis and HIV-AIDS (among others).

According to two new studies, copay accumulator programs (which don't allow a coupon's dollar amount to count toward reaching a customer's deductible), significantly decrease patient adherence by creating a payment abyss known as a never-ending deductible --NED). NED talks. Patients suffer.

Per a study conducted by ConnectiveRx of 503 patients being treated for serious chronic conditions that frequently require specialty medicines, 75 percent of patients who used a copay coupon at least once in the last 12 months said copay accumulator programs would make it harder for them to adhere to their medicines. Not surprisingly, 66 percent believe such programs are unfair.[vii]

These patients pay 10 times more out-of-pocket than healthy patients and are forced to try cheaper or more rebate-rich drugs before getting medicines that work best. Faced with higher out-of-pocket costs and barriers to access, people are more likely to stop their treatment, getting sicker and more expensive to treat.

It's also important to note that PBMs do not share their rebate savings at the point of sale with patients while enforcing accumulator programs. The sharing of savings occurs in every other

segment of health care (physician services, hospitalizations, dental services), but not pharmaceuticals.

Why is this important to all of us? A review in the Annals of Internal Medicine estimates that a lack of adherence causes nearly 125,000 deaths, 10 percent of hospitalizations and costs the already strained health care system between $100 billion and $289 billion a year.[viii] That's why. And the problem is growing larger.

Many low-premium, high-deductible insurance plans are now incorporating copay accumulator programs — and, per Magda Rusinowski, vice president of health care cost and delivery at the National Business Group on Health, many employers are now only offering such plans to their employees.[ix] As such, educating employees about copay accumulator programs becomes essential. But what is the state of patient/employee knowledge of the NED issue — particularly urgent since we are now entering into the annual open-enrollment period?

The ConnectiveRx study found the level of copay accumulator awareness at 25 percent. And, if knowledge is power, ignorance is not bliss. A new report from McKesson found that, not only do patients not understand what a copay accumulator program is — what they believe to be true is wrong.[x]

For example, 60 percent believe copay accumulators are a plan "benefit," and less than 40 percent know what "out-of-pocket" means.

This confusion is augmented and abetted by the misleading nomenclature used by health plans and PBMs. For example, three of the biggest PBMs promote their programs with terms such as "Coupon Adjustment: Benefit Plan Protection," "Specialty Copay Card Program," and "Out of Pocket Protection Program." The facts speak otherwise.

According to the McKesson report, "Patients can think these protection programs are a health plan benefit or a medication support tool." The reality is that these programs are being marketed to employees (via materials created by the PBMs) as cost-saving tools that make patients pay a "fair share" for specialty medicines. The net effects are that targeted patients (those with "expensive conditions") pay more for their health care.

One way to even the playing field is to recognize and address the need for patient programs designed to enhance "health plan literacy." Considering that 72 percent of health care-related bankruptcies impact patients with health insurance[xi], this should be a public health priority. "Counter detailing" against well-funded and highly motivated PBM marketing schemes will be difficult and expensive.

Who should create and run these programs? It will have to be a collaborative effort between patient organizations (whose members are being impacted), physicians (whose patients aren't getting the medicines they need) and employers (whose employees are being misdirected). Eighty percent of plan sponsors (aka "employers") haven't looked at their PBM contracts in 10

years.[xii] Employers must step up to the plate and do the right thing for their most valuable resource — their employees. It will take time, effort and … integrity.

Another cost-reducing strategy is "decoupling" PBM fees. Manufacturers often pay PBMs administrative fees for certain services (e.g., prescription prior-authorization, formulary development, etc.), and these fees are calculated as a percentage of the list price of a particular drug product. The Administration could consider developing and implementing a policy that would require manufacturer payments for administrative services to be paid as a flat administrative fee (rather than based on list price). The amount of the administrative fee would vary based on the service provided (e.g., a higher administrative fee would be paid for more comprehensive administrative services). Employers such as Caterpillar have negotiated similar programs with their PBM partners.[xiii] The Obama Administration's jettisoned Medicare Part B demonstration program on physician administration fees[xiv] also employed a flat fee strategy.

Zeroing out rebates isn't a panacea for high costs, but it sends a powerful message: It's time to pass savings along to patients. The safe harbor concept must evolve to create and support models to improve health outcomes, promote competition, and manage overall healthcare spending.

As policymakers attempt to inject value into our healthcare system, all participants in the supply chain can and should be paid based on the value they provide.

Rebates are tactics for negotiation and have a place in formulary management. The problem is list price-based rebates and administrative fees elicit percentage-based payments to middlemen, resulting in a preference for higher-priced products, and can be used to promote anti-competitive behavior.

The bad news for PBMs is the days of hiding behind the "beast of big pharma" are over. The good news for consumers is savvy health policy experts are at the wheel and focusing on free-market solutions.

Knowledge is power. Health plan literacy begins with honesty and sunshine, the best medicine. This is precisely why PBMs loathe public attention. Too bad — but not too late.

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[ii] http://geolib.com/smith.adam/won1-02.html

[iii] https://www.bloomberg.com/graphics/2018-drug-spread-pricing/

[iv] Ibid

[v] https://www.healthaffairs.org/do/10.1377/hblog20180726.670593/full/

[vi] https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/02/a-look-at-drug-spending-in-the-us

[vii] https://www.connectiverx.com/wp-content/uploads/2018/10/connectiverx_pm360_eoc_0318_eprint_unlocked-1.pdf

[viii] https://www.nacds.org/news/the-cost-of-medication-non-adherence/

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[xii] https://www.drugchannels.net/2010/02/why-do-pharmacy-owners-care-about-pbm.html

[xiii] https://drugwonks.com/blog/the-big-cat-finds-roi-where-the-sun-don-t-shine

[xiv] https://www.cms.gov/newsroom/press-releases/cms-proposes-historic-changes-modernize-medicare-and-restore-doctor-patient-relationship