Benefit Based Co-Pays: Fewer Tears

David B. Nash, MD, MBA

I am sold!

I was very skeptical about the design and construction of a multitiered, co-payment drug benefit that could link improvement in clinical outcome with a lowered out-of-pocket cost for patients. I am sure that your P&T committee has at least heard of such value-based or benefit-based co-payment schemes.

I had the privilege of chairing a national roundtable of Fortune 500 companies and watched the participants' reactions to a passionate presentation by some of the leading researchers in benefit-based co-payments, including Drs. A. Mark Fendrick and Michael Chernew of the University of Michigan. Let me set the stage for the recent explosion in interest for benefit-based co-payments and quickly analyze aspects of the key literature.

Recent research has shown that so-called incentive-based formularies have a direct impact on prescription drug use and spending by patients. Nearly two years ago,[1] researchers at Harvard Medical School, writing in the *New England Journal of Medicine*, found that changes in formulary administration may have dramatically different effects on drug utilization and spending and may, in some instances, lead enrollees to discontinue therapy.

We have always known that compliance and adherence are tough subjects. What we are grasping only now is the impact of these multitiered formularies on compliance and adherence behaviors. Medicare beneficiaries, especially, tend to report low satisfaction rates with plans that have multitiered access to needed prescriptions.[2] They are also confused about even the basics of a drug benefit program.[3] Finally, more recent evidence suggests that the number of tiers in these programs will increase and that co-payments will rise as well, to $50 or more within three to five years.[4]

Drs. Fendrick and Chernew have introduced the term *benefit-based co-payment* to refer to contributions based on the potential for clinical benefit, taking into consideration the patient's clinical condition.[5] For any given drug, patients with a high potential benefit would have lower co-pays than patients with a low potential benefit. How might this type of system be administered?

The co-pay would vary by the evidence-based benefit of the medication for the individual patient. The key to implementing the benefit-based co-payment system is as follows:

> managed care organizations and their clinicians accept the responsibility for decision making on the benefits and costs of prescription drugs and create clearly defined systems for their determination. For example, one might establish a lower co-payment based on specific patient characteristics, such as a prior myocardial infarction or heart attack.[5]

Imagine a patient or employee paying less for a statin than a patient who receives primary prevention therapy. Another example might be lower co-pays for asthmatic patients who have recently been hospitalized or who have visited the emergency room because of their condition. How about lowering the cost for patients with diabetes so that they can receive insulin and related products if they have had a recent episode of diabetic ketoacidosis? Does this sound revolutionary to you?

I simply cannot, in print, portray the passion that Drs. Fendrick and Chernew have for the benefit-based co-payment. They have planted a large flag on the moral high ground and are battling all those who are assaulting their position. Yet several companies, most notably Pitney Bowes, have already implemented components of the benefit-based co-payment for prescription drugs.[6] Not surprisingly, Pitney Bowes reports dramatic savings from this program through improved compliance and lower utilization of emergency departments and hospitals. The company also reports that most employees within the organization support this new concept.

Clearly, benefit-based co-payments are not for every organization. The data demands are significant, the medical leadership demands are even more so, and the educational hurdles for employers and employees are formidable.

Despite these challenges, I am hopeful that more firms will experiment with aspects of the benefit-based co-payment model. I am sure that Drs. Fendrick and Chernew, as well as others, will continue to spread the gospel.

I hope that your P&T committee will examine the available evidence and encourage employers to do the same. I am convinced that our tiered system creates unnecessary tears. Now you can appreciate why I am sold on the benefit-based co-payment.

Dr. Fendrick's e-mail address is amfen@umich.edu. Dr. Chernew's e-mail address is mchernew@umich.edu.

As usual, I am interested in your views. You can reach me at my e-mail address, david.nash@jefferson.edu.

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