BENEFIT-BASED COPAYS: AN ALTERNATIVE APPROACH TO FORMULARY MANAGEMENT

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In the standard tiered copay structure, patients are allowed access to low-cost, preferred drugs (tier 1 and tier 2), as well as to more expensive drugs (tier 3) that may lead to better management of their conditions. In this system, patients' access to highly effective yet expensive drugs depends on their ability to afford the copay amount specified by their health plan. A recent study [1] suggests that increased copays for brand name drugs can result in decreased utilization and expenditures associated with brand name drugs as well as increased utilization of generic drugs without resulting in discontinuation of chronic medications. However, the tiered copay system may pose problems for members with limited incomes. Such members may be unable to purchase more expensive medications and thus may be less inclined to fill or refill prescriptions for them. When these expensive medications are essential for health maintenance, members may experience avoidable emergency department or inpatient admissions.

However, there is a more equitable alternative to the standard tiered copay structure, which may be termed a *benefit-based copay system*. In a benefit-based copay system, the level of a patient's contribution to pharmacy costs would be based on 2 factors: 1) his or her individual disease severity and 2) the likelihood that he or she would receive benefit from a specified intervention as determined from available scientific evidence. Adopting a benefit-based copay system would ensure that patients who could benefit most from expensive medications actually receive them.

For example, one could propose that an individual with documented coronary artery disease (CAD) and an elevated cholesterol profile (eg, low-density lipoprotein [LDL] > 200 mg/dL) should pay a lower copay for a cholesterol-lowering drug for secondary prevention than a patient treated with the same drug for primary prevention who has a better total cholesterol profile (eg, LDL around 160 mg/dL). The former patient with documented CAD is significantly more likely to experience an adverse coronary event that the intervention is designed to prevent. Because the cost-effectiveness of the cholesterol-lowering agent is superior in the former patient [2], an argument can be made that the patient is most likely to benefit and, therefore, should have greater access to the drug (ie, a lower copay).

A similar argument can be made regarding access to cyclooxygenase (COX)-2 inhibitors. COX-2 inhibitors are innovative nonsteroidal anti-inflammatory drugs (NSAIDs) that have equal efficacy but a better safety profile compared with agents that inhibit both COX-1 and COX-2 enzymes [3]. Individuals at increased risk for developing NSAID-related complications (eg, who have been treated with anticoagulants or concomitant corticosteroid therapy or who have had prior gastrointestinal bleeding) are statistically more likely to benefit from the relative safety advantage of these new agents and to avoid the morbidity and cost of their occurrence [3]. Therefore, one could argue on cost-effectiveness grounds that patients at risk for NSAID-related adverse events should pay less for COX-2 inhibitors than individuals without such risk factors.

If a new copay strategy—one based on likelihood of benefit as opposed to ability to pay—were to evolve, a more equitable distribution of effective drugs would result and the number of patients who are denied indicated therapy would be minimized.

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References

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