Rx Benefits Brief

For Employer Health Care Economic Decision Makers

Co-pay Assistance and High Deductibles

Have you evaluated the impact of co-pay adjustment programs on your members' health care costs?

Executive Summary

- For members with complex, chronic conditions like RA, finding the right treatment can be a long and difficult journey[1]
- Many members are facing high costs due to cost sharing for premiums, deductibles, and Rx out-of-pocket (OOP) amounts[2]
- Many manufacturers offer commercial co-pay assistance, but there are financial limits to this help
- Pharmacy benefit managers (PBMs) are offering programs to reverse application of this assistance from a member's deductible, but that process can result in a financial burden to members
- It has been shown that when some members face higher cost sharing for their medications, they become nonadherent to their therapy[3]
- For some patients, medication nonadherence has been associated with increased utilization of costly health care services such as emergency room (ER) visits and hospitalizations[4]
- Other strategies exist that can help members stay on treatment as prescribed

Chronic diseases affect almost 200 million Americans[5]

In 2015, 191 million Americans had at least one chronic condition. Of this population, 75 million had two or more chronic diseases.[5] If current trends continue, chronic diseases could cost the United States almost $2.8 trillion annually in medical costs and lost employee productivity.[5,*]

Although the prevalence of complex, chronic diseases such as psoriasis, inflammatory bowel disease (IBD), rheumatoid arthritis (RA), and multiple sclerosis (MS) is relatively low, conditions such as these can be costly.[6-14]

For members with conditions like RA, finding the right treatment and achieving stable health status on treatment can be a long and difficult journey.[1] Once diagnosed, some patients may receive and then discontinue multiple treatments before a specialty medication is prescribed.[15] In some cases, specialty drugs may offer the only option for members with chronic diseases. For some diseases, they are the only treatment for conditions that historically had few treatment options.[16]

Members with chronic conditions may face high OOP costs

Patients with complex, chronic conditions may face high cost sharing for premiums, deductibles, and Rx OOP amounts.[2] The percentage of covered employees in health plans with four or more drug tiers increased substantially in the past decade, from 3% in 2004 to 23% in 2015.[17] In 2016, plan members with individual coverage faced an average deductible of more than $2100, and those with family coverage had an average deductible of more than $4600.[18]

*Average costs per year, 2016 to 2030.[5]

Unfortunately, the majority of members in plans with high deductibles* lack the funds to pay for costly health care needs prior to meeting their deductible. In fact, according to a 2016 national online survey of covered employees, only two in five full-time employees said they had the funds available to pay a $3000 OOP medical expense.[20] A survey of more than 400,000 health savings account (HSA) holders showed the median employee contribution was only $700.[21]

So what happens when members can't afford the health care services they need? They may stop taking their medications.[3] For some patients, medication nonadherence has been associated with increased utilization of costly health care services such as ER visits and hospitalizations.[4]

Members with chronic conditions may use patient co-pay assistance programs

Members facing high cost sharing may be at risk for therapy nonadherence. Co-pay assistance programs from US biopharmaceutical companies are a potential source of financial assistance.[22] Because generic options are not available for certain specialty medications, some people have no less expensive alternative to the medication their doctor has prescribed.[23]

It's important to note that co-pay assistance for patients with chronic conditions is usually consistent with the design of the formulary structure. These programs are designed to reduce the influence of cost as a barrier to treatment after a prescribing decision has been made.

Co-pay assistance programs, however, do not have unlimited pools of money. They have limits—monthly, annually, or sometimes both. As benefit designs have changed over the years, with increasing deductibles, more and more members are getting closer to reaching those limits.

For some members in high-deductible health plans (HDHPs),* co-pay assistance programs are usually counted toward the deductibles. But consider the member with a complex, chronic condition who is taking a specialty medication. Does she have a choice? Does she have the $2000 to $4000 available in January (or at the start of her plan year) to pay for her medication? Maybe not.

Pharmacy benefit managers (PBMs) offer programs—some call them *accumulator adjuster programs*—in which the co-pay assistance provided by the manufacturer is applied not to the member's deductible but rather to the employer's share of the cost. Conceptually, it sounds reasonable. This practice requires the member to be responsible for paying for 100% of his or her health care before meeting the deductible. However, given the limits of these co-pay programs, there may be unintended consequences.

*For calendar year 2017, the IRS defines an HDHP as a health plan with an annual deductible that is not less than $1300 for self-only coverage and $2600 for family coverage, with OOP expenses capped at $6550 for self-only coverage and $13,100 for family coverage.[19] HDHPs are also referred to as *consumer-directed health plans (CDHPs)*, which are HDHPs paired with a savings plan.[2]

Consider the following example for a member with RA*:

An employee with RA, after having tried and failed other medications, is eventually prescribed a specialty medication. In this scenario:

- The monthly negotiated employer cost for his specialty medication is $4000
- The employee has family coverage with a $4000 deductible
- Once he has met the deductible, the employee has a 20% medication co-insurance with a $150 cap
- The manufacturer co-pay assistance program has an annual limit of $12,000, and the member is responsible for $5 OOP each month

Without an accumulator adjuster program in place, the following would be the monthly and annual costs for each stakeholder:

Table 1: Without Accumulator Adjustments

For Illustrative Purposes Only

Member Has Met the Deductible in January

Month	Member Deductible Balance at Beginning of Month	Medication Cost	Member OOP	Manufacturer Support
January	$4000	$4000	$5	$3995
February	$0	$4000	$5	$145
March	$0	$4000	$5	$145
April	$0	$4000	$5	$145
May	$0	$4000	$5	$145
June	$0	$4000	$5	$145
July	$0	$4000	$5	$145
August	$0	$4000	$5	$145
September	$0	$4000	$5	$145
October	$0	$4000	$5	$145
November	$0	$4000	$5	$145
December	$0	$4000	$5	$145
Annual Totals	**$0**	**$48,000**	**$60**	**$5590**

Without accumulator adjustments, the co-pay assistance is applied to the employee's deductible. The employee meets his deductible in the first month and thereafter must pay only **$5 OOP each month** for the rest of the year. The assistance program covers the remaining $145 of the monthly co-insurance cap.

***Accumulator Adjustment Scenario Qualifying Information**

The data in Table 1 and Table 2 present a hypothetical scenario intended to isolate and provide one illustrative example how an accumulator adjustment program may work. In order to clearly illustrate the mechanics in this example, our assumptions exclude some key inputs from this scenario that, if included, would likely change the potential effect of an accumulator adjustment program: (i) Patients may have other healthcare expenses that reduce their deductible and this would reduce the financial impact to patients and manufacturers; (ii) a lower drug cost might reduce the financial impact to the relevant parties; (iii) manufacturer co-pay assistance programs may have different limits, including annual, monthly or other limits on the amount of co-pay assistance provided, which could either increase or decrease the financial impact to the relevant parties; and (iv) changes to plan benefit design, including the deductible, co-pay/co-insurance amounts, and maximum out-of-pockets could either increase or decrease the financial impact of an accumulator adjustment to the relevant parties.

But what happens if the employer implements an accumulator adjuster program? The following scenario shows what could occur in the first four months of the new plan year:

Table 2: With Accumulator Adjustments **For Illustrative Purposes Only**

Month	Member Deductible Balance at Beginning of Month	Medication Cost	Member OOP	Manufacturer Support
January	$4000	$4000	$5	$3995
February	$3995	$4000	$5	$3990
March	$3990	$4000	$5	$3985
April	$3985	$4000	$3955	$30

Patient Now Faces Very High OOP Costs

Manufacturer Support Limit Has Been Reached

If there is no other health care utilization subject to the deductible, the cost of the RA medication is the only amount contributing to the employee's deductible. By April, the manufacturer's annual co-pay assistance limit of $12,000 has been reached, and the employee is faced with high OOP costs.

What will this employee do? Will he have the money in his HSA to cover that expense? Maybe not. Will he have enough money to personally cover this expense? Maybe not.

Employers should consider the big picture

What if the employee couldn't afford that expense in April? What would be the outcome if he simply stopped taking his medication? Perhaps he would end up at the emergency room or require an inpatient hospitalization. What would these health care services cost the employer?

Don't force your members to face a "co-pay surprise." Consider the unintended consequences that may be the end product of an accumulator adjuster program.

What could an employer do instead?

By aligning pharmacy benefit strategies with HDHPs, employers can help ensure that costs are not a barrier to needed therapy, especially for members in HDHPs who are taking specialty medications. Consider some of these tactics to optimize your health benefits design:

- Help members with HSAs optimize their accounts by offering some initial funding or providing additional initiatives for funding to help offset a portion of their health care expenses
- Offer a health reimbursement arrangement (HRA) option that allows prescription drug coverage outside the deductible and without cost sharing[24]
- Implement an expanded preventive drug list to cover certain specialty medications outside the deductible
- Assess the opportunity to implement wage-based deductibles
- Provide point-of-sale rebates for members to reduce OOP costs

References

1. Lipsky PE. Rheumatoid arthritis. In: Fauci AS, Kasper DL, Longo DL, et al, eds. *Harrison's Principles of Internal Medicine*. 17th ed. New York: McGraw-Hill; 2008:2083-2092. **2.** Benfield | Arthur J. Gallagher & Co. *Employer Market Intelligence*: *Employer Market Trends*. Report presented at: AbbVie; July 28, 2016; Chicago, IL. **3.** Goldman DP, Joyce GF, Excarce JJ, et al. Pharmacy benefits and the use of drugs by the chronically ill. *JAMA*. 2004;291(19):2344-2350. **4.** Roebuck MC, Liberman JN, Gemmill-Toyama M, Brennan TA. Medication adherence leads to lower health care use and costs despite increased drug spending. *Health Aff*. 2011:30(1):91-99. **5.** Partnership to Fight Chronic Disease. What is the impact of chronic disease on America? http://www.fightchronicdisease.org/sites/default/files/pfcd_blocks/PFCD_US.FactSheet_FINAL1%20%282%29.pdf. Accessed March 22, 2017. **6.** National Stem Cell Foundation. Psoriasis. http://www.nationalstemcellfoundation.org/psoriasis/. Accessed January 3, 2017. **7.** Fowler JF, Duh MS, Rovba L, et al. The impact of psoriasis on health care costs and patient work loss. *J Am Acad Dermatol*. 2008;59(5):772-780. **8.** Crohn's & Colitis Foundation of America. What is Crohn's disease? http://www.ccfa.org/what-are-crohns-and-colitis/what-is-crohns-disease/. Accessed February 15, 2017. **9.** Crohn's & Colitis Foundation of America. What is ulcerative colitis? http://www.ccfa.org/what-are-crohns-and-colitis/what-is-ulcerative-colitis/. Accessed February 15, 2017. **10.** Centers for Disease Control and Prevention. An expensive disease without a cure. https://www.cdc.gov/ibd/pdf/inflammatory-bowel-disease-an-expensive-disease.pdf. Accessed January 3, 2017. **11.** Helmick CG, Felson DT, Lawrence RC, et al. Estimates of the prevalence of arthritis and other rheumatic conditions in the United States: part 1. *Arthritis Rheum*. 2008;58(1):15-25. **12.** Birnbaum H, Pike C, Kaufman R, Marynchenko M, Kidolezi Y. Societal cost of rheumatoid arthritis patients in the US. *Curr Med Res Opin*. 2010;26(1):77-90. **13.** National Multiple Sclerosis Society, Northern California Chapter. Progress Report 2009. http://www.nationalmssociety.org/NationalMSSociety/media/Northern-California/About%20this%20Chapter/Files/2009-Annual-Report.pdf?ext=.pdf. Accessed April 4, 2017. **14.** Campbell JD, Ghushchyan V, McQueen RB, et al; for Multiple Sclerosis Resource Centre. Burden of multiple sclerosis on direct, indirect costs and quality of life: national US estimates. *Mult Scler Relat Disord*. 2014;3(2):227-236. **15.** Singh JA, Furst DE, Bharat A, et al. 2012 update of the 2008 American College of Rheumatology Recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis. *Arthritis Care Res*. 2012;64(5):625-639. **16.** Pharmaceutical Care Management Association. Specialty benefit design. https:// www.pcmanet.org/policy-issues/specialty-benefit-design/. Accessed January 3, 2017. **17.** Claxton G, Rae, M, Long M, et al; Kaiser Family Foundation, Health Research & Education Trust, NORC at the University of Chicago. *Employer Health Benefits: 2016 Annual Survey*. http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey. Published 2016. Accessed March 22, 2017. **18.** United Benefit Advisors. *Health Plan Intelligence for Business Decisions: 2016 Executive Summary—Benefit Plan Design and Cost Benchmarking Key Results*. https://www.ubabenefits.com/wisdom/surveys. Published 2016. Accessed March 23, 2017. **19.** Internal Revenue Service. Tax forms and instructions. 26 CFR parts 601, 602. https://www.irs.gov/pub/irs-drop/rp-16-28.pdf. Washington, DC: Internal Revenue Service; 2016. Accessed April 13, 2017. **20.** Guardian. *A Crack in the Foundation: Working Americans Rely Heavily on Their Employee Benefits for Financial Security, but Higher Out-of-Pocket Medical Costs Are Taking a Toll*. https://wbs2016.guardianworkplace.com/pdf/Guardian_WBS_FlipBook.pdf. Accessed March 23, 2017. **21.** Spiegel J; HelloWallet. *Health Savers: the Consumer Finance of Health Savings Accounts*. http://www.hellowallet.com/research/health-savings. Published July 2015. Accessed April 20, 2017. **22.** Pharmaceutical Research and Manufacturers of America. Access to medicines: patient assistance. http://www.phrma.org/advocacy/access/patient-assistance. Accessed March 23, 2017. **23.** UnitedHealthcare. Generic medications 101. http://c.ymcdn.com/sites/www.aimsmddc.org/resource/resmgr/imported/Generic%20Medications%20101.pdf. Published 2011. Accessed March 23, 2017. **24.** Sammer J, Miller S; for Society for Human Resource Management. Consumer-driven decision: weighing HSAs vs. HRAs. https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/hsasvshras.aspx. Published May 6, 2011. Accessed March 30, 2017.

©2017 AbbVie Inc. North Chicago, IL 60064 400-1908715 May 2017