



CRA Insights: Life Sciences

CRA Charles River
Associates

November 2014

The economics of co-pay coupons

Background

In a series of ongoing lawsuits, health plans have alleged that co-pay coupons are kickbacks that result in increased total spending on drugs.¹ The suits allege that pharmaceutical companies structure coupons to encourage the use of higher-cost drugs while hiding the coupon use from insurers. When a patient fills a covered drug, the health plan (an insurer or a pharmaceutical benefits manager) pays the pharmacy all but the co-pay, with the understanding that the pharmacy collects the co-pay from the patient. When there is a co-pay coupon, the pharmaceutical manufacturer pays the co-pay (or a portion thereof) in place of the patient. The suits allege this payment is invisible to the health plan and by changing the co-pay differential between drugs, the drug coupon permits branded manufacturers to circumvent the incentives to encourage utilization of lower-cost alternatives. According to plaintiffs, this leads to health plans paying for higher-cost drugs.²

As of 2013, co-pay coupons were available for 374 drugs, up 335 percent from 2009.³ With increased use of these coupons, as well as several high-profile cases in the courts, it is timely to explore the economic effects of co-pay coupons and consider a framework for assessing their impact.

Health plan formularies: incentives to encourage lower-cost alternatives

Health plans typically use lists of covered drugs (“formularies”) and beneficiary cost sharing obligations (such as co-pays) to encourage the use of preferred products. The vast majority of plans use tiered formularies, where generic drugs have lower patient co-pays (Tier 1) than drugs

¹ See, for example, Amended Complaint in *Plumbers and Pipefitters Local 572 Health and Welfare Fund v. Merck & Co. Inc.*, 3:12-cv-01379-MAS-LHG (D.N.J., Sep. 12, 2013); Amended Complaint in *New England Carpenters Health and Welfare Fund v. Abbott Laboratories*, No. 12-cv-01662 (N.D. Ill., Jul. 15, 2013).

² See *New England Carpenters v. Abbott* at ¶¶ 2, 7; *Plumbers and Pipefitters v. Merck* at ¶ 7; see also Visante, “How Copay Coupons Could Raise Prescription Drug Costs by \$32 Billion Over the Next Decade,” Prepared for PCMA, November 2011, p. 8.

³ Joseph S. Ross and Aaron S. Kesselheim, “Prescription-Drug Coupons — No Such Thing as a Free Lunch,” *New England Journal of Medicine*, September 26, 2013, vol. 369, pp. 1188–89; Cleveland Research, “How Co-pay Discount Cards Are Affecting Drug Spend” (presented at Pharmacy Benefits Academy, August 2011). See also IMS Institute for Healthcare Informatics, “The Use of Medicines in the United States: Review of 2011,” April 2012.

categorized as preferred brands (Tier 2) or non-preferred brands (Tiers 3+). Higher tiers result in higher co-pays, sometimes including co-insurance, for patients, creating incentives for patients to ask doctors for generics or preferred brands. The decision to place a drug in a certain tier tends to be driven by questions of cost effectiveness (inclusive of rebates and other price concessions from the manufacturer), resulting from the health plan's assessment of a drug and its therapeutic alternatives. Nonetheless, co-pays represent only a fraction of total drug cost; the remainder is paid by plans and ultimately through premiums. Plaintiffs allege that a coupon that covers the co-pay differential between tiers erodes the incentive to choose the more cost-effective drugs.

For their part, health plans have a range of potential responses. For example, plans could accept coupons and attempt to pass on any additional cost in premiums, or they could require contracted pharmacies to refuse coupons, as UnitedHealthcare recently attempted.⁴ As a further alternative, plans could simply refuse to cover drugs that use coupons, as CVS Caremark and Express Scripts have done with certain drugs.⁵ Because co-pay coupons only work when a drug is covered by the health plan, the failure to cover a drug would neutralize the coupon, substantially increasing a patient's cost of filling the drug and consequently limiting use of the drug. A plan considering this approach could use this leverage in rebate negotiations with the manufacturer. Consequently, despite the advent of co-pay coupons, options remain for attentive plans to control the use of high-cost drugs and/or to require price concessions in exchange for coverage.

Manufacturers: co-pay coupons to enable access

Co-pay coupons can serve a number of legitimate roles as pharmaceutical manufacturers compete for business. For example, research suggests the co-pay burden could lead some patients to skimp on filling prescriptions.⁶ Accordingly, co-pay coupons could encourage appropriate utilization. Coupons allow certain patients who might choose an alternative drug, go without treatment, or take medications irregularly to have access to the drug. Coupons also represent a form of price competition. They are an avenue for manufacturers to provide targeted price reductions—in this case, reductions that are directly visible to patients. Additionally, some manufacturers use coupons as another way to provide low-cost samples. In particular, the burden of new reporting requirements for drug samples has led many to view co-pay coupons as an easier alternative. Further, at launch, when new products are often on Tier 3 prior to rebate contracts being established, coupons can help speed uptake.

Frameworks for evaluation

Co-pay coupons shift the relative cost burdens borne by patients and plans. The results certainly could benefit the provision of health care: for instance, coupons may reduce the irregular use of medications and may facilitate access to more effective or better tolerated medications. On the other hand, co-pay coupons could create incentives for patients to request and choose drugs that impose a greater cost burden on third-party payers.

⁴ Note that in the case of UnitedHealthcare, this approach failed and was recently rescinded. See Jane Dubose, "UnitedHealthcare's reversal on copay coupons," *HealthLeaders Interstudy*, April, 2014.

⁵ Andrew Pollack, "Health Insurers Pressing Down on Drug Prices," *New York Times*, June 20, 2014; Tracy Staton, "The formularies are here! Brace yourselves for the 48 new exclusions," *FiercePharmaMarketing*, August 6, 2014.

⁶ See, for example, Michael E. Chernew, et al., "Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment," *Health Affairs*, vol. 27, no. 1, (2008).

One framework that permits the disparate effects of a co-pay coupon program to be distilled into a single measure and evaluated is aggregate consumer welfare. The change in aggregate consumer welfare associated with a co-pay coupon program takes into account the consumer surplus (i.e. the net value perceived by consumers) when a co-pay coupon program is available as compared to the consumer surplus that would have occurred without the program. Consumer surplus consists of a consumer's valuation (i.e. willingness-to-pay) for the pharmaceutical product purchased less the effective co-pay, as well as the consumer's valuation of the health plan less the premiums paid. For example, although already paying for a health plan, a consumer may be willing to pay an additional amount, the co-pay, for access to a particular drug. If the consumer receives a co-pay coupon, changes products, and experiences greater convenience, the consumer's surplus may increase.

At the same time, however, the consumer may face a change in the cost of health plan premiums, perhaps as a result of an increase in the health plan's drug costs due to the consumer's use of a co-pay coupon. In addition, the consumer may place greater value on a plan that permits co-pay coupons than one that does not. Consumers who would rather pay more in premiums and less in co-pays would have a greater willingness-to-pay for plans that allow co-pay coupon programs. All factors must be considered in order to determine the net effect on consumer welfare. The changes in a consumer's valuation of going from one drug to another, less the co-pay differential, plus the change in the consumer's valuation of the health plan less the change in premiums, is likely to represent the change in consumer welfare. Ultimately, whether a consumer is better off under a co-pay coupon program must be considered on a case-by-case basis.

As for harm to health plans from a co-pay coupon program, such harm may be quantified in the form of lost profits, if any. The effect of a co-pay coupon program on a health plan's profits occurs both through changes in costs and changes in the revenues it collects.⁷ A health plan's costs could be affected by: differences in the net price of drugs when members switch products due to co-pay coupons; changes in rebates if patients less frequently take preferred-tier drugs; additional drug cost when patients fill their prescriptions more regularly; and potential savings in health care costs (e.g. hospitalizations, artificial limbs, dialysis) if adherence increases with coupon use. On the revenue side, a health plan's revenues will change as its premiums and number of members change. The number of members, however, is likely to be a function of the premiums and the features of a health plan, including whether the plan decides to allow co-pay coupons. Ultimately, the extent to which a health plan is injured, if at all, should be considered on a case-by-case basis.

Conclusion

Co-pay coupon programs have become a regular feature of prescription drug marketing. They serve a purpose for manufacturers and reduce co-pays paid by consumers. While health plans allege harm to themselves and consumers, it remains to be seen whether co-pay coupon programs improve or harm consumer welfare and whether health plans suffer losses as a result of these programs.

⁷ Quantitatively, lost profits can be assessed by the number of members times the per-member premium minus the plan costs in the actual world with a co-pay coupon program minus the number of members times the per-member premium minus the plan costs in a world without the specific co-pay coupon program.

Contacts

Dr. Peter Rankin

Vice President
Washington, DC
+1-202-662-3935
prankin@crai.com

Dr. Andrew Tepperman

Vice President
Toronto
+1-416-413-4084
atepperman@crai.com

About CRA's Life Sciences Practice

CRA is a leading global consulting firm that offers strategy, financial, and economic consulting services to industry, government, and financial clients. Maximizing product value and corporate performance, CRA consultants combine knowledge and experience with state-of-the-art analytical tools and methodologies tailored to client-specific needs. Founded in 1965, CRA has offices throughout the world.

The Life Sciences Practice works with leading biotech, medical device, and pharmaceutical companies; law firms; regulatory agencies; and national and international industry associations. We provide the analytical expertise and industry experience needed to address the industry's toughest issues. We have a reputation for rigorous and innovative analysis, careful attention to detail, and the ability to work effectively as part of a wider team of advisers. To learn more, visit www.crai.com/lifesciences.



The conclusions set forth herein are based on independent research and publicly available material. The views expressed herein do not purport to reflect or represent the views of Charles River Associates or any of the organizations with which the authors are affiliated. The authors and Charles River Associates accept no duty of care or liability of any kind whatsoever to any party, and no responsibility for damages, if any, suffered by any party as a result of decisions made, or not made, or actions taken, or not taken, based on this paper. If you have questions or require further information regarding this issue of *CRA Insights: Life Sciences*, please contact the contributor or editor at Charles River Associates. This material may be considered advertising. Detailed information about Charles River Associates, a registered trade name of CRA International, Inc., is available at www.crai.com.

Copyright 2014 Charles River Associates