COPAY STRUCTURE

CASE STUDY:
You are the Director of Pharmacy for the Central States Health Plan covering 500,000 lives. Most of these lives are in small and moderate size employer groups in a self-insured arrangement. Employers are looking for solutions to curb rising drug costs and are asking your health plan for answers. If the trend continues at the current rate, several employers have stated that they may no longer be able to offer a pharmacy benefit to their employees. As the Director of Pharmacy, it is your job to make recommendations that affect benefit design. You will have assistance from the health plan’s actuary to analyze potential savings.

Your market has been non-aggressive with copay structure, and the majority of your groups are in a two-tier copay arrangement. Members pay the lesser of a ten dollar copay or the retail cost for generic drugs, and a twenty dollar copay for all branded formulary and non-formulary products. There are no deductibles for members. Data from last quarter indicate that after copay, a 30 day supply of a generic product costs an average of $7.25 whereas a 30 day supply of a branded product costs an average of $56.00.

- What changes would you consider to the current copay structure that would provide savings to your self-insured groups?
- How would you determine which tier to place various drug products?
- What are the potential consequences of implementing a tiered benefit design?

KEY TERMS:
- Self-insured (self-funded)
- Copay
- Fixed Dollar Copayment
- Deductible
- Tiered benefit design
- Trend
- Plan Limits

PRINCIPLE:
Pharmacy Benefit Management
- Organizational activities designed to influence the behaviors of prescribers, pharmacists and patients to affect the cost and use of prescription drugs.4

PRACTICE:
Coinsurance
- A payment sharing agreement between the insurance company or federal entity and the patient, which often includes the copayment concept of a specific amount per visit or for an established amount of supplies (such as $10 for a doctor visit or $5 for a 30-day prescription), or a stated percentage (such as the patient’s 20% responsibility of payment).1
APPLICATION / TEACHING POINTS:

- Strategies to have the student consider:
  - Implement a benefit design with more than two tiers

  Three tier advantages:
  - Consumer has incentive to choose generic or cost-effective drugs
  - Generic Dispensing rate increases
  - Controls increases in drug spend
  - Allows great access to medications (non-formulary)

- There are three design considerations:
  1. Previous cost share
  2. Dollar difference between tiers
  3. Drug assignment to tiers

  Regarding previous cost share, transition will be easier for plans that already have a high-copayment two-tier system. Members are already accustomed to the differential copay system and in some cases new copayments will be lower than their previous copayments.

  In the case study, the student may recommend to place the generic copay at $5 – thus providing a copay that is less expensive than the previous arrangement.

- What cost difference would they recommend between the tiers?
  - As a rule of thumb, the average copayment should be 25% of the average ingredient cost of medications for a plan.\(^1\)
  - The greater the dollar difference between tiers, the greater the shift in drug mix to generics and preferred drugs, and the greater the savings. A $15 or greater difference results in maximum change.\(^3\)

- How would the student structure the tiers? Examples:
  - 1\(^{st}\) tier generics, 2\(^{nd}\) tier formulary brands, 3\(^{rd}\) tier non-formulary
  - 1\(^{st}\) tier generics, 2\(^{nd}\) tier single source products, 3\(^{rd}\) tier multi-source products
  - 1\(^{st}\) tier generic and formulary agents for chronic conditions, 2\(^{nd}\) tier generic and formulary agents for non-chronic conditions, 3\(^{rd}\) tier non-formulary products and lifestyle medications/quality of life drugs (consider 4\(^{th}\) tier)
  - Take into consideration specialty pharmacy products (Therapies for oncology, cystic fibrosis, growth disorder, HIV/AIDS, Transplant, etc.), and where they would be placed and the co-pay for such products.
  - What impact will OTC drugs have on the benefit design
  - What about member paid deductibles?
  - Note: Designs that place many products in an expensive high tier produce greater savings but create a large cost shift and greater member dissatisfaction.\(^3\)
  - Cost and rebates should be considered for all “me-too” products - this would be handled by the Pharmacy and Therapeutics Committee when determining the Formulary.

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**PRINCIPLES IN PRACTICE**

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- In addition to a three-tier system, would the student consider not covering selected products, or moving products to a coinsurance arrangement? Some examples of products currently being excluded by health plans are: cosmetic drugs, abortifacients, appetite suppressants, smoking cessation products, fertility drugs, anabolic steroids, erectile dysfunction agents, growth hormones, allergy agents, injectables, oral contraceptives, pre-natal vitamins, diabetic supplies, insulin syringes, and irritable bowel agents. It would be appropriate to consider prior authorization for many of these products.

- What consequences may higher copays have on the member?
  - May make them consider a generic or product on a lower tier
  - May provide overall savings to themselves or their employer
  - May cause member dissatisfaction and much preparation must go into the transition
  - May adversely affect compliance – this should be monitored

- How would the student propose to ease the transition to a three-tier system
  - Send notification letters to members on a 3rd tier agent about alternatives in lower tiers
  - Educate the physician and pharmacy network regarding the changes and the reasons for the change.
  - An explanation of the formulary for members, physicians and pharmacists and how the formulary can be accessed (i.e. internet, printed formularies, member services, provider services.)
  - Consider a “grandfather” period that would allow members to obtain current 3rd tier agents they are taking at a lower tier for a defined period of time until they can get new prescriptions for lower tier agents.
  - Use AMCP communication grid to help educate members

ADVANCED TEACHING POINTS:
- Timing of utilization of drugs in certain tiers (i.e., second generation antihistamines, antibiotics)
- What impact will a defined contribution plan or flexible spending accounts have on utilization?
- Differential copayments
- Cost-effective (brand going generic)

RECENT STUDIES (JMCP ARCHIVES):
  (Concluded that 3 tier members reported lower satisfaction with their plans compared to members in 2 tier plans)
- Effects of a 3-tier pharmacy benefit design on the prescription purchasing behavior of individual with chronic disease. 2003; 9(2):123-133
  (Formulary compliance increases-5.8%, Generic utilization increased 6-8%)

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REFERENCES: