Employers Try Cutting Diabetes Drug Copays

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Several large employers and employer coalitions are finding that it may be a worthwhile gamble to reduce or eliminate copayments for medications that control diabetes or treat comorbid conditions.

Pitney Bowes, for instance, reduced copays for diabetes drugs, as well as for asthma drugs, in 2001. The company realized first-year savings of about $1 million, according to an article published online in the Jan. 30 issue of Health Affairs.

Diabetes is a fat target. Some 20 million Americans have the condition, leading to $132 billion in medical costs, disability, and lost productivity, according to the University of Michigan, one of the employers that recently launched a reduced-copay program. However, only about half of diabetes patients stick to their prescribed medication regimens, which can include as many as a dozen therapies. Out-of-pocket costs for those medications add up, and this may deter patients from adhering to their treatment plans, according to the university.

These reduced copay programs are in stark contrast to a trend toward shifting costs onto workers. Copays for pharmaceuticals in particular have grown in the last decade. Making consumers shoulder more of the cost has helped bring down prescription drug spending from double-digit growth rates. Overall drug spending is expected to rise from $201 billion in 2005 to $214 billion in 2006—a 6.5% increase, according to Centers for Medicare and Medicaid Services analysts.

But overall health spending continues to grow, and will increase at least 7% annually over the next 10 years, according to CMS data.

And, higher copays can backfire. "When cost sharing is too large in relation to a consumer's resources, the result is either serious financial strain or reduced access to care," according to an analysis issued in February by Ha Tu and Paul Ginsburg of the Center for Studying Health System Change. The authors also found that these benefit structures "do not distinguish between services that are considered extremely important, such as testing, insulin, and physician visits to manage diabetes, and services that are more elective, such as knee surgery to play recreational sports."

It seems counterproductive to erect hurdles that might prevent patients from accessing proven effective therapies for diabetes, Dr. William Herman said in an interview. Dr. Herman is medical director of M-Care, an HMO participating in the University of Michigan's 2-year pilot program for employees that aims to determine if reducing the cost of diabetes drugs will encourage more patients to stick to their treatment regimens and also cut overall health costs.

"If these copayments are interfering with desired processes of care and adversely affecting health outcomes, then this is not something we want in our benefit design," said Dr. Herman.

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Employees began enrolling in the Michigan program in July 2006. If they already were receiving an oral antidiabetic agent or insulin, they were automatically signed up. About 2,100 of those covered by university health plans are participating, out of a total worker and dependent population of 60,000, said Dr. Herman.

Under the program, enrollees can get free yearly eye exams and they pay nothing for generics (compared with $7 normally), $7 for preferred brands (instead of $14), and $18 for nonpreferred brands (instead of $24). These copays also apply to other drugs taken by diabetes patients, including β-blockers, calcium channel blockers, lipid-lowering agents, antihypertensives, and antidepressants.

Two-thirds of the prescriptions are generics, almost a third are in the preferred tier, and very few are in the nonpreferred tier, Dr. Herman said.

University workers belong to a variety of health plans, but they all receive their prescriptions through a single pharmacy benefit manager. That will allow for easier tracking of medication uptake and compliance, said Dr. Herman. Through its HMO, the university also will be able to compare medication compliance and health outcomes between diabetic workers and diabetes patients who aren't employees, he said.

So far, the program is costing the university about $30,000 a month, Dr. Herman said. That's how much patients are not spending. There are no data yet on changes in hemoglobin A_{1c} levels, lipid levels, or medication uptake. If there are positive changes, the university is likely to stick with the reduced and waived copays, said Dr. Herman. The school also has looked at making similar reductions for other chronic diseases.

The Michigan program is unique in that patients do not have to enroll in a disease management program. Other employers have coupled reduced or waived copays with coaching from pharmacists.

That model was pioneered by employers in Asheville, N.C., and the North Carolina Center for Pharmaceutical Care. The program began in 1997 with 47 employer-participants. By 2003, those employers were reporting improved A_{1c} levels, a 50% reduction in average annual sick leave, and overall medical costs 58% below the expected level (J. Am. Pharm. Assoc. Wash. 2003;43:173-84). Employers saved $1,600-$3,300 per worker because of fewer emergency department visits and fewer diabetes-related hospitalizations, according to the American Pharmacists Association Foundation.

Soon after those results were published, the APhA Foundation, with financial backing from GlaxoSmithKline, created an initiative patterned after the Asheville Project. Thirty employers in 10 cities are now participating in the Diabetes Ten City Challenge. The employers include municipal and county governments, utilities, supermarket chains, schools, health care systems, universities, and corporations in Charleston and Spartanburg, S.C.; Chicago; Colorado Springs; Cumberland, Md.; Dalton, Ga.; Honolulu; Los Angeles; Milwaukee; Pittsburgh; and Tampa Bay, Fla.

More than 1,100 diabetics are participating among the 30 employers, Bill Ellis, executive director and CEO of the APhA Foundation, said in an interview.

The majority—70%—are white; 19% are African American and 40% are aged 50-59 years. About a quarter are aged over 60 years, and 22% are aged 40-49.

It is a voluntary program, but once in, patients have to agree to meet with an assigned pharmacist—about 4-7 times yearly—for education and training, and to show they are working toward certain goals such as getting annual eye and foot exams. The pharmacists set the goals, but patients are prompted to consult regularly with their physicians, said Mr. Ellis.

In return, the cost of diabetes medication is reduced or eliminated, depending on the employer's benefit design, he said. On average, patients save $400 a year, said Mr. Ellis. Employers foot the bill for the pharmacists' fees and the copays. In some cases, they may also cover medications that have been found to be effective in managing diabetes complications, he said.

The employer participants and the APhA Foundation are tracking clinical and economic outcomes and will eventually report those, along with patient satisfaction scores.

Although employers are in many cases contributing a significant amount of money up front, they are willing to, said Mr. Ellis. "They're making an investment in keeping people well," he said.

Nancy Kennedy, executive director of the Dalton, Ga.–based Northwest Georgia Healthcare Partnership, said in an interview that her member companies were interested in the diabetes program because a majority of their health care dollars go to that disease. Half of the jobs in Dalton are in manufacturing (mostly carpets) and surrounding Whitfield County has a large Hispanic population. Hispanics have a 1.5 times higher prevalence of diabetes than do whites, which makes the condition a major concern for the northwest Georgia companies. ■

Dalteparin Aids Oxygenation, Helps Heal Diabetic Foot Ulcers

BY LESLIE SABBAGH
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Dalteparin-treated patients have increased foot skin microcirculation and oxygenation, resulting in better foot ulcer outcomes, compared with controls, a Swedish study has found. Dr. Majid Kalani, of the Karolinska Institutet and Danderyd Hospital, both in Stockholm, and colleagues conducted a prospective, double-blind, placebo-controlled, multicenter study to evaluate dalteparin on peripheral macro- and microcirculation and hemostatic function in 85 diabetic patients with peripheral arterial obliterative disease and chronic foot ulcers.

Inclusion criteria were toe/arm blood pressure index equal to or less than 0.6, foot ulcer duration longer than 2 months, ulcers of Wagner classification stages I and II, and aspirin 75 mg/day. Forty-three patients were randomized to subcutaneous injections of dalteparin 0.2 mL once a day, and 42 were randomized to physiological saline 0.2 mL injections once daily. Treatment continued for 6 months or until the ulcer healed, whichever came first. Ulcer outcomes were defined as healed with intact skin; improved; unchanged; impaired; or amputation above or below the ankle (Thromb. Res. 2007 Feb. 2 [Epub doi:10.1016/j.thromres.2006.12.006]).

Plasma fibrinogen, fibrin gel structure, prothrombin fragment 1+2 antigen, plasminogen activator inhibitor-1 (PAI-1) activity, and tissue plasminogen activator (TPA) antigen were analyzed at baseline and at the end of treatment. Foot skin microcirculation was measured with transcutaneous oxygen tension and laser Doppler fluxmetry (LDF).

The combined ulcer outcome results showed that the dalteparin-treated group had significantly better outcomes than did controls. Dalteparin treatment inhibited thrombin generation and increased fibrin gel porosity, thereby encouraging fibrinolysis. Dalteparin also improved fibrinolytic function by increasing TPA antigen and by blunting increases in plasma PAI-1 activity. Plasma PAI-1 activity increased significantly in the 20 controls who improved and the 13 who deteriorated, but did not significantly change in the dalteparin group.

The seven patients in the dalteparin group with impaired ulcer outcomes (two amputations; five increased ulcer area) had worse baseline peripheral macro- and microcirculation and longer time-to-peak LDF compared with baseline values in the 13 patients with improved outcomes. Two amputations were performed in the dalteparin group compared with eight in the placebo group.

The increase in local skin oxygenation in the dalteparin group "suggests improved blood distribution to nutritive capillaries due to decreased shunting of blood through arteriovenous channels," which might explain the trend toward improved ulcer outcome in these patients, they said. ■