Employers See Virtue in Cutting Diabetes 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 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, which 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.

But 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 by 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," Dr. Herman said.

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, he said.

Under the program, enrollees 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.

University workers belong to a variety of health plans, but they all receive their prescriptions through a single pharmacy benefit manager, allowing for easier tracking of medication uptake and compliance, Dr. Herman said. 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, he said. 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 HbA_{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. 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, Bill Ellis, executive director and CEO of the APhA Foundation, said in an interview. In return, the cost of diabetes medication is reduced or eliminated, he said. On average, patients save $400 a year. Although employers are in many cases contributing a significant amount of money up front, they are willing to, Mr. Ellis said.

"They're making an investment in keeping people well," he said.

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

POLICY & PRACTICE

CMS Extends Claims Form Deadline

The Centers for Medicare and Medicaid Services has extended the deadline for filing Medicare claims using its new version of claims form CMS-1500, because of formatting errors on the revised form, CMS announced. The original deadline for switching to the new form, known as CMS-1500 (08-05) originally was April 2. But CMS said last month that contractors have been directed to continue to accept the old form until the agency notifies them to stop. In addition, the agency advised physicians who must use the form to use legacy provider numbers as the form cannot accommodate a National Provider Identification (NPI) number.

Oncologist Shortfall Predicted

The United States will have a shortage of 2,550-4,080 oncologists by 2020—roughly one-quarter to one-third of the 2005 supply—as the demand for services increases by 48%, according to a report by the American Society of Clinical Oncology. Meanwhile, the supply of services provided by oncologists is expected to grow by just 14% by 2020, leading to a shortage representing up to 15 million visits per year. Options to fill the shortfall include redesigning service delivery, increasing fellowship positions and the use of nonphysician clinicians, and having primary care physicians provide more care for patients in remission. The report on the final results of the ASCO Oncology Workforce Study based its conclusions on the current age distribution and practice patterns of oncologists and the number of oncology fellowship positions.

Prescription Drug Sales Up

U.S. prescription drug sales grew more than 8% to $275 billion in 2006, fueled by the Medicare Part D prescription benefit, increased utilization of generics within new therapy classes, and new drug launches, said pharmaceutical data firm IMS Health. Total dispensed prescriptions grew at nearly a 5% pace, compared with slightly more than 3% in 2005, the firm said. Part D was a large driver of the upward trend, lifting prescription volume by an estimated 1-2 percentage points and pharmaceutical sales by about 1 percentage point. The benefit "increased prescription coverage to the previously uninsured and underinsured, and provided generous plan benefits to seniors," said Diana Conmy, corporate director, IMS Market Insights, in a statement. Meanwhile, drug makers released new generic forms of lipid regulators, antidepressants and inhaled steroids, resulting in significant growth for those classes of medications. Sales of prescription drugs in the United States are expected to decline in 2007, IMS Health said.

Veterans Bill Introduced

Veterans with service-connected disabilities would be able to go to the hospital or medical clinic of their choice under legislation introduced by Sen. Larry Craig (R-Idaho). The senator said he was concerned about the care lapses documented at Walter Reed Hospital in Washington, but said that he was willing to pit the health care system run by the U.S. Department of Veterans Affairs against private sector providers because he considered the VA system among the best in the nation. "This bill is about my confidence in the VA," Sen. Craig said in a statement. "Let's see where veterans choose to go. It's very simple: If service-connected veterans leave in droves, we've learned something. But, if veterans overwhelmingly stay, and I think they will, we've also learned something."

Medical Debt Increasing

Families are turning to credit cards to pay for medical care as health care costs continue to rise faster than incomes, according to new research by public policy advocacy groups Demos and the Access Project. The groups found that 29% of low- and middle-income households with credit card debt reported that medical expenses contributed to their current balances, and within that group, 69% had a major medical expense in the previous 3 years. Low- and middle-income medically indebted households had, on average, 46% higher levels of credit card debt than those without medical debt. In addition, the medically indebted were almost twice as likely to be called by bill collectors than were the nonmedically indebted. "Congress should address this new and serious consequence of our nation's growing health care crisis before more families go into debt, and risk their financial stability, to get the medical care they need," report coauthor Cindy Zeldin of Demos said in a statement.

Drug Executives Admit Fraud

Four executives from the bankrupt generic drug maker Able Laboratories Inc., pleaded guilty in March to roles in a 7-year scheme to falsify data at the company, which had made 46 generic versions of brand-name, mostly prescription drugs for pain, inflammation, obesity, and cardiovascular conditions. The highest ranking official of the four, Shashikant Shah, vice president for quality control and regulatory affairs, also pleaded guilty to a securities fraud charge. The Food and Drug Administration has said that the company, based in Cranbury, N.J., invented data so its drugs would appear to meet federal standards when in fact they had too much or too little of their active ingredients. This occurred 41 times dating back to 2001, while on nine other occasions, Able failed to issue alerts about impure drugs. Able, which recalled all of its prescription products in May 2005 as part of an agreement with the FDA, filed for bankruptcy protection in July 2005 and liquidated its assets in March 2006.

—Jane Anderson