Patient Cost Sharing & Access

Ensuring patients have access to affordable, high-quality health care, including prescription medicines, is essential for the health of the U.S. population. Prescription medicines are cost-effective treatments which save the health care system money in the long run by avoiding more costly medical services such as emergency room visits and hospitalizations. Patient cost-sharing tools such as copays should be applied thoughtfully and carefully so as to avoid negatively impacting patient access, adherence and health outcomes.

Background

Ensuring patients have access to affordable, high-quality health care has long been a goal of many policymakers and members of Congress—and was a significant point for discussion during the health care reform debate that led to passage of the Affordable Care Act (ACA)[1] in March 2010. Supporters of health care reform and ACA noted throughout the debate that millions of Americans, including both the uninsured and many "underinsured" citizens, are unable to receive quality care and medically necessary treatments due in part to the high cost of obtaining adequate health insurance coverage. Under ACA, affordable access to insurance for these individuals will be provided through new health insurance exchanges, co-ops, Medicaid expansion, new subsidies, an individual mandate and employer mandates.

While expanding patient access to affordable health insurance, many policymakers and members of the health care system—including both public and private payers—are also working to minimize growth in health care spending. Sometimes, however, efforts to reduce health care costs can have an adverse impact on patient access to necessary care and treatments. Most payers use cost-sharing tools such as **copayments** ("copays"—a fixed fee patients must pay each time they access a service or treatment) or **coinsurance** (a fee charged to patients that is a set percentage of the cost of the service or treatment) to discourage use of costly services or redirect patients toward lower-cost alternatives. For example, many payers use a system of tiered copays for prescription medicines, charging a lower copay for generic medicines and higher copays for branded and newer medicines. In addition, more expensive specialty medicines are subject to coinsurance and are placed in "specialty tiers" that lie outside of the traditional tier system.

Research shows that higher patient copays can reduce use and adherence to prescribed health care services and treatments, including prescription medications.[2] This can adversely impact patient health and drive higher long-term costs. Research has demonstrated this effect where short-term savings result from higher consumer cost savings but a consequence of limiting treatments and services is an increased need for more expensive services such as emergency room visits and hospitalizations.[3]

Key Facts and Figures

- **Access to Coverage**
  - As of 2007, an estimated 25 million adult Americans were underinsured—up 60 percent from 2003.[4]
  - Nearly 46 million Americans are uninsured. That means 1 in 7 Americans likely aren't receiving the care they need when they need it.[5]
  - More than 90 percent of the uninsured report cost as a barrier to receiving timely care.[6]
  - In 2007, 59 million people reported not getting or delaying needed medical care—up 43 percent since 2003.[7]

- **Copays and Coinsurance**
  - Studies demonstrate that low income patients are more sensitive to increases in copays (i.e., higher out-of-pocket costs), resulting in larger declines in adherence than for other patients.[8]
  - A RAND review reports that for each 10% rise in patient cost sharing, medication use fell between 2 percent and 6 percent.[9]

- A RAND review found that doubling copays reduced adherence by 25 percent to 45 percent.[10]
- A RAND review found that, all else being equal, doubling copays led to a 17 percent increase in emergency room visits and 10 percent more hospital days among patients with diabetes, asthma and gastric acid disease.[11]
- Harvard researchers estimate that reducing copays for four chronic medicine classes resulted in a 7 percent to 14 percent increase in prescription drug uptake compared to adults whose copays were not reduced.[12]
- Prescription drugs are the least-insured medical benefit: 34 percent of consumer out-of-pocket health care spending goes toward medicines.[13]
- Nonadherence to medication regimens contributes direct annual costs of $100 billion to the U.S. health care system. Indirect costs exceed $1.5 billion annually in lost patient earnings and $50 billion in lost productivity.[14]
- A *Journal for Managed Care Pharmacy* article found that out-of-pocket expenses greater than $100 for tumor necrosis factor (TNF) blocker medications for rheumatoid arthritis, and greater than $200 for multiple sclerosis therapies, were associated with increased prescription abandonment.[15]

Pfizer's Position

Obtaining health insurance coverage can be a financial hardship for low- and middle-income individuals, and Pfizer supports efforts (including insurance subsidies) which make insurance and access to care more affordable. In order for expanded health insurance coverage to most effectively improve patient outcomes, Pfizer believes adequate minimum benefit requirements must also be developed to ensure that everyone has access to needed treatments and prescription medicines. In designing insurance benefits, tools such as copays and coinsurance should be used thoughtfully and carefully to ensure they do not adversely impact patient access to required treatments and medicines. Pfizer supports efforts to reduce the cost burden on patients and improve patient outcomes and adherence by lowering or eliminating medication copays.

How Patients and Health Care Professionals Benefit

Financial assistance will help those who were previously uninsured afford health care insurance that offers access to essential health services and treatments. Lowering copays will help eliminate patient financial hurdles by reducing out-of-pocket costs. Health care professionals will have greater confidence that patients will seek, adhere to, and follow up on needed care due to insurance coverage.

How the Health Care System Benefits

Expanded access to health insurance and lower copays can help improve the quality of patient outcomes throughout the health care system while saving money by avoiding use of more costly services such as emergency room visits and hospitalizations.

What It Means for Pfizer

Insurance subsidies will help many patients purchase health insurance coverage, including medication benefits—providing more patients with access to potentially lifesaving treatments and medicines. Lower copays will help patients better adhere to prescribed treatment regimens.

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[1] The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152), is collectively referred to in this paper as the Affordable Care Act of 2010 (ACA).
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[3] Ibid.
[4] Schoen, C., et al. "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007." *Health Affairs.* Web Exclusive. 10 June 2008: w298–w309. Available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.4.w298v1.
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[7] Ibid.
[8] Chernew, M., et al. "Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care." *Journal of General Internal Medicine.* August 2008: 23(8), 1131–1136. Available at http://www.springerlink.com/content/t67005764w4n1432/.
[9] Goldman, D., G. Joyce, and Y. Zheng. "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health." *Journal of the American Medical Association.* 4 July 2007: 298(1):61–69. Available at http://jama.ama-assn.org/cgi/content/full/298/1/61. See also Goldman, D., et al. "Pharmacy Benefits and the Use of Drugs by the Chronically Ill." *Journal of the American Medical Association.* 19 May 2004: 291(19), 2344–2350. Available at http://jama.ama-assn.org/cgi/content/abstract/291/19/2344.
[10] Ibid.
[11] Ibid.
[12] Chernew, M., et al. "Impact of Decreasing Copayments on Medication Adherence within a Disease Management Environment." *Health Affairs.* January/February 2008: 27(1), 103–112. Available at http://content.healthaffairs.org/cgi/content/abstract/27/1/103.
[13] PhRMA Analysis of 2004 MEPS, 11 July 2007. Based on under age 65, civilian non-institutionalized population with private health insurance.
[14] Goldman D.P., et al. (2004). Pharmacy benefits and the use of drugs by the chronically ill. JAMA., 291(19): 2344-2350.
[15] Patrick P. Gleason, PharmD, FCCP, BCPS 1, 2, Catherine I. Starner, PharmD, CGP, BCPS 1, 2, Brent Gunderson, PharmD. Prime Therapeutics Study: "Multiple Sclerosis Medication Out-of-Pocket (OOP) Expense Association with Decline to Fill Rate."