High Deductible Health Plans and Your Brand’s CoPay Program: Key Considerations

How High Deductible Health Plans impact your copay program and how you can prepare for and address these new plans in your planning process.
High Deductible Health Plans
What are they?

Overview
For the last several years marketers have had to deal with the emergence of High Deductible Health Plans (HDHP’s) which have come to the forefront because of “Obamacare”. It used to be relatively easy to understand what your brand’s average out of pocket cost was based on your managed care contracts, but today that important calculation is much more complex as a result of the HDHP’s. If you have been over budget on your copay program the past few years it is most likely because you did not properly forecast the impact these plans have had on your patients.

Looking at some recent copay data, the average abandonment rate for patients is about 9% for patients who are not on a HDHP, however for patients on a HDHP plan it’s over 22%. The number of Americans age 18 to 64 with a high-deductible plan increased from 26.3% in 2011 to 39.3% in 2017, according to a report from the CDC’s National Center for Health Statistics. The estimate for 2018 is that approximately 41% of US households are enrolled in one of these plans.

In this white paper, I will outline how these plans impact your copay program and how to address this in your planning process.

Defining a High Deductible Health Plan
To be called a “High-Deductible Health Plan” (HDHP), plans must conform to established federal guidelines. HDHPs cover preventive care before the deductible, but no other benefits are provided until the insured patient has met the deductible. With an HDHP, the policyholder pays out of pocket for everything other than preventive care until the stated deductible is met. After that, the insurance will pay benefits based on the plan’s coinsurance level (some HDHPs have 100 percent coverage after the deductible). Within the federal guidelines, each plan can have differences in the form of annual maximum out of pocket costs and deductibles which need to be met before their coverage will kick in.

Statistics to Keep In Mind
◆ For 2019 coverage, the minimum required deductible for HDHPs is $1,350 for an individual, and $2,700 for a family. And the upper limit on total out-of-pocket exposure under an HDHP in 2019 increased to $6,650 for an individual, and $13,300 for a family.
◆ The uninsured rate in the U.S. has fallen from 15.7% in 2009 to 9.1% in 2015, according to a report from the CDC.

If you have been over budget on your copay program the past few years it is most likely because you did not properly forecast the impact that HDHP plans have had on your patients.
Some Startling Statistics

The Kaiser Family Foundation reports the following:

1. Rising insurance deductibles have outpaced the average increase in employees’ wages during the past five years.
2. Employee deductibles increased by 67% on average from 2010 to 2015.
3. The average annual out-of-pocket costs per patient rose almost 230% between 2006 and 2015.
4. Workers’ wages increased 1.9% between April 2014 and April 2015, whereas America’s out-of-pocket medical expenses jumped 9% from 2014-2015.
5. In 2017, forty-three percent of insured patients said they delayed or skipped physician-recommended tests or treatment because of high associated costs.
6. Among privately insured U.S. adults with HDHPs in 2016, 15.5% reported difficulty paying medical bills in the past 12 months. That compares to 10.3% of adults with a traditional health plan.

In addition, patients are being asked to pay more for prescriptions as plans are shifting pharmacy benefits to medical benefits. So, rather than a fixed copay, patients with medical benefits for prescriptions will have a co-insurance payment which can be higher than the fixed copayment they may now have with a pharmacy benefit.

Patient Types Defined

There has been a lot of confusion in the market about three different types of patient statuses. So let’s be clear before I continue:

Cash Patient – these patients do not have commercial or government health insurance of any kind. Most likely these patients pay full retail for their therapy.

Insured Not Covered Patients (INC) – These are commercially insured patients who are currently in “not covered” status with their plan. There can be three distinct situations for these patients:

- Those who have not met their deductible yet, but will have a reasonable out of pocket cost once the deductible is met. For the time being, they must pay full retail until their coverage kicks in. Once they meet their deductible, they will have substantially reduced out of pocket expenses.
- Those whose insurance doesn’t cover the brand at all (not on formulary).
- Those whose insurance covers the brand but with step edits etc. so the patient may be covered down the line once they’ve gone through other therapy, but not yet.

Also remember that the new norm is that many new products launch without coverage as their products are still under formulary review. Most are expected to have coverage in the relatively near future.

A High Deductible Health Plan (HDHP) Patient - is simply a patient enrolled in a high deductible plan. They are considered an INC patient when they are in the “not covered” status in their plan (because they have not yet met their deductible), and they are a commercially insured patient once they have met their deductible.

Clearly, these trends are not positive for patients. And, as the monthly premiums of these plans rise, patients can afford less coverage, so they opt for a lower coverage plan. So, while the percentage of patients with coverage has been increasing, the level of coverage has been decreasing.
Patient Type

An important consideration in planning your copay program

Considering Patient Type

When determining your copay program structure, it’s important to consider the patient type.

Insured Not Covered Patients

Many copay programs we see treat the Insured Not Covered (INC) patient like a cash paying patient, but these patients are not as similar as they may seem. The first important distinction is that most of the INC patients have commercial coverage while true cash paying patients don’t. So while it is true that INC patients will have to pay full price for your medication while they are in “uncovered” status, that status may not last long.

If you are managing an acute brand, the “waiting period” for these INC patients to secure coverage may be too long, and by the time they secure it, their therapy may already be complete. But for chronic brands, it is very important that the INC patients be treated differently because in a few months their insurance plan will likely kick in some funding and your copay program cost will be greatly reduced. Here, it may be worth your while to reduce the patients’ out of pocket burden to get them through their deductible since once they are firmly established on therapy, they may very well become adherent, long-term patients.

For the “insured not covered” patients, many chronic brands may choose to lose money while getting the patients through their high deductible periods hoping to recover some of those losses as patients continue their therapy longer term when their coverage kicks in. Unfortunately, this strategy does not work for the acute brands where patient therapy is three months or less. This is one of the reasons that patients may not see deep discounts on those acute brands.

Cash Patients

The same scenario does not apply for the cash patients who have no coverage. In this case, the outlook even for chronic brands isn’t as rosy, because cash paying patients will unfortunately always have to pay full retail and subsidizing that financial burden may be too much for a brand to handle. You can still set up a copay offer for the cash patient but you must make sure to watch your margins so you don’t lose money. Cash paying patients should be directed to any PAP programs in place to see if they qualify for additional subsidies based on their income level.

The key to putting together offers for both the cash and INC patients is to make sure you are accounting for all costs in your calculations including managed care contracting costs, cost of goods etc., so you don’t get into a situation where you unknowingly lose money.

Where the overwhelming majority of HCP’s do not start patients on a drug based solely on cost, patient affordability can, and has altered recommendations for therapy. Today, it’s not simply a matter of what physicians should do based on what’s best for the patient, rather they may have to prescribe the drug they know the patient can afford.
The impact of HDHPs on Patients

All brands know that high deductible health plans are having a major impact on both the industry and on the costs of their individual copay programs. However, I was recently told by a client that all brands are impacted the same way by these HDHP’s. While it may appear that way on the surface, every brand is impacted differently by HDHP’s.

Here are four major areas which will impact your brand when it comes to HDHP’s:

1. Average age of your patient
2. Chronic or Acute Condition
3. Net cost of your drug
4. Patient Comorbidities

**Average patient age**: Brands with an older patient base will have a greater percentage of their patients with government coverage (Medicare and Medicaid) and therefore a lower percentage of patients with HDHP’s. However, patients who are in their 60’s who have not reached Medicare age are particularly susceptible to needing additional assistance as they may not be working and may not be able to afford any health care coverage.

**Chronic or acute condition**: Brands treating acute conditions don’t have the luxury of providing higher subsidies via their copay program for just the first few scripts until their patients meet their deductible. These are “one or two uses and you’re done” drugs, so high deductible plans certainly can be an issue for these acute medications. For an acute brand, INC patients and cash paying patients are pretty much the same with neither patient type expecting to have coverage during their therapy period.

**Cost of drug**: In terms of drug pricing, medications that have higher costs due to high WAC prices and/or poor managed care coverage will be impacted more by HDHP’s because their patients will face a very high OOP cost.

**Co-morbidities**: Patients who take several additional medications will likely meet their deductible threshold faster, so having an understanding of the comorbidities affecting the patient base for your drug will also be important when estimating the impact of high deductible plans on your brand.

As these high deductible plans become more and more common, all these things should be considered when planning your copay program and when performing your copay program optimization analysis.

Easing the burden for your high deductible patients

Easing the burden for your insured not covered “high deductible” patients is a problem for every drug today. Now that approximately 41% of American households are on high deductible health plans, it may be difficult for your patients to pay for their medications without assistance from you.

Any subsidy you provide will indeed help each patient get over their plan’s deductible “hump” as it counts towards their deductible (except for specialty pharma drugs which have accumulator programs – a separate topic we will cover in a different white paper). The plan will only see the amount owed and will deduct that OOP from the patient’s deductible. The brand’s copay program is essentially a secondary payer and any discount provided will be attributed to the out of pocket for the patient - thereby reducing the remaining deductible for the calendar year. Later in the year, as the patient’s deductible is met, the patient will have coverage on your drug and lower out of pocket costs will apply.

The hope is that the patient gets to their deductible threshold as quickly as possible so that full coverage will kick in. Remember other factors, such as such as co-morbidities and other medications the patient is taking, will impact the speed with which the deductible threshold is met.
Selecting the Most Effective Strategy
Each brand is different

Copay Program Strategies to Address HDHP Influences

Commercial Patients: With the number of HDHPs increasing every year, brands are searching for ways to best cope with the issue of uncovered patients with high OOP costs. Having excellent managed care coverage is great but brands know that at certain points, those patients could end up with a bill for the full retail cost of the drug unless they can utilize the brand’s copay program.

Looking for the best way to manage this situation, many brands are considering one of three different cap strategies for their commercially covered patients:

1. **Annual cap** – no "cap per use" but rather one flexible overarching cap that will cover the entire cost of the first few scripts to get the patients through their high deductible.

2. **Increased Q1 cap** – Increasing the cap for the first 3 months of the year to help cover the patient's deductible when it is reset each January.

3. **First 3 uses inflated cap** – A higher cap for the first 3 uses regardless of when the patient starts their therapy.

Which Strategy Will be Effective?

Not every one of these strategies will work for each brand. Knowing which of these strategies will be effective will depend on a) whether your brand is for an acute or chronic condition, b) what comorbidities may be present, and c) the final out of pocket price the average patient will have to pay after your coverage pays its part.

For example, if your drug is for an acute condition with an average of 2 uses and with patients coming in and out of the franchise throughout the year, then an increased Q1 cap would not be effective because those patients could have a need at any time of the year. So just offering that incentive at the beginning of the year may only impact a small portion of your patient base.

Annual caps can work well but their values need to be carefully determined as the brand may wind up paying much more than is needed to keep trial and adherence numbers optimal.

Increasing the cap for the first three uses regardless of when the patient enters your franchise may be the best approach, depending on the brand’s specific situation.
What about Patients Who are Not Covered?
Strategies for other patient types

Cash and INC Patients

Cash Patients: The best way to address cash patients is to decide what level of subsidy you can afford that will get the out-of-pocket levels into a range where at least a portion of the cash patients will be able to fill the script. It is important to pick a level that ensures profitability for the brand since it is likely that cash patients will not receive any type of coverage for a long period of time, if ever. So, you need to make sure you offer what you can, but not at a negative margin. That ensures a positive outcome for both the patient and the brand!

Insured Not Covered Patients: Here is where your decisions are most important for your program. Make no mistake about it... if you have a chronic brand, in most cases you want to put your best foot forward in trying to attract this patient. The key is to get them into your franchise profitably and for the long term. I am not saying that every patient fill needs to be profitable for the brand, but I’m saying that over their length of therapy you should make a profit.

Let’s go back to the three types of INC patients:
1. Those who have coverage but are in their deductible phase
2. Those who have coverage but the particular brand is not on formulary
3. Those who have coverage but the particular brand is a new launch and doesn’t have coverage yet

A Deeper Look into INC Patients

We can start by looking at group #2. These are essentially just cash paying patients for you unless you expect a major formulary change. If your brand has more than a $300 WAC (most do these days), the chances of you bringing this patient into your franchise profitably are very low so many brands have no patient offer.

Years ago, products used to be covered until reviewed by the PBM’s but today most are uncovered until they get through the review. These patients fall into group 3 above. This creates many problems for brands. Depending on your expectations for coverage it would most likely be worth your while to cover these patients with a copay or bridge program until your coverage is approved.

For patients in group #1 the situation is very different. These patients have coverage, but they are in their deductible phase. Here you need to look at a few things in order to help you figure out how quickly they will meet their deductible. We look at (a) the cost of your brand (for example, a higher price for a non accumulator situation means more dollars going towards meeting the deductible more quickly, (b) Acute or Chronic condition – an acute brand with 2 uses has a lesser chance of their patient meeting their deductible based on just that medication alone, and (c) Comorbidities: other conditions mean more physician visits and more scripts and all of that spending (along with subsidies from other brand’s copay programs) will help the patient meet their deductible more quickly.

For patients in groups #1 or #2, chances are that approximately 30%+ of your prospective patients will most likely be in this classification at the time they are introduced to your brand. This gives chronic brands some flexibility on what to offer in their copay program, but the key is still to find the “sweet spot” where patients are close to but not at the point of price abandonment. For many brands that is a hard number to find. How much is your patient really willing to pay? Buy the price down too little and that patient may never start their therapy with you. Buy them down too much and you are throwing money away and lowering your gross to net.
Two Components: Face Value and Cap

Here we have two key components to consider: the face value on the card and the cap. Until recently, pharma marketers have been very focused on the face value for their patient offers - the price that patients and physicians see on the co-pay discount cards. Everyone is focused on the “pay as little as” $15 offer and then reality hits at the point of purchase if the patient has a high deductible health plan. Unless there is no cap or a very generous cap, the patient will most likely pay more than the advertised $15 out of pocket because the cap will be insufficient to cover all the patient’s out of pocket expense. Keep in mind that the cap amount is usually hidden from view in smaller text and many times is on the back of the card in the fine print or not explicitly stated at all.

Let’s look at two offers: a pay as little as $5 with a $50 max cap, and another with a pay as little as $25 with a $75 cap. The $25 offer, on the surface, seems inferior to the $5 offer, certainly from a face value perspective, but it’s actually the other way around. What is most important to a patient with high out of pocket costs is the cap (maximum value of the coupon). If a patient has a $100 out of pocket amount and uses the $5 face value card they will have to pay $50, whereas if they used the $25 card which offers a max benefit of $75 they would only have to pay $25.

Most brands can’t afford to cover every patient through their entire high deductible period, so properly structuring the copay program (offer and cap) is critical.

Some patients are surprised to have to pay more because they interpret the “pay as little as” to mean “this is what you will pay.”

More surprised than the patient is their physician who probably spent little time looking at these cards and even less time trying to figure out how the card would impact their patient’s out of pocket costs at the pharmacy. However, after hearing from their patients over the years, these physicians are now paying a little more attention to all parts of the patient offers (face value PLUS cap PLUS patient eligibility etc.). Now these physicians know that the value posted on the card is not necessarily what each patient will pay.

The Cap is Becoming More Important

The lesson here is that the cap is becoming more and more important from both a physician and patient perspective. If you have extra budget to spend, don’t rush to bring your face value down while leaving your cap the same as this has no impact on the patients who need it most. Focus on what offer gets you the best patient coverage to the face value of your offer. You’ll make both your patients and physicians happier!

Moving towards calculating your Average Patient’s True OOP Cost Including HDHP Impact

As shown in figure 9.3 below, the latest study by the Kaiser Foundation shows that even within the coverage tiers, the breakdowns of patients who have copayments versus coinsurance can differ significantly.

Approximately 29% of patients that have tier #2 coverage have coinsurance, while 39% of patients with tier #4 coverage for a specific drug have coinsurance.

Source: KFF Employee Health Benefits Survey, 2018
Determining True Out-Of-Pocket
A key step to optimizing your copay program

The First Step

The first step to optimizing your copay program in light of the HDHP impact is to get closer to what your brand’s average OOP cost is going to be at the pharmacy. The number you typically get from your managed care department is only relevant to covered lives (HDHP not included). These numbers are not accurate and need to be “massaged” to get you to a more realistic number of what is actually occurring for the patients attempting to fill scripts. Sophisticated modeling is recommended to determine the true OOP cost range, but the following rudimentary example demonstrates the type of analysis that should be incorporated.

1. Start with the average OOP number from your managed care team for your average covered patient (let’s assume for this example your brand has primarily tier #3 coverage and the average OOP cost for your patients is $75).

2. There are about 41% of US households enrolled in HDHP’s so, as a starting point, assume 41% of patients would be impacted by a high deductible. Then, adjust this 41% level downwards to eliminate those patients whose high deductible doesn’t apply to pharmacy.

3. Then consider the following:
   - Is your brand is a chronic or acute brand? An acute brand would be more likely to be impacted by the deductible for the duration of therapy, while a chronic brand would likely be impacted by the deductible for only a portion.
   - The greater the number of co-morbidities, the faster the deductible would be met as other drugs are helping to pay down the deductible as well.
   - Other brand specific issues; coverage gaps, step edits, NDC blocks, etc. Each of these situations will increase a patient’s OOP cost.
   - If you are targeting a certain patient out of pocket amount at different times of the year, you need to consider what happens in Q1 where deductibles are reset and OOP costs are again higher.

When you complete your adjustments what you will find is the actual OOP cost for most retail brands can be more than 50% more than what your managed care coverage says it is. Specialty pharma products will be at least double, and launch products (without some type of bridge program) will be much higher.

Why is understanding HDHP influence of the utmost importance to you?

One of the key starting points for any copay program optimization analysis is the average patient OOP amount. Today without overlaying the impact of HDHP’s on that starting point, many brands greatly underestimate their drugs average out of pocket cost and thus can underfund their copay programs. If you set your targeted copay OOP after your discount to be $25, at the point of purchase patients might be faced with a number that is much higher. The result of underfunding will be that the patient will run through your copay subsidies faster than your expectations leaving them with high OOP costs. This can easily be the difference between patients starting on therapy and those abandoning your brand for another therapy due to the higher cost.

Getting as close as you can to your true average patient OOP number including the HDHP impact is vitally important not only to your copay program but to the overall health of your franchise.
HDHPs Have a Major Impact
The percentage of patients impacted by high deductible health plans continues to grow and this has a major impact on patient out of pocket costs. This impact needs to be thoroughly considered when structuring a brand’s copay program. The fact is that Higher Patient Copays = Lower Compliance Rates.

Key Considerations
Due to that fact, the brand group should determine the level to which HDHP’s will be impacting the brand’s patient base by considering the average age of the patient, whether the brand treats a chronic or acute condition, the cost of the medication, any patient comorbidities as well as any other brand specific factors.

Of Utmost Importance
Of utmost importance is determining the range of out of pocket amounts before copay program for the various patient types (commercially insured, cash, or insured not covered patients), incorporating the impact of HDHP’s. With this out of pocket amount for each patient type as a starting point, the optimal copay program details can be established.

Two Key Components Work Together
The face value and cap combinations should be set for each eligible patient type to cover as many patients to an appropriate level as possible, while staying within the brand’s profitability guidelines. This is the only way to help improve copay budget forecasting accuracy.

Good News May be Coming
There may be some good news out on the horizon. A new survey of employers done by National Business Group on Health indicates that for the first time since they were introduced, the popularity of HDHP’s has stabilized. Maybe it’s because employers now realize the impact of these plans on their employees who are pushing back.

The real question is will the HDHP’s fall out of favor with these employers? Only time will tell…
About Al Kenney

Al Kenney has 30 years experience in sales, marketing, and analytics within the pharmaceutical, OTC, food, direct marketing, and software industries. Al’s expertise lies in the areas of marketing, sales, business process redesign, data, software application design, program implementation, forecasting, and the analysis and measurement of marketing and sales spending. Al is now applying his knowledge and skills specifically to the pharma and bio-technology industries.

Al is the founder of Alpha 1C, an innovative company focusing on strategic marketing, predictive modeling and measurement. Prior to this, Al spent eight years in the software industry specifically focused on advanced analytics, supply chain, and forecasting. He founded, owned and operated Performance Wave Inc. a software company which also specialized in modeling and forecasting pricing and product assortment for both major Consumer Goods manufacturers and retailers. Performance Wave was sold in 1999. Later, he served as the General Manager for Demantra Inc., a leading provider of scenario optimization and program measurement software (which is now part of Oracle).

Al has been working on planning, forecasting, and optimizing copay programs since 2008. In addition to evaluating thousands of sales and marketing programs across many different industries, Al has analyzed and optimized hundreds of copay incentive programs in over 90+ pharma, bio-pharma, and specialty pharma categories. Al has written almost a dozen white papers on various subjects around copay program deployment. Al also works on securing partnerships for Alpha 1C with some of the leading companies in the copay and managed care industries.

About Alpha 1C

We are marketing, sales, and analytical industry professionals with a deep background in strategy, predictive forecasting, and post event tracking and analysis for sales and marketing programs (with a major focus on copay). We have vast experience solving complex problems and providing key insights across more than 20+ core industries. For the last 7 years, we have been focusing our solutions primarily on the Pharmaceutical and Bio-Tech marketplaces.

Alpha 1C provides key insights to brand teams allowing them to make more informed decisions that provide a better ROI. We are known for goals based predictive models which recommend the best options for you based on your stated objectives and budget.

We apply truly innovative, strategic thinking and leverage predictive analysis tools to help solve your complex business problems and ensure that business goals are achieved.

Alpha 1C has unparalleled experience in:

- Strategic Marketing
- Marketing Program Optimization
- Predictive Modeling & Forecasting
- Sales and Marketing Program Measurement and Reporting
- Brand Building

Our work is easily paid for through the efficiencies and insights we bring to your business.

Alpha 1C is headquartered in Sherman, CT and was founded in 2012.

To learn more you can contact Al Kenney @ al@alpha1c.com or call 860-354-7979