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AstraZeneca strikes a ‘novel’ deal with a Medicare plan to lower patient out-of-pocket costs

By Ed Silverman @Pharmalot

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Kirsty Wigglesworth/AP

In what is being called a novel bid to lower medicine costs, a drug maker has agreed to adjust the discounts that a Medicare Part D plan will receive for a treatment based on how patients respond — and the deal automatically lowers out-of-pocket costs for patients, as well.

In this instance, the UPMC Health plan will pay less for an AstraZeneca (AZN[1]) blood thinner known as Brilinta, which is given to patients who suffered a heart attack, if it fails to prevent another attack over 12 months. Conversely, the health plan pays more if Brilinta works. At the same time, the patient copay will drop to $10, from around $45, for a month’s supply, bringing the cost closer to a generic version of a rival medicine.

The agreement between AstraZeneca and UPMC Health plan is apparently the first time that so-called outcomes-based contracting — an increasingly popular tool that drug companies dangle before payers to

potentially lower their costs — has been coupled with a mechanism that can make less of a dent in patient pocketbooks.

“There are many patients today who are not taking their (blood thinners) because they say their out-of-pocket costs are too high,” said Rick Suarez, who is senior vice president of market access at AstraZeneca. “This is a way to move the conversation away from list price … and, in turn, for the government to see there can be cost savings in the overall health care system.”

The gambit comes amid intensifying debate over the cost of medicines, an issue that has angered Americans and prompted a growing number of federal and state lawmakers to search for ways to the address the problem. The Trump administration has also responded with a blueprint of proposals, although nothing concrete has yet emerged.

Beyond ever-rising prices for old and new medicines, the issue is complicated by the opaque nature of pharmaceutical pricing. A key point is the curious interplay between list, or wholesale, prices charged by drug makers and rebates paid to win favorable insurance coverage. This Rube Goldberg-like system occurs behind the scenes and, meanwhile, patients complain their out-of-pocket costs are escalating.

This explains why Suarez views the arrangement with UPMC Health Plan as an attempt to shift the focus to what patients will actually shell out for the medicine. And beyond talking up the deal as a way to pursue “true risk-based contracting,” Chronis Manolis, the chief pharmacy officer at UPMC Health Plan, noted that patients were first surveyed to gauge their reactions.

“It’s an innovative model,” said Stacie Dusetzina, associate professor of health policy at Vanderbilt University Medical Center, who studies drug pricing. “The reason is this alters the patient benefit design and not just changing the amount of the rebate that gets paid after the point of sale, which tends to be the way other contracts looked.

“The novel aspect is that they are creating incentives for patients for these value-based contracts. They’re allowing them to pay less up front for using the product, which is an important advance over other contracts that have been made public.” And, she added that lower out-of-pocket costs should prompt patients to refill their prescriptions and, presumably, result in better outcomes.

Currently, she noted, Medicare Part D patients pay about $3 for clopidogrel, a generic version of Plavix, a brand-name blood thinner. Meanwhile, a study released nearly a decade ago found that patients with acute coronary syndrome who took Brilinta were 16 percent less likely than those on Plavix to die from cardiovascular causes or suffer a heart attack or stroke.

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One cardiologist, Dr. Steven Nissen of Cleveland Clinic, told us that “when cost is not a major issue, most

physicians will prefer Brilinta. But occasionally, we see patients who can't afford the medication, so for those patients the generic Plavix is still a very good drug. But anything that can reduce the costs for any medication is a good thing."

But will this be a good deal for Medicare? Dusetzina pointed out that the health care program currently pays about $375 a month for Brilinta and just $3 for clopidogrel, although prices can vary depending upon health plan and pharmacy, according to the Medicare Drug Finder. This is a substantial difference, but Medicare could compensate by sharing in rebates as well as patient outcomes, she explained.

"It's hard to say if it's a good deal for Medicare. It depends on how often those negative outcomes occurred. Hospitalization for another heart attack in a year can trigger a lot of spending," she told us. "If they can avoid that, it may be worth the additional spending per person. And I think that's the bet UPMC is making. If there are enough benefits compared to the cheaper generic, they hope to achieve savings."

A spokeswoman for the UPMC Health Plan said that 810 of its members are currently taking Brilinta.

To what extent other drug makers and health plans attempt to mimic this arrangement remains to be seen, of course. But another expert on pharmaceutical pricing explained that UPMC may have an advantage because the organization is led by health care providers and has several medical programs that can be exploited to improve outcomes of drug therapy.

"Their managed care plan works hand in glove with the provider organization, so they can use clinical programs to drive toward better rebate-based deals," said Roger Longman, who heads Real Endpoints, an advisory and analytics firm that tracks reimbursement issues. They're leveraging clinical control to get better deals on better drugs. Not everybody can do it.

"One of the major problems we have in getting drug therapy used by people who really need it is that, for those people who are on Medicare, who have to pay co-insurance or copays, there is no really good way for manufacturers to provide copay assistance, because they are not allowed to do so," he continued.

"The clever thing they're doing is getting AstraZeneca to compromise on the price and put the drug on a generic tier and, therefore, they're giving patients a significantly lower co-pay. They couldn't do that unless they had real clout to drive prescribing and adherence, which they can do rather uniquely because of their medical programs."

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