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Six strategies to identify and assist patients burdened by out-of-pocket prescription costs

ABSTRACT

Many patients find that their out-of-pocket costs of medications are burdensome. Physicians can help, first by remembering to ask about the problem, and then by applying simple strategies to limit the patient's costs.

KEY POINTS

In this article we present practical information about six strategies:

- Switching to a less expensive but equally effective medication
- Stopping nonessential medicines or using them only as needed
- Splitting pills
- Using office samples
- Taking advantage of governmental and private pharmaceutical assistance programs
- Encouraging patients to shop around for the lowest price.

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MOST OFFICE VISITS end with a prescription either being written or renewed. However, as many as one in five people report that they did not fill a prescription in the previous year because of the cost.[1] Even with insurance and prescription coverage, patients' out-of-pocket costs can be high.

Nearly two thirds of patients say that they want to talk about out-of-pocket costs with their physician, yet these conversations occur infrequently and may be an important yet neglected aspect of current clinical practice.[2]

Given busy clinic schedules and complicated insurance plans, here are some concrete steps that you can take to reduce your patients' out-of-pocket costs for prescription medicines.

IDENTIFYING THE PROBLEM—ASK!

Make it a habit to ask about patients' copayments when writing or renewing a prescription.

Talking with patients about how they are doing with the cost of their medications can be a sensitive topic. However, without a conversation about cost, doctors often do not recognize when a patient is having difficulty affording his or her medications.[2]

One way to help put patients at ease is to preface questions with a statement that legitimizes their possible concern. For example, one can say, "Many patients have a hard time affording the cost of their medicines. Do you have any problem with this?"

Asking all patients on a regular basis may help patients to feel more comfortable discussing their costs by indicating that you are

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TABLE 1

Examples of price differences for generic vs brand-name medicines*

DRUGS	COST FOR 30-DAY SUPPLY	
	GENERIC	BRAND-NAME
Antihypertensives		
Hydrochlorothiazide (Microzide)†	$3	$22
Metoprolol (Toprol XL) 50 mg	$5	$25
Nifedepine (Adalat CC) 30 mg	$26	$40
Lisinopril (Zestril) 20 mg	$17	$33
Losartan (Cozaar) 25 mg	NA‡	$43
Lipid-lowering drugs		
Lovastatin (Mevacor) 20 mg	$37	$69
Atorvastatin (Lipitor) 10 mg	NA	$63
Pravastatin (Pravachol) 20 mg	NA	$80
Simvastatin (Zocor 10 mg)	NA	$70
Nonsteroidal anti-inflammatory drugs and cyclooxygenase-2 inhibitors		
Ibuprofen (Motrin) 200 mg	$8	$8
Naproxen (Naprosyn) 500 mg	$9	$46
Celecoxib (Celebrex) 200 mg	NA	$75
Rofecoxib (Vioxx) 25 mg	NA	$78
Drugs for gastroesophageal reflux disease		
Ranitidine (Zantac) 75 mg	$5	$7
Omeprazole (Prilosec) 20 mg	$94§	$116
Lansoprazole (Prevacid) 15 mg	NA	$121
Antidepressives		
Fluoxetine‖ (Prozac) 20 mg	$34	$92
Paroxetine‖ (Paxil) 20 mg	$71	$78
Citalopram (Celexa) 20 mg	NA	$67

*Prices were reported by one online pharmacy in November 2003 and do not include dispensing fees
†Prices for generic hydrochlorothiazide 25 mg tablets vs Microzide 12.5 mg
‡NA = not available in generic form
§Available over-the-counter for $18/month
‖Prices expected to drop considerably as manufacturer's patent expires

receptive to their concerns. It can also provide you with the information you need at the time you need it most, such as when making changes to a patient's prescription regimen.

The benefit of this approach is that fewer patients will come back to the office to say that they stopped their hypertension or high cholesterol medicine (or never even started it) because they couldn't afford it.

Physicians may make a special effort to reduce medication costs for patients who are especially vulnerable, such as patients who are uninsured, have low incomes, are elderly, or take multiple medicines. However, without discussing costs, it is easy to miss the substantial proportion of the general public that does not have these risk factors but may still face considerable burden from their out-of-pocket costs.

MANAGING THE PROBLEM

There are many ways to help make medications more affordable for your patients. Below, we give practical information and resources on six strategies:

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- Switching to a less expensive but equally effective medication
- Stopping nonessential medicines or using them on an as-needed basis
- Splitting pills
- Using office samples
- Taking advantage of governmental and private pharmaceutical assistance programs
- Encouraging patients to shop around for the lowest prices.

Which strategy is right for a particular patient? The best strategy will depend upon the individual's circumstances; however, becoming familiar with each strategy will maximize your chances of helping patients when they can't afford their medications.

Find a less expensive but potentially effective medicine

Doctors are often trained to use the "latest and greatest" cutting-edge medications arriving on the market. Many of these medicines are heavily promoted by the pharmaceutical industry.

However, while a newer and more expensive medication may provide additional benefits for some patients, there may be no significant advantage for most patients to pay the higher cost. For instance, for patients with hypertension, diuretics or beta-blockers ($3/month; **TABLE 1**) are still considered first-line therapy unless the patient experiences intolerable side effects or has another chronic condition (eg, diabetes with proteinuria) or other indications for a more expensive medication (eg, angiotensin-converting enzyme inhibitors, costing $17–$33/month).

Generic drugs, in particular, offer considerable opportunities for cost savings and with few exceptions offer patients the same therapeutic benefits provided by their more expensive brand-name equivalents. For instance, for patients with hypercholesterolemia, statins are often considered first-line therapy. The generic drug lovastatin ($37/month) is available as a lower-cost but potentially effective alternative to brand-name statin drugs ($69–$80/month).

Some physicians may not be in the habit of writing medications by their scientific name rather than brand name. Using the scientific name of a medicine gives patients the opportunity to benefit from newly introduced generic equivalents as soon as they become available, and it also reduces the aggravation of dealing with competing formularies when, for example, a health plan covers Prinivil but not Zestril.

Increasing the number of generic equivalents used will offer considerable reductions in pharmaceutical expenditures for patients without prescription coverage, as well as for those patients whose drug benefit plans charge a higher copayment for brand-name ($20–$25 per prescription) vs generic ($5–$10 per prescription) medications.

Several groups are making efforts to provide physicians with this information in a convenient and timely format, such as making the data available through Hippocrates and other software programs that physicians may use to seek drug indications and dosing schedules.

Over-the-counter medications can also provide some patients with a good alternative to expensive brand-name medications. For example, for patients with gastroesophageal reflux disease, brand-name proton-pump inhibitors cost on average $116 to $121 per month, but omeprazole (Prilosec) is now available over the counter for $18 a month and often goes on sale for even less. Histamine-2 blockers such as ranitidine (Zantac) cost even less at $5 to $7 per month and may be sufficient for people with mild or moderate reflux symptoms.

Use the scientific name rather than the brand name, whenever possible

Review the medication list and stop nonessential medicines

Polypharmacy is a common problem, especially among the elderly and those with many health conditions. A critical review of patients' medication lists may identify medicines that can be stopped because they do not appear to be helping after a trial period (eg, medication for urinary incontinence).

Other medicines may be safely used on an as-needed basis, such as symptom-relieving medicines used for arthritis (nonsteroidal anti-inflammatory drugs or cyclooxygenase-2 inhibitors), dyspepsia (histamine-2 blockers or proton-pump inhibitors), or constipation (stool softeners or laxatives).

Hormone replacement therapies used for menopause offer yet another example of medi-

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cines that may be safely discontinued if there is no indication that the benefits outweigh the risks.

Stopping unnecessary prescription and over-the-counter medications will not only lower patients' out-of-pocket costs, but also can prevent adverse drug events.

And don't forget alternative and complementary medicines—discussing patients' use of these products may help to ensure that their use is limited to those providing clear benefit.

Give the patient office samples

The use of office samples is a common method used by physicians to assist patients with high out-of-pocket costs (G.C. Alexander, unpublished data, 2003).

The impact of such use on overall prescription costs, borne by both insurers and patients, remains unclear. On the one hand, the use of office samples may offer practices a valuable economic means to assist patients. On the other hand, the use of office samples has been criticized due to poor compliance with guidelines for dispensing medication, lack of counseling and medication review with the use of samples, sample misuse by physicians and other health care personnel, and encouraging inappropriate prescribing.[3]

Polypharmacy is a problem: Which drugs can the patient stop taking?

Office samples may be most handy when used for time-limited conditions (eg, respiratory infections) or in other settings in which their use does not initiate an expensive new medicine that a patient will not be able to afford in the long term.

Tell the patient to split pills

Pill-splitting is yet another way for patients to reduce their out-of-pocket costs. Tablets or pills that contain double the dose of a medicine often cost only a little more, and in many cases may not increase patients' copayments at all. Therefore, prescribing a higher dose of a medicine and having the patient take a half tablet per day is an effective way to significantly cut patients' out-of-pocket costs for some medicines.

Although many extended-release formulations cannot be split owing to concerns about adverse events, and some pills come in only one dose, the cost savings associated with splitting the minority of medicines that *can* be split is considerable.[4] These include medicines commonly used, such as Lipitor (atorvastatin), Viagra (sildenafil), and Paxil (paroxetine).

Given the number of considerations involved, you should consult a pharmacist if you are unsure whether a pill can be safely split to reduce patients' out-of-pocket costs.

Refer the patient to a state agency or pharmaceutical assistance program

Most states have pharmaceutical assistance programs for low-income patients struggling to afford their prescriptions. In addition, each of the major pharmaceutical companies offers pharmaceutical assistance programs that often provide medications for free.[5,6] Although enrolling a patient often requires a physician to complete a form, such efforts are generally brief and require little more time than completing a referral or radiology request.

There are Internet sites that provide a comprehensive and accessible summary of these programs, as well as the documentation necessary to enroll patients in the programs (eg, **www.rxassist.org** and **www.needymeds.org**).

Some physicians find that training one or two members of the office staff on how to assist patients with the paperwork is well worth the time and benefit to patients when a problem paying for medicines has been identified.

Encourage the patient to shop around

Many patients are quite savvy at shopping around for the lowest prices for their groceries but may not realize that the same can hold true for medications.

Some patients either travel or use mail order to purchase medicines from other countries, such as Canada or Mexico. But even within the United States, prices for prescriptions vary widely from pharmacy to pharmacy and may differ within the same retail chain.

In general, large retailers can obtain bulk discounts and offer lower prices than smaller retail drugstores. In addition, health plans often have mail order services that may allow patients to fill a 3-month quantity of prescriptions and provide a discount on the patient's copayment. Organizations such as the American Association of Retired Persons,

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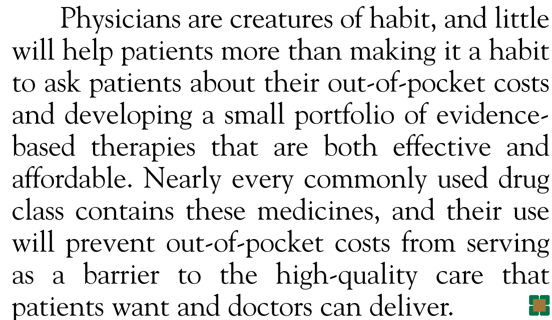
pharmaceutical companies, and online pharmacies may offer access to discounted medicines, sometimes in return for an annual membership fee.

Since these memberships may be limited in the discounts they offer or the drugs that they cover, not all patients will benefit from joining these programs. In addition, patients should ensure that any Internet or overseas pharmacy used is a well established and credible site.

A quick comparison of many of the discounts offered is available on the Web site **www.rxassist.org**.

THE BOTTOM LINE

The bottom line is that as physicians we can help our patients afford the medications that



they need. Patient advocacy must extend beyond the prescription pad to consider the resource constraints that may make a prescribed therapy impossible to obtain or take as directed.

Physicians are creatures of habit, and little will help patients more than making it a habit to ask patients about their out-of-pocket costs and developing a small portfolio of evidence-based therapies that are both effective and affordable. Nearly every commonly used drug class contains these medicines, and their use will prevent out-of-pocket costs from serving as a barrier to the high-quality care that patients want and doctors can deliver.

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