

Prescription-Drug Coupons — No Such Thing as a Free Lunch

Joseph S. Ross, M.D., and Aaron S. Kesselheim, M.D., J.D., M.P.H.

Visit nearly any official website for a brand-name drug available in the United States and, mixed in with links to prescribing and safety information, you'll find links to drug "coupons," including copayment-assistance programs and monthly savings cards. Most offers are variations on "Why pay more? With the [drug] savings card, you can get [drug] for only \$18 per prescription if eligible" or "Get a free 30-capsule trial of [drug] with your doctor's prescription and ask your doctor if [drug] is right for you." Why do manufacturers offer drug coupons? Are they good for patients in the long run? Are they even legal?

Commercial drug-insurance plans typically have tiered pharmaceutical formularies to guide prescription-drug use, requiring relatively small patient copayments (approximately \$5 to \$15) for inexpensive generic drugs and higher copayments (perhaps \$25 to \$100) for brand-name drugs. Manufacturers use coupons to reimburse patients for this difference in copayments when they buy brand-name medications, so that, for people with commercial insurance coverage, the out-of-pocket costs are the same as those for generic drugs.

Drug coupons are implemented through subsidies paid by drug manufacturers. Patients nearly always print coupons off manufacturers' websites, often after going through a registration process. Patients may also obtain coupons from physicians' offices, where they may be distributed in lieu of samples. Coupons are redeemed

when the drug is purchased at the pharmacy, although some require that a physician submit certain information — or instruct patients to bring the coupon to their physician to request a prescription for the specified medication, a behavior associated with an increased likelihood of brand-specific prescribing.¹

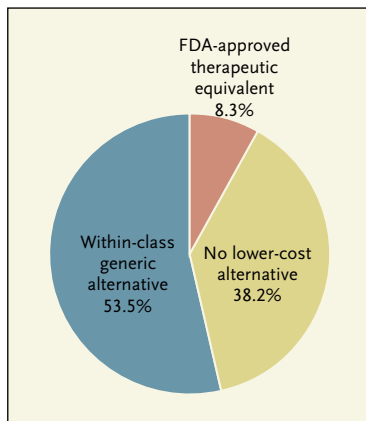
According to a report from IMS Health, coupons were available for nearly 400 brand-name pharmaceutical products in 2011,² and drug-coupon use had increased by more than 50% in the previous year alone, although coupons were still used for less than 5% of brand-name prescriptions dispensed in the United States.² Other analysts have calculated that coupons were used for approximately 100 million dispensed prescriptions in 2010 — about 11% of prescriptions for brand-name drugs.³

We did our own analysis by manually abstracting information on each coupon advertised in March 2013 at www.internetdrugcoupons.com, a large Internet drug-coupon repository. We identified drug coupons for 374 brand-name, prescription-only drugs, addressing a wide range of clinical conditions — from gastric reflux and seasonal allergies to cancer and HIV-AIDS. More than 75% were for chronic conditions for which therapies would be expected to be used for 6 months or longer. The median monthly manufacturer subsidy was \$60, although the amount ranged from \$5 to \$5,000. Most coupons required consumers to provide at least limited personal informa-

tion, such as their state of residence and insurance coverage, to register and have their eligibility assessed. For more than 40% of coupons, consumers were asked to provide additional information, such as contact details, socio-demographic characteristics, or clinical information.

One important question in terms of drug coupons' effect on health care costs is whether they are generally being offered for brand-name medications for which lower-cost therapeutic alternatives are available. We found (by searching the Food and Drug Administration [FDA] website and the Tarascon Pharmacopoeia) that a lower-cost FDA-approved therapeutic equivalent was available for 8% of the drugs in our sample (31 of 374; see pie chart). For more than half the remaining products (58%, 200 of 343), there was a lower-cost generic alternative within the same drug class. Thus, 62% of coupons (231 of 374) were for brand-name medications for which lower-cost therapeutic alternatives were available.

The widespread availability of coupons for brand-name pharmaceuticals that can be expected to be used long term and for which lower-cost alternatives are available has important implications for patients. Despite the short-term savings achievable with coupons, they do not offset higher long-term costs, because they're nearly always time-delimited. Some coupons can be used once, and others more than once. But we found few that offered savings for more than a year. Once a coupon program ends, patients



Availability of Lower-Cost Alternatives to Brand-Name Drugs for Which Coupons Are Offered.

Data are for the 374 drug coupons advertised at www.internetdrugcoupons.com in March 2013. FDA denotes Food and Drug Administration.

with chronic diseases face copayments for these brand-name medications that are higher than those for generic alternatives. By that point, however, patients may have developed loyalty to the particular brand or may be skeptical about switching away from a medication that they perceive as effective — or they may not even be aware of alternative therapies. Physicians have been slow to switch patients from brand-name medications to available generic versions,⁴ either because of clinical inertia or simply because they are unaware of the cost implications of their prescription choices.

Drug coupons may also pose cost problems for society more broadly.⁵ On a population level, drug coupons undermine the tiered-formulary system that commercial insurers have implemented to limit prescription-drug spending. When patients use coupons to obtain brand-name medications, their out-of-pocket spending is reduced. But insurers must

still pay the higher cost of the medication to the manufacturer.³ The more that patients use drug coupons to obtain brand-name medications when lower-cost alternatives are available, the more expenses will rise for their insurers. A predictable response from the insurers would be to raise coverage rates for all patients.

Beyond the cost implications, the legality of drug coupons has also recently been questioned. The intersection of drug coupons with the tiered-formulary system has inspired lawsuits against some of the largest manufacturers offering coupons. These lawsuits alleged that drug coupons subvert the cost-sharing arrangements established in patients' contracts with their insurance companies and should be disallowed as illegal kickbacks. The cases are still pending, although so far the judges have been skeptical that the programs violate antitrust or racketeering statutes. The federal anti-kickback statute, however, prohibits knowingly paying a party to stimulate business that is in turn paid for by a federal health care program. Thus, federal policy currently prohibits the use of coupons by patients in publicly subsidized drug-insurance programs such as Medicare and Medicaid. Coupons had also not been redeemable in Massachusetts until this year; pressed by industry lobbyists, the state legislature and governor decided to temporarily allow the use of coupons for drugs for which a generic version is not available.

It has famously been said that "there is no such thing as a free lunch." Drug coupons are no exception to this rule. Everyone likes to save money, and coupons for essential therapies may be

helpful for certain patients, particularly those with life-threatening conditions for which there are not reasonable generic substitutes. However, the majority of drug coupons are for therapies for which lower-cost and potentially equally effective alternatives exist. Physicians need to talk to their commercially insured patients about the implications of drug-coupon use and make sure that their inclination to reduce short-term out-of-pocket spending doesn't come at the cost of higher long-term expenses for themselves and society.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Section of General Internal Medicine and the Robert Wood Johnson Clinical Scholars Program, Yale University School of Medicine, and the Center for Outcomes Research and Evaluation, Yale–New Haven Hospital — both in New Haven, CT (J.S.R.); and the Division of Pharmacoepidemiology and Pharmacoeconomics, Department of Medicine, Brigham and Women's Hospital, and Harvard Medical School — both in Boston (A.S.K.).

This article was published on August 28, 2013, at NEJM.org.

1. Kravitz RL, Epstein RM, Feldman MD, et al. Influence of patients' requests for direct-to-consumer advertised antidepressants: a randomized controlled trial. *JAMA* 2005;293:1995-2002. [Erratum, *JAMA* 2005;294:2436.]
2. IMS Institute for Healthcare Informatics. The use of medicines in the United States: review of 2011. April 2012 (http://www.imshealth.com/ims/Global/Content/Insights/IMS%20Institute%20for%20Healthcare%20Informatics/IHII_Medicines_in_U.S_Report_2011.pdf).
3. Pharmaceutical Care Management Association, Visante. How copay coupons could raise prescription drug costs by \$32 billion over the next decade. November 2011 (<http://www.pcmanet.org/images/stories/uploads/2011/Nov2011/visante%20copay%20coupon%20study.pdf>).
4. Shrank WH, Choudhry NK, Agnew-Blais J, et al. State generic substitution laws can lower drug outlays under Medicaid. *Health Aff (Millwood)* 2010;29:1383-90.
5. Grande D. The cost of drug coupons. *JAMA* 2012;307:2375-6.

DOI: 10.1056/NEJMp1301993

Copyright © 2013 Massachusetts Medical Society.