Co-pay cards in Canada: Improving choice or institutionalizing bribes?

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Between 2010 and 2015, many patents for blockbuster drugs expired, and pharmaceutical companies were faced with competition from the makers of generic versions (“generics”). It was called the “patent cliff.”\(^1\) To preserve their market share, producers of brand-name drugs introduced loyalty cards as a critical marketing strategy to promote drugs that were no longer under patent, like Lipitor, Crestor and Nexium. Also called co-pay cards (CPCs), these loyalty cards lower patients’ co-pay amount for a brand-name product to the level it would have been if they had purchased a generic.\(^2\) Essentially, pharmaceutical companies act as a second insurance payer through the cards so that patients are free to choose between a (more expensive) brand-name drug or a lower-priced generic without having to pay more out of pocket for the former. In Canada, 2 loyalty card programs dominate the market, covering about 150 products. The introduction of mandatory generic substitution was intended to entirely mitigate the negative effects that CPCs could have on payers’ costs. However, the findings of a linked study by Law and colleagues\(^3\) suggest that this is not entirely the situation.

Serious concerns related to CPCs have been highlighted previously.\(^4,5\) First, use of the cards means that confidential clinical data of individual patients are provided to drug companies. Second, concerns have been raised about the costs and financial incentives associated with CPCs. To illustrate this, let’s assume that a drug costs $100 for the brand-name version, $20 for the generic version; the dispensing fee is $10; the pharmacy margin is 10%; and the insured patient pays a co-pay rate of 20%. Public and private drug plans usually use cost-sharing mechanisms like co-pays to steer the insured toward the most cost-efficient choice of medications.\(^6\)

Box 1 presents some typical payment structures for a prescription based on different scenarios. Scenarios A and B consider the situation where an individual without a CPC chooses between a generic or brand-name drug. Because of the cost-sharing mechanism, the insured would normally pay less out of pocket for a generic version of the pill ($6.40) than for the brand-name product ($24). However, if the insured uses a CPC to buy a brand-name product when a lower-priced generic is available, as in scenario C, the pharmaceutical company through the CPC will pay the difference in the 20% co-pay rate.

**KEY POINTS**

- Loyalty cards were drug companies’ response to the “patent cliff” of the early 2010s, to encourage patients to continue using brand-name drugs as cheaper generics became available.
- Also known as co-pay cards, these brand loyalty products have been shown to allow drug companies access to patients’ confidential clinical information and to increase prescriptions stipulating that brand-name drugs must be supplied.
- Co-pay cards may also increase drug costs for payers by increasing the insured’s premiums, although the introduction of mandatory generic substitution was intended to mitigate this effect.
- New evidence suggests that the purveyors of loyalty cards may even financially incentivize patients to push for brand-name drugs by ensuring that the patient’s co-pay is less for a brand-name than a generic drug.

**Box 1: Typical payment structures in $ for a prescription based on different drug and CPC scenarios**

| Scenario | Insurer | Insured | CPC | Total cost |
|----------|---------|---------|-----|------------|
| A. Generic | 25.60 | 6.40 | 0 | 32.00 |
| B. Brand-name without CPC | 96.00 | 24.00 | 0 | 120.00 |
| C. Brand-name with CPC | 96.00 | 6.40 | 17.60 | 120.00 |
| D. Brand-name with CPC and mandatory generic substitution | 25.60 | 6.40 | 88.00 | 120.00 |
| E. Average cost within public plans based on results of Law et al.\(^3\) | 25.93 | 10.93 | 83.14 | 120.00 |
| F. Average cost within private plans based on results of Law et al.\(^3\) | 37.38 | 6.27 | 76.35 | 120.00 |

Note: CPC = co-pay card.
Source: Calculations by the author, based on cost of $100 for brand-name version; $20 for generic version; $10 dispensing fee; 10% pharmacy margin; and 20% co-pay for insured patient.
between the brand-name product and the generic. Although the
insured may have the impression that the CPC saves them money,
the drug plan pays $96 for the brand-name drug instead of $25.60 for
the generic. If the insured is on a private plan for which premiums are
determined based on last year’s total expenditures, savings incurred
over the counter when using a CPC are not true savings, as the
insured’s premiums will increase.

The best way for drug plans to protect themselves against
higher expenditures for a similar therapeutic treatment is to
introduce generic substitution; in this case, the drug plan will
reimburse only for the equivalent of the generic. However, phys-
icians can circumvent generic substitution easily by writing “no
substitution” on the prescription, in which case the drug plan
must pay for the brand-name product.7 When CCPs were intro-
duced, pharmacies saw a substantial increase in prescriptions
stipulating “no substitution” (Jason Kennedy, Data from 2012
TELUS Health Book of Business, Presentation for Telus Health: un-
published data, 2013); to protect themselves against this
trend, all public and most private plans introduced “mandatory
generic substitution,”8 where the drug plan pays only the equiva-
lent cost of the generic even if “no substitution” is written on the
prescription. Alternatively, the plans require medical justifica-
tions before agreeing to reimburse for the brand-name product,
as shown in Box 1, scenario D.

However, the findings of the linked research1 show that,
while costs seem to have been contained for public plans (Box 1,
scenario E), there is still cause for concern for private plans
(scenario F) because the cost for the insurer goes from $25.60 to
$37.38 — an increase of 46% — for a product that does not pro-
vide any additional therapeutic benefit.

The most surprising finding of the linked research, however,
is that use of a CPC was found to be associated with a decrease
in the average cost paid by the insured when they select the
more expensive treatment.1 A more granular analysis of Law
and colleagues’ work shows that, while CPCs cover only half of the
co-pay difference for some drugs, such as Effexor, Norvasc or
Lipitor, they cover more than the co-pay difference for others,
such as Concerta, Nexium, Wellbutrin and Suboxone. This is
concerning. These findings imply that drug companies, some-
times, appear to be paying patients to select the more expensive
drug option.

Consider this hypothetical analogy, which could not occur in
Canada but might, arguably, be possible in health systems where
services are not paid for out of the public purse. Imagine if a user
fee of $20 existed for every visit to a hospital’s emergency
department, but to attract more patients and collect more fees
for service from insurers, hospitals would pay that user fee and
give the patient an additional $10 to increase the number of vis-
its. We would probably all agree that, in such a case, the hospital
could be perceived to be increasing revenues in a manner that
artificially wastes resources and inflates costs. Yet, the situation
in Canada in which people covered under private drug plans use
CPCs to purchase some brand-name drugs might not be so very
different. Under the guise of reducing costs and increasing
choice for patients, CPCs may be doing much more.

As noted previously, CPCs potentially allow the transfer of
confidential clinical information of individual patients to drug
companies. In addition, as previously reported,4 CPCs may influ-
ence health care professionals to promote the message that
brand-name products are better (by complying with patient
requests to specify “no substitution” on prescriptions). They
likely also waste resources, increase costs for patients (by
increasing their insurance premiums) and may even incentivize
patients to push for brand-name drugs through a mechanism
that many might consider to border on institutionalized bribery.

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