Six COPD Trends You Need to Know

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COPD is a costly disease for patients and payers alike-but in order to control costs, you must fi

The costs of chronic obstructive pulmonary disease (COPD) are so complex that keeping pace may seem as tough as trudging up sand dunes.

But that challenge must be met, says Robert A. Wise, MD, professor of medicine at Johns Hopkins University School of Medicine in Baltimore.

“The cost of drugs places a substantial burden on COPD patients-more than any other chronic condition,” he says. “If drugs were more affordable for patients, you’d have better adherence, and that would lead to fewer adverse effects and hospitalizations.”

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Instead, COPD carries a hefty price tag for the healthcare industry: $50 billion yearly and $7,100 per hospital stay, according to a University of Tennessee survey, “The clinical and economic burden of chronic obstructive pulmonary disease in the USA,” in a 2013 issue of *ClinicoEconomics and Outcomes Research*.

Eighty-four percent of those whose COPD drugs were not reimbursed stopped taking their medications or took less than prescribed, versus 59% of those with single-tier coverage that shaved some patient drug costs, according to a 2006 study published in the *Journal of Managed Care Pharmacy.*

"The drug companies spend billions on marketing efforts but that doesn't guarantee patients take drugs," says Jeromie Ballreich, PhD, MHS, director of the Masters in Health Economics and Outcomes Research Program at Johns Hopkins University School of Public Health in Baltimore.

Here's the latest on how to handle COPD costs-and boost patient adherence to their prescriptive drugs:

1. Combination-inhaled medications are game changers

Combination-inhaled meds accomplish two benefits: patients can take fewer drugs, which raises compliance to their regimen, and drugs become potentially more affordable.

Integrating two or three drugs in a single inhaler could-and should-cut patient costs as much as two-thirds, Wise says. "Yet formularies don't always cover combination inhalers.

With 50 new medications in the pipeline, according to the University of Tennessee survey, Wise hopes that changes. "Patients have been taking two to three different inhalers-which is harder for them to keep track of."

Some new longer-acting combination agents-with both bronchodilators and steroids-only need be taken once daily, says Stephen Clum, MD, PhD, pulmonary and critical care specialist and assistant professor of medicine at University of South Florida in Tampa.

While expensive, he says, insurers are short-sighted if they fail to assume much of the cost. That expense is far less than a hospitalization for acute exacerbation. "Compliance goes up astronomically if a drug that's administered twice a day goes to once a day," he says. "If we improve compliance, the healthcare system wins, the patient wins, everybody wins."

2. Don't discount the delivery

Insurers need to recognize that drugs are not all created equal-in part because three types of inhalers exist-and often patients' limitations due to their disease, arthritis or other ailments make them unable to use one or more of them, Wise says. "Formularies will prescribe particular inhalers, which may be cost-effective for the insurer. The type of inhaler may make no difference to some patients-and a significant difference for others."

Delivery methods include:

- **Meter-dosed inhalers, which** are the most common. When users press on a button, a quick aerosol blast comes out. That requires coordination to press and inhale at the same time, which can be tough for chronically ill COPD patients.
- **Dry powder**, in which capsules or blister packs are filled with powder, require the strength to breathe in quickly and deeply.
- **Slow-mist inhalers**, such as ipratropium bromide and albuterol (Combivent Respimat), have slow-moving, long-lasting and fine droplets that patients may find easier to breathe in, allowing the medication to more deeply into their lungs.

3. A generics gap

Many drugs lose their patents, enabling competitors to create lower-priced generics, cutting the cost to patients 80%.

That's not the case for COPD medications: The drug itself might lose its patent or market exclusivity, but pharmaceutical companies patent the inhaler itself, Ballreich says. Any alteration to the inhaler gives the drug makers market protection.

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That's why top-selling anticholinergic inhaler drug tiotropium (Spiriva Handihaler) dates back to 2004 yet has no generic competition. "True generics compete on price, whereas branded drugs essentially have a quasi-monopoly," Ballreich says.

Failure to discount unaffordable prescriptions backfires for insurance companies since many patients cannot afford to fill them.

"The biggest benefit for patients is keeping them out of the hospital-and that's delivered via the right medication," Clum says.

Many COPD patients get caught in the financial gulley known as the donut hole. That occurs once they've reached the copay out-of-pocket threshold (TrOOP) for Medicare Part D prescriptions yearly of $3,750. They then pay in full all prescriptions till they reach catastrophic coverage of $5,000. At that point, they are charged 5% of prescription costs.

"In between, patients often are not taking their medications-and that's crucial with COPD medications, a number of which are most effective when taken regularly," Ballreich says.

5. Urge patients to keep you in the loop

Sometimes the patient is first to learn their prescribed drug no longer is covered by Medicare or insurance.

If that occurs between appointments and patients fail to alert their doctor that insurance has changed and they've stopped taking a drug that's no longer affordable, "by their next clinic visit, the damage is done," Wise says. "Acute exacerbations occur, and the drop in quality of life may be irreversible."

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While physicians use EPIC or other electronic health record software that lists formularies, these records are not always accurate, he says. "You get warnings that a drug isn't covered when it actually is, or that a drug you think is covered actually isn't."

6. A sliver of patients get pulmonary rehab

Just 1.9% of COPD patients take advantage of pulmonary rehabilitation within six months of being hospitalized for a COPD exacerbation-despite Medicare's policy since 2010 to cover such services, according to a study published in the *Annals of the American Thoracic Society*.

Doctors may be to blame in part: 62% of people diagnosed with COPD had never heard of pulmonary rehab, according to that same study. Records of 223,832 patients hospitalized with COPD in 2012 were reviewed, and more than half of those who started pulmonary rehab completed at least 16 sessions of physical, psychological, and smoking cessation counseling.

Medicare typically pays for up to 36 sessions. The study did not determine why participation was so low.

"These programs are markedly beneficial to COPD patients," Clum says, "but may not be covered by their insurance. Anything we can do to get them to stop smoking will decrease risk of hospitalization."