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Doctors Paid To Prescribe Generic Pills

By VANESSA FUHRMANS

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Health plans are drawing scrutiny for offering financial incentives to entice doctors to prescribe cheaper generic medicines, including paying doctors \$100 each time they switch a patient from a brand-name drug.

Pharmaceutical companies have long gone to great lengths to try to get doctors to prescribe their brand-name pills. They spend billions of dollars, plying physicians with samples, educational lunches and speaker fees. But as the patents for a growing number of blockbuster medicines expire, some health insurers are trying to trump those perks with bonuses or higher reimbursements for writing more generic prescriptions.

The idea, health plans say, is to save everyone -- patients, employers and insurers -- money. And many doctors argue that it's only right to reimburse them for spending time evaluating whether a cheaper generic alternative is better or as good for a patient.

But the more aggressive approaches, such as cash rewards for each patient switched from a given list of drugs, are coming under fire for injecting financial incentives into what some patient advocates and legislators say should be a purely medical decision. Medical societies are also concerned that such rewards may put doctors in the ethically questionable position of taking a payment that patients know nothing about.

"I'm all for saving health-care dollars, but my concern is if there's a direct financial incentive for a physician to prescribe a certain generic drug, we cannot really trust that decision," says Peter Koutoujian, house chairman of the Massachusetts legislature's Joint Committee on Public Health. He introduced a bill in the committee last month to ban drug-switching incentive payments to doctors.

The incentive program that has drawn the most scrutiny is one initiated last year by Blue Care Network, a health-maintenance organization owned by Blue Cross Blue Shield of Michigan. Under the three-month program, called Blue Reward\$, primary-care physicians were asked to consider switching patients from a brand-name drug and received \$100 for each plan member who filled a generic cholesterol-lowering statin prescription. To assist doctors, the HMO mailed them a list of Blue Care Network patients who were taking Lipitor and Lescol, two brand-name statins.

Blue Cross Blue Shield of Michigan says the program was a one-time event to take advantage of the recent introduction of simvastatin, the generic equivalent of another brand-name statin, Zocor. It says the \$2 million its HMO spent in payments to doctors saved Blue Care Network \$5 million in drug costs and its individual members \$1 million in co-payments.

Though that program ended in March 2007, it continues to generate a backlash. In Michigan, a state Senate committee planned a hearing last fall on the incentives before being sidetracked by the state's budget crisis. Halfway across the country, Mr. Koutoujian said reports of the Michigan program prompted his legislation in Massachusetts "to keep it from spreading."

The American Medical Association says it was contacted by numerous doctors and at least one medical society that wanted to know whether the incentives exposed them ethically or legally. In response, the AMA posted advice to doctors on its Web site under the heading "Kickback Questions and Answers." Its view: "Accepting payment for moving a patient from a brand name to a generic could be viewed as an antikickback statute violation."

Several medical associations say that **Pfizer Inc.**, the maker of Lipitor, contacted them to drum up awareness about the incentive program. Pfizer confirms that it has pointed out to some medical societies the potential clinical and policy implications of those programs.

Alternative Medicine
Generic drug prescription target rates, proposed by pharmacy-benefit manager Express Scripts, compared to actual fill rates in 2005

Drug type	Target rate	Actual rate	Potential saving, in billions*
Anti-hyperlipidemics Such as Zocor, Lipitor	70%	7%	\$6.8
Gastrointestinals Such as Zantac, Prilosec	95	32	6.5
Anti-depressants Such as Prozac, Zoloft	80	50	3.8
Anti-hypertensives Such as Avapro, Aceon	75	54	2.1
NSAIDs Such as Celebrex	95	68	1.8
Calcium channel blockers Such as Norvasc	95	44	0.7

*To plan members and plan sponsors if generic usage targets were reached

Source: Express Scripts

Helen Stojic, a spokeswoman for Blue Cross Blue Shield of Michigan, says while it doesn't plan to repeat the statin drug-switching program, it periodically provides the same kind of physician incentives for other moves to improve care and cut costs, such as increasing the number of mammograms or colorectal cancer screenings. "We considered [the drug-switching program] to be very successful," she adds.

Other health plans have avoided controversy so far by providing more indirect incentives to physicians for raising their overall share of generic drug prescriptions. Excellus Blue Cross Blue Shield in upstate New York began a pilot project with several medical groups in Syracuse, N.Y., in 2006 as part of a broader consumer campaign to boost generic drug use. If they increased their ratio of generic

drug prescriptions to brand-name ones by five percentage points, their physicians receive a slightly higher

reimbursement for their patient office visits.

Excellus's chief pharmacy officer, Joel Owerbach, says the medical groups in the pilot project all met that target, and at least one increased its rate of generic prescriptions by eight percentage points, compared with a six- to seven-point increase overall in the Syracuse area. He estimates the practice's improved generic prescription ratio saved patients between 10% and 12% in drug copayments and costs.

Other insurers are nudging doctors to prescribe more generics by making it a factor in annual "pay-for-performance" bonuses that have become increasingly common. In these programs, physicians' practices are typically paid 2% to 8% more if they meet certain criteria designed to improve care and efficiency, such as prescribing more drugs electronically and reducing cholesterol levels.

Blue Cross Blue Shield of Massachusetts, for instance, gives doctors a bonus of up to \$4 per patient a month, paid annually, for meeting a list of goals that includes higher generic prescription rates, it says.

Regardless of the incentive structure, many physicians say there shouldn't be a problem with health plans paying doctors to help reduce costs. Given that primary-care doctors have seen their real incomes decline for at least a decade because of higher administrative costs and stagnant reimbursements, "why shouldn't they get paid for doing the right thing?" asks Robert Jackson, a Detroit-area family physician.

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