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Summer Price Spike: A Case Study About Publicly Funded Clinics and the Cost of Contraceptive Supplies

By Adam Sonfield

Early this summer, the news broke that Ortho-McNeil Pharmaceutical was drastically raising the prices publicly funded clinics pay for their contraceptive products. The Ortho Evra contraceptive patch—already relatively expensive for clinics to make available, but in demand for its effectiveness and ease of use—nearly doubled in price between the second and third quarters of 2006. The price increases for oral contraceptives were even more extreme, going from as little as one penny for a month's supply to nearly $19. Only one of the manufacturer's major products—their newest and top-selling pill, Ortho Tri-Cyclen Lo—maintained its low price of a little more than three dollars.

Weeks later, amidst stories of clinics scrambling to respond and a chorus of protest, Ortho-McNeil Pharmaceutical reversed itself, decreasing prices first for the patch and then for its pills, although in neither case to their original levels. Across the nation, family planning providers and advocates let out a collective sigh of relief: another crisis averted, at least for the moment. Yet, it is likely that the incident has had real consequences in the short and long terms.

The Cost Pressures Clinics Face

One of the oddities of publicly funded family planning is that clinics have long relied on extremely low priced oral contraceptives to help them suffer through insufficient funding for the rest of their operations. Many drug manufacturers have provided oral contraceptives to clinics at low or "nominal" prices that are far below those in the private-sector market. These prices may be negotiated by a group of providers, by a state government or—for Title X–funded clinics and others that are eligible—by the federal government through what is labeled the 340B drug pricing program (see box). Ultimately, however, these favorable prices stem from decisions by drug manufacturers to invest in the public sector, at least in part as a means of promoting their products and generating brand loyalty.

From all accounts, manufacturers are moving away from this model, which may no longer work in a world in which the use of generic drugs is promoted by insurance companies and prescription drugs are marketed directly to consumers on television and in magazines. From the perspective of family planning providers, the reasons behind this shift are murky, and largely irrelevant. What matters to providers is its impact.

Although comprehensive data on the prices clinics pay are not available, largely because of confidentiality agreements, anecdotal reports and small-scale studies on the subject suggest that a real problem has developed over the past decade. According to a 2002 Guttmacher Institute investigation of 12 large family planning agencies from across the country, the reported cost per client of providing contraceptive supplies had risen 58% over six years (related article, December 2002, page 6). A somewhat larger 2005 follow-up survey found that grantees had increased their Title X spending on contraceptive supplies by an average of 26% over just three years, and the proportion of their grant spent on these supplies each year increased by an aver-

How Contraceptives Are Priced for Public Clinics

The prices paid by publicly funded clinics for contraceptive and other supplies are set through a range of channels. First, drug manufacturers often offer a discount on their products to any nonprofit purchaser. Larger nonprofit or government agencies have sometimes succeeded in negotiating directly with manufacturers for deeper discounts. Planned Parenthood Federation of America, for example, negotiates on behalf of its affiliates across the country, and some state governments—on their own or as part of multistate groups—have negotiated discounts on pharmaceuticals more broadly. Manufacturers agree to these types of discounts because of the promise of large and sustained volumes of purchase. Typically, they require purchasers to agree to strict confidentiality agreements and may place limits on buying from their competitors.

Clinics that are unaffiliated with Planned Parenthood or a state government can also band together to pool their purchasing power. The most prominent example is the Family Planning Cooperative Purchasing Program, founded and run by the California Family Health Council. Founded in the early 1990s, the program now encompasses over 2,000 Title X–supported clinics in 44 states. A parallel program, started in 2001, serves nonprofits that do not receive Title X funding, although program staff report that in this case, they have been more successful in negotiating discounts for such basics as copy paper and cleaning supplies than for contraceptives.

The federal government uses its own substantial influence to drive down prices: For example, federal law requires drug manufacturers to provide substantial rebates to state Medicaid programs. Moreover, a range of federally funded public health entities and programs, including Title X family planning clinics, community health centers and states' AIDS drug assistance programs, qualify for the 340B Drug Pricing Program, named after a section of the Public Health Service Act and run by the federal Office of Pharmacy Affairs. Pharmaceutical companies participating in this program are required to abide by a price ceiling that is discounted from their private-sector prices; the companies are permitted to set even lower prices. Additional discounts on some products—including, as of July, the contraceptive ring—are negotiated through 340B's Prime Vendor Program, leveraging public health entities' collective purchasing power. The actual prices charged under both programs are considered proprietary and are not generally made available to the public.

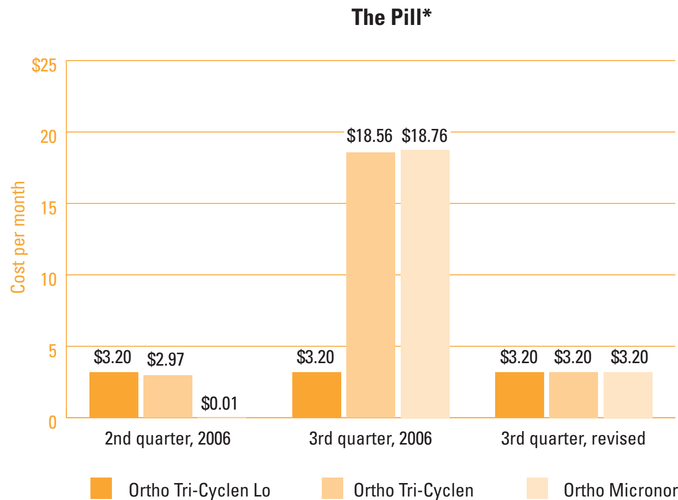
age of 12% over the same period. Clinic revenues and government funding have not nearly kept pace.

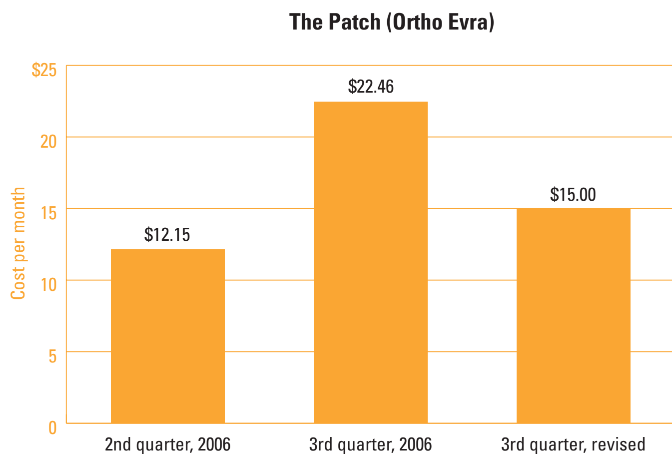
Some of the increased costs to clinics come from rising prices for brand-name oral contraceptives. The other major pressure has been the emergence over the past decade or so of new methods, including the injectable, the patch and the vaginal ring. Compared with the pill, these methods are easier for women to use and thus offer extremely low failure rates; however, they have also been more expensive, at least at first. Injectable contraceptives—Depo-Provera and its generic equivalents—have been available long enough that prices, particularly in generic form, have become roughly comparable to the pill for many clinics. Reflecting these prices, virtually all family planning clinics now offer the injectable to clients, alongside oral contraceptives and the male condom, according to a 2003 Guttmacher survey. The patch and the ring, on the other hand, do not yet have generic alternatives and still cost clinics many times more per client than the pill. Only three-quarters of clinics reported offering the patch and only 40% reported offering the ring, which until this summer had been priced substantially higher than the patch for most public clinics. In fact, two-thirds of Title X agencies reported that they did not stock certain methods because of their high cost.

Having a broad choice of contraceptive methods and specific formulations of the pill is important to women's successful practice of contraception. It helps them to select a method that best fits their life and that has the fewest side effects. In turn, this should increase their chance of using the method correctly, consistently and successfully to avoid unplanned pregnancy.

PRICE SWING

For clinics participating in the national 340B drug pricing program, the cost for Ortho-McNeil Pharmaceutical's contraceptive patch and most of its oral contraceptives jumped dramatically between the second and third quarters of 2006, but were later revised downward.





**The pills shown are Ortho-McNeil Pharmaceutical's three most popular oral contraceptives.*

How Clinics Have Responded

To be sure, cost pressures have been a persistent burden for publicly funded clinics, especially because they have been paired with underfunding; in more than half the states, inflation-adjusted family planning dollars have stagnated or declined since the mid-1990s. Still, the Ortho-McNeil increases experienced by clinics that participate in the federal 340B pricing program were particularly sudden and severe. Prices under that program are released on a quarterly basis with essentially no lead time. Having budgeted for the year based on extremely low prices for Ortho's oral contraceptives, clinics were forced to scramble in response.

One natural response was to search for alternative suppliers of contraceptives, particularly manufacturers of generic products. The price to clinics of many generics, however, are not all that much lower than the price of name-brand drugs, and clinics fretted about the time it would take for the manufacturers to expand production to match a surge in demand. (One reason for the popularity of Ortho-McNeil's products has been that some of their competitors are considered notorious for having limited stocks of their pills available to public clinics.) But clinics were also forced to look for savings in other areas of their operations and in more draconian ways, including raising prices for clients even marginally above the poverty level, reducing hours of operations and limiting the choice of methods and the amount of pills or patches offered to clients.

Even as they sought to cut short-term costs, clinics and their advocates worked to reverse Ortho-McNeil's decision. They contacted the manufacturer in protest, both on their own and collectively under the leadership of the National Family Planning and Reproductive Health Association (NFPRHA). (Planned Parenthood Federation of America negotiates its own prices with manufacturers, and because of confidentiality agreements, it is not known whether the federation's affiliates experienced a price spike.) Behind the scenes, family planning advocates and supportive federal and state policymakers pressured Ortho-McNeil to change course. Some groups reportedly explored the possibility of a lawsuit. NFPRHA and others pursued media attention for the issue, although only a few national outlets took much notice.

Consequences, Now and Later

One place where the media did pay heed was West Virginia, where the local *Charleston Gazette* ran a series of articles on the situation. The state's family planning program had been purchasing three-quarters of its oral contraceptives from Ortho-McNeil, and the state's reserve of contra-

ceptive supplies was measured in weeks, rather than months. By the time the company reversed itself in late August, West Virginia had already ordered a three-month supply of generally higher priced generic oral contraceptives, after the program was given approval to bypass a bidding process that normally takes several months.

In the near term, there is reason to believe that this price spike may have had some impact on individual clinics and their clients. As Denise Smith, West Virginia's family planning director, noted in the *Gazette*, Ortho-McNeil's reversal is "good news overall, but it's a little late for us," having committed for a time to generics at prices beyond her budget. No one may ever know for sure the extent to which women in West Virginia or across the country were affected, but some have surely been faced with a more limited choice of methods, the prospect of having to return more frequently to their clinic for refills, less convenient clinic hours, and—for women above the federal poverty level, Title X clinics' income threshold for free care—higher cost-sharing.

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Any interruption in women's access to contraception may mean an interruption in contraceptive use. And that, in turn, may translate into unintended pregnancy. An illustration of that truth may be seen in the recent announcement that nine months after Hurricane Katrina, the birthrate in New Orleans had risen dramatically. As noted in *USA Today*, much of that increase may stem from couples having more sex as a way to comfort each other or fend off boredom; however, in at least some cases, women simply were unable to refill their contraceptive prescriptions.

In the long term, there is ample cause to believe that the problem of contraceptive costs will not only continue but grow worse, as will its implications for women seeking subsidized family planning services. First, the new Ortho-McNeil prices are still in most cases a significant increase over what they had been: The price of several oral contraceptives went from a penny to dollars per month, and the price of the patch is now about one-quarter higher (see chart). West Virginia's Smith noted that without additional funding, the program will stop buying the patch and will shift patch users to other methods.

Moreover, the summer's crisis made clear that many family planning clinics were relying on a business model based on unsustainably low prices. For now, Ortho-McNeil has publicly committed itself to be the "lowest cost provider of oral contraceptives to public health services." Yet this commitment, however public-spirited, is in the last analysis a business decision, not an act of charity. The challenge for family planning providers is to find ways to survive the day when companies like Ortho-McNeil decide that their best interests lay elsewhere. www.guttmacher.org