



Pharmacy **Benefits** R O U N D T A B L E

Across Canada provincial legislation governing pharmacy practice is undergoing a fundamental shift.

It will redefine the role of pharmacists as key providers of healthcare. The legislation aims at tapping into their skills to help Canadians manage their health better. In Alberta and some Maritime provinces — and soon across the whole country — pharmacists prescribe medications for patients, perform immunizations and support patient care in ways that are not fully appreciated. How these changes will impact employers, benefit plan managers and other industry stakeholders is not clear. In an effort to explore what the opportunities and implications are, MHCSI — Managed Health Care Services Inc. — held a roundtable on December 1, 2009, in Toronto, with key industry players to discuss what the future holds. Here is what they had to say.

The opportunity for pharmacists

What everyone around the table agreed upon was that more information was needed about the coming changes. The main question, posed by Barbara Martinez, a principal with Mercer, was what are the services provided by pharmacists, besides extending or writing new prescriptions? “Where I really see pharmacists playing a key role is in motivation,” said Peter Zawadzki, professional affairs executive with Pharmasave Drugs Ltd. “They can start right away with medication therapy management and adherence monitoring. These things over time will add value for employers.” Pharmacists are in a unique position to help patients and employers because they are so accessible in communities and they have relationships with the patients based on trust.

As Shellina Sevany, manager of clinical services and pharmacy relations at ClaimSecure Inc. explained,



“Pharmacists can clinically intervene and help increase patient compliance by reviewing their medication utilization when patients come to pick up or renew a prescription,” she said. She sees a pharmacist as another member of a patient’s healthcare team, which includes doctors and nurses, that helps to

keep them as healthy as possible. This, in turn, will help save money, not only for the healthcare system, but also for employers who pay for drugs and disability benefits.

Bruce Fraser, a national manager, disability & wellness with Sobeys agreed that pharmacists can be part of a larger group of professionals helping a patient, or employee, manage their health. “Somebody has to have the conversation with the employee. For example, it’s not good enough to have an employee do a health risk assessment (HRA) and then ignore it. This type of data has to get into the hands of someone, like a pharmacist, or more than one party, so the employee is getting a reinforced message about their health. If more than one healthcare professional in the employee’s life could have access to their drug and health history, they could help that person,” he said.

Arthur Fabbro, Jr., director, total compensation programs with Magna International sees pharmacists playing an even more direct role. One key area he sees pharmacists and pharmacy benefit managers (PBMs) helping with is HRAs of patients, capturing that data and

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coordinating action on it. “An HRA could be delivered at a pharmacy. They could discover that a patient has high blood pressure, or is diabetic and doesn’t know it. They could get them referral and treatment. That is what will ultimately drive plan costs down. Pharmacists could play a role like that because we, as a company, don’t have the resources to do that in all of our locations,” he said.

Martinez added that HRAs could be used to incent employees to take more interest in their health. “There is a trend in the U.S. to say to employees, if you do not fill out your HRA your premiums are \$100 more. All of a sudden there is a huge increase in the number of people filling them out,” she said.

Bill Redden, senior director, pharmacy services for Lawtons/Sobeys said the value pharmacists can bring to HRAs are by personalizing them. “You may have three people with the same HRA and only one is going to respond to intervention. Because of the trust factor and accessibility, the pharmacist is in a great position to complete an HRA with an employee, assess it and provide recommendations or treatments. Right away employers get bigger bang for the buck,” he said. Ms. Sevany pointed out that the regulatory changes that are happening should allow pharmacists more time to intervene clinically. Right now, pharmacists are stuck behind the counter signing off on prescriptions and missing these opportunities for intervention. The new regulations will allow pharmacy technicians to do more, which will free up the pharmacist to be a more effective player in the

healthcare system and, hopefully, help drive costs down.

However, all of these opportunities for pharmacists bring with them concerns about limits, governance and overall role. Jamie Farrell, senior manager of benefit programs for Rogers Communications Inc. questioned what the pharmacist’s role should be. “What we’re getting at is a health-coaching concept. Some people think that’s not a role pharmacists should play or

whether there could be an independent health coach that could advocate from a patient's perspective?" he wondered. Martinez asked if

director business development with MHCSI, advised that ultimately plan design dictates



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—Mike Sullivan

pharmacists can prescribe, will they be able to prescribe antacids and toothpaste for sensitive teeth, which will then come with an additional dispensing fee and rising costs for employers? Martin Chung, vice president with AON Consulting pointed out that what pharmacists will be able to prescribe will likely be based on the nurse practitioner model. "They will start with a very small basket of prescription drugs that are allowed to be prescribed and over time, with the demonstration of capability, the scope will expand. I don't think pharmacist prescribing of over-the-counter products are going to be supported by most employers even if included in regulations," he said.

Marilee Mark, vice-president, marketing, group benefits, Manulife, also raised the issue of governance and the need for controls. "A nurse practitioner prescribing is not the one also dispensing and so I think it's how you get the right controls in. Not for a moment do I think pharmacists are out there prescribing things that aren't necessary or are in their benefit, but we need to make sure there are controls in place for the end customer and other payers," she said. Zawadzki suggested that the industry could look at the models used with dentists and optometrists for ideas on how to set up controls to protect patients and address governance issues. While neither of those industries is perfect, pharmacy can take what works and see potential problems as they work to create their own model. Leanne MacFarlane, senior

the nature and value of the benefit plan. "What should be covered — whether we're talking about formulary listings or pharmacy care services — is the right care at the right time. That's what drives better health outcomes and ROI."

Integration of drug and disability data

What excited the participants the most was the potential to compare drug use data with disability data. Mike Sullivan, president with Cubic Health Inc. explained that in the past plan sponsors have looked at the pharmacy benefit solely from the perspective of determining whether or not claims were being paid properly, and that's changing. "A growing number of plan sponsors understand there is a huge expansion of the way in which the pharmacy benefit is leveraged, and that includes making better use of the robust data at their disposal. We are expanding the use of pharmacy data for the plan to a point where plans can layer on absence data, as well as short- and long-term disability data, to get a really valuable data set," he said. What he sees is pharmacy benefit management evolving. "I think over time, pharmacy benefit management will expand to become health benefit management, like in the U.S.," he added. "Many employers are also recognizing that when they look at their transactional-level claims data — not just general trend numbers — they realize how much they can optimize within the plan,

and isolate where their plan design hasn't evolved with changes in the demographic and utilization profile of the plan population. They've got a lot of waste going on in their plan. Once an employer discovers this, the whole question about where the funding for expanded pharmacy benefits is going to come from is eliminated because a whole pool of resources will be opened."

But Fabbro was not entirely convinced combining drug and disability data could provide substantial insights. The first problem is that employers do not have access to comprehensive health data and, secondly, the disability data is not always a good enough quality to be valuable. The reliable data, he said, for getting a picture of what their employee base looks like is the drug data. "Across all of our operations, musculoskeletal and mental disabilities are driving the majority of our disability costs. We know because there is a correlation to painkillers and antidepressants in our drug data. But our number one drug spend, for both occupational and non-occupational healthcare, is cardiovascular and number two is diabetes. There is no evidence of outcomes of what's happening with our populations relative to those two, so all we have is drug data to show we have those issues," he said. While that is valuable, it does not help him to know if his employees with cardiovascular problems are

getting better, or are they headed toward short- or long-term disability claims that will further drive up his health plan costs. "Are they getting worse? Are they staying the same? Is the medication adherence really being followed and is it making a difference in their lives? We just don't know," he said. Bill Redden concurs that you need to drill down even further. "Drug data is just the activity. The missing link is what's the pattern."

Review plan design

If pharmacists can prescribe medications and provide additional healthcare services, fresh new insights will arise into how to improve plans for employees. For example, if a patient is having problems on a drug, a pharmacist can switch that patient to another drug that treats the same condition. This can also be done with switching from name brand to generic drugs. Both types of changes can mean major cost savings for employers. In order to make such things easier for pharmacists, plan design changes might be needed and Ms. Sevany wondered how willing employers

are to do that. "We can come up with any kind of plan design. For example, if a patient doesn't take the generic then co-pay is 50%," she said. "But is there willingness on the part of the employers to take that up and implement it?"

The other side of plan design change is when pharmacy data provides extra insight into a company's employees, which can be used to create a more tailored plan. At his company, Fraser has been trying to uncover valuable information about the overall state and cost drivers of his employees' health from various stakeholders, not just PBMs. "We have put a lot of energy into driving all of our stakeholders to help us to understand what our risks are and the current disease states. The goal being to use that as a global statement of the health of our employee population. From there, we can look back at plan design and say 'Here is a place where we need to increase our spending, to support prevention and employees' efforts to stay well,'" he said.

When it comes to tweaking a plan in order to maximize benefits for the employee, Fabbro thinks health-spending accounts are a

great tool. They allow employees to spend dollars on whatever they want in order to improve their health, whether that's massages or seeing a therapist. "You can include all paramedical benefit options in it, give employees the money and they can choose how to spend it," he said. And hopefully they spend it wisely. Zawadzki suggested trying to include pharmacists in health-spending accounts. "One of the first things we can work on collaboratively is to ensure that every insurance carrier across the country has a pharmacist as an eligible provider for services," he said.

The bottom line

For employers the key question around the changes to the role of pharmacy is: does it help my bottom line? Before that can be answered, pharmacy has to define their services. Plan sponsors need to know what they are paying for.

Fraser raised another key issue for employers around taking on extra cost without seeing any bottom line benefit. "Employers would not be in favour of picking up the cost of something that's going to provide exponential savings to the public sector and little to no savings for the private sector. I don't think the public sector should pay for all of the pharmacy services, but the private sector shouldn't pay for it if they don't see some benefit from it," he said. Ultimately though, he and others believe that pharmacists are in a unique position. "If pharmacy can come to the employer and say, 'Add this to your plan because there is a cost savings,' and then outline exactly what the ROI is for an employer, they will not be ignored. If there is an ROI, then employers will spend the dollars on pharmacy," Fraser said. ■



Pharmacy benefits roundtable participants

Back row L to R: Peter Zawadzki, Pharmasave Drugs Ltd.; Shellina Sevany, ClaimSecure Inc.; Bill Redden, Lawtons/Sobeys; Connie Dickson, Actra Fraternal Benefit Society; Jamie Farrell, Rogers Communications Inc.; Bruce Fraser, Sobeys; Barbara Martinez, Mercer; Mike Sullivan, Cubic Health Inc.

Front row L to R: Leanne MacFarlane, MHCSI; Martin Chung, AON Consulting; Marilee Mark, Manulife; Arthur Fabbro, Jr., Magna International; Cindy Dyer, MHCSI