

Pharmacy Benefits 2010 Roundtable



Exploring the Future of Health Benefits

Attendees

Martin Chung
Vice-President, Aon

Tim Clarke, Benefits Practice Leader
Hewitt Associates

Cindy Dyer, Manager Operations
Managed Health Care Services Inc.

Elaine Gulliver, Manager Benefits
Praxair Canada Inc.

Carmen Hogan, Director
Business Development, Sun Life

Maddy Hoogstraten, Benefits Specialist
Toronto Transit Commission

Sam Lanctin, Manager
Pharmacy Consultant Services
Medavie Blue Cross

Leanne MacFarlane, Director Operations
& Business Development
Managed Health Care Services Inc.

Barbara Martinez, Senior Associate
Mercer Human Resource Consulting

Kerri O'Neill
Disability and Wellness Consultant,
Staples Business Depot

Andrew van der Gugten
Market Access and Government
Relations, RatioPharm

Faced with increasing pharmacy benefit costs, Canadian employers are seeking new ways to offer their plan members the best benefits for the best value. On December 9, 2008, a group of experts came together for a roundtable at the Sutton Place Hotel in Toronto to discuss both the advantages and limitations of these strategies, as well as the opportunities to propel cost-effective healthcare plans into the future. The highlights of their discussion are summarized in the below text.

What is your number one challenge when it comes to pharmacy benefits?

Kerri O'Neill: We're focusing on encouraging generics. It's not something we currently have planned but we are looking at revamping our plan in the next while, potentially going to 60/80 (cost share).

Maddy Hoogstraten: We already have generics, so the employee would pay the difference. Since it's very difficult to make those kinds of (plan design) changes with unions, I don't see any changes in the near term. We see there'll have to be changes, but I don't know right now what we'll do.

Sam Lanctin: Along with the cost

challenges is the rapidly changing legislative landscape—it's another factor that's driving costs. We're all used to benefiting from legislative changes when it came to regulating the costs that pharmacies could charge. Now, Ontario has a two-tiered system that's having repercussions right across the country. And plan sponsors are now paying higher drug costs because of some of these changes.

Tim Clarke: I think it's about balance. You need to consider costs but also consider what products are driving the cost increases of today versus what they were 10 years ago. The kinds of solutions you put in place and the kinds of



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priorities you have today are very different. You don't necessarily want to limit coverage for cancer drugs. That completely goes against the reasons for having a medical and benefits plan in the first place. So the question is, how to balance employee needs with the costs to the organization?

Andrew van der Gugten: We see a considerable delta between U.S. and Canadian utilization of generics. On a macro level, it's about the availability of the same generic drug versus the brand product. From a market opportunity perspective, it seems to be the lowest hanging fruit, but no one seems to be able to address it. Why?

Leanne MacFarlane: I think I know exactly what it is, and it's bumpers. Every time a prescription gets delivered and it's interchangeable, it's almost always getting filled with a generic in Canada. But prescriptions here are not written for generics as often as they are in the U.S. because of plan bumpers and rules. For example, plan designs using tiered co-pays that encourage the use of generics and other cost-effective medications are much more common in the U.S. and so the doctor, pharmacy benefit manager and patient are much more invested in the choice of treatment.

Martin Chung: I think there are a lot of employers who do not have sufficient awareness of current and emerging issues. For example, there are two or three elements of Bill 102 that impact them today and potentially more so in the future. That's just one example of the lack of awareness of some of the basic drivers—not cost drivers—but policies that influence the net impact on financial elements around providing group health benefits. Also, it goes far beyond employers. For instance, how well do insurers and consultants understand how the business environment of pharmacy really works? Pharmacy, employers, the various service providers such as insurers and benefit consultants need to truly understand each other's potential role, existing role and how we can best work together.

Sam Lanctin: Plan sponsor education is a challenge. I think the simple answer to your question is complacency—that's why there is not a higher substitution rate.

What pharmacy benefit management tools and techniques do you use (e.g., formulary design, cost sharing, etc.)? What tools/techniques would you consider using and why?

Maddy Hoogstraten: We impose caps—so much per year, per person, per employee or dependant.

Barbara Martinez: One of the newer trends is going into tiered formularies. In Canada, the standard offering has been all drugs, or most, at one co-insurance. So, anything that legally requires a prescription is put in a basket and covered at one co-insurance. I think that now we're going to see two (or three or four) baskets being formed, where the total list of prescription drugs is reimbursed on two (or more) different levels of co-insurance. And then we'll have to educate employees that the higher reimbursement is the more cost-effective drugs and if they want to spend less out of their pocket, they'll take the drug on the higher tier.

Sam Lanctin: The problem is that doctors don't know the costs of medications. There's a role for us to educate doctors as to the costs.

Carmen Hogan: We try to educate plan members on the big role pharmacists play—they can talk to the pharmacist about options even though the doctor may have already prescribed the drug.

Leanne MacFarlane: Cost effectiveness is not an accountability issue for anyone and it really ought to be. Healthcare providers should get compensated for doing the right job and not just a job. The pharmacy-funding model needs to be modernized.

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What impact might an expanded scope of services have on your plan? For example, pharmacist prescribing, medication management services, disease state management and wellness and prevention programs.

Barbara Martinez: I think that pharmacist prescribing certainly is going to have potentially very positive impacts for employers. There's also going to be some potential cost impacts as well. On the positive side, plan members will get greater access to healthcare professionals. Another positive is less absenteeism from people waiting at the doctor's office to get a prescription refill. As pharmacists start to license themselves in the various aspects, we'll see what the impact is. However, I think there will be cost implications possibly in increased prescribing of non-prescription drugs because that's one of the things pharmacists, at least in Ontario, want to be able to do. Many plans will cover over-the-counter drugs if they are prescribed by a health professional, but patients often don't know this so they don't claim the drug on the drug plan. But now the pharmacist could inform the patient that the medication is eligible and prescribe it for a fee. That may be a real implication of what could happen. So there will be some positives and negatives, but hopefully the positives will

outweigh the negatives in terms of cost.

Martin Chung: The complexity of this is interesting, though. You're suggesting that the compensation model needs to be revised to include ancillary services that pharmacies do not currently provide. I think your comment is very much the million-dollar comment: Show me the proof. Rightly or wrongly, the onus is on pharmacy to illustrate that. Ideally, we would look at all of the cost offsets that may be possible—you save some money on the price of drugs but pay more for pharmacy professional services. But how do we show that right now?

Sam Lanctin: It'll be up to the pharmacist to show what they're providing is bringing value. And maybe employers will see that it isn't so much a cost as a good return on investment.

Cindy Dyer: What you're saying is something that is not available today: the reporting. It's fine to have the service but you have to be able to report on it to know you are getting value and a return on investment.

Tim Clarke: There's no doubt that chronic disease management through regular physicians isn't filling all the needs. People can't just have a 15 minute chat with their

doctor every couple of weeks. There's a gap between what people would like to have available in healthcare resources and what's actually available. There is a desire and need to have greater access to just regular coaching on healthcare.

Elaine Gulliver: One of the challenges of a plan sponsor is developing programs that enable employees to manage their diseases more effectively, use prescription drugs more cost effectively and steer them towards the correct use of those drugs.

How do you see the relationships between various stakeholders evolving in the future?

Martin Chung: I think one trend is that B2B relationships between stakeholders will evolve and develop. For example, employers who today do not have direct B2B relationships with pharmacy will develop them. Plan members are individuals who are part of the business entity, which is the plan sponsor. In addition to just B2B, multiple businesses will intertwine with each other. Carriers will become involved in different lines of businesses and services. Employers and employees have to play a very instrumental role. Healthcare solutions going forward will be termed as business solutions with healthcare nuances. Hopefully, we will dialogue differently.

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Each stakeholder has different customers and that's the crux of the problem. Pharmacy customers are not carrier customers; and the employer's customer is the employee. That's why the B2B relationship has to fundamentally change. In five to 10 years, governments may put employers in such a predicament; they will have no choice but to react. But they should react proactively rather than waiting for governments to enact change first.

What role do preferred provider networks play in your plan? What do you see as the main advantages, disadvantages and opportunities?

Martin Chung: It's interesting to look at the evolution of PPNs. Most view PPNs based on fee capping with some complementary health programs. Before we offer a PPN solution, we have to agree on how a PPN is currently defined. In the absence of drug price advantages, I don't see PPNs getting any significant traction. Do I think it's possible? Absolutely. But it should involve drug price adjustments. It's not going to be based solely on generic substitution.

Maddy Hoogstraten: We have people in small communities who may not have one of these providers in their area.

Barbara Martinez: You have to make provisions where the population needs access to pharmacies and that may mean not penalizing people in certain geographic regions. Plans just have to be designed so that people aren't disadvantaged if they live in a remote community. And if you add mail order to that mix and have all the maintenance medications being filled through mail order, then you're really only dealing with the acute medications that members need to get in their communities.

Leanne MacFarlane: Mail order services can be combined with local community pharmacy services in such a way that provides comprehensive, cost-effective and seamless care. So the concept of a preferred network in terms of cost advantage is also a service advantage.

Martin Chung: We need to have pharmacies collect and disseminate information that continues to build on the potential value from a business

and a health outcome standpoint. In that way employers and plan members have something they can touch and feel in terms of benefits in participating in the network.

Barbara Martinez: Taking that experience to the next level also depends on where your plan is today. Today, if you're 100% paid for everything at any pharmacy, the challenge is getting those members to preferred pharmacies. One solution would be a financial disincentive or reward.

In Summary

The group is in agreement that effective and sustainable solutions will only be possible if there is productive collaboration amongst all stakeholders. In the current environment all stakeholders must strive to understand each other better and take interest in how to deliver cost-effective healthcare plans.

Leanne MacFarlane: It's an interesting time. There are a lot of challenges for sure, but that's the ideal opportunity to find a better solution if people are willing to put the work into it. The time is now.

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