Decision Time

The growing impact of high-cost specialty drugs, coupled with shifting roles for health practitioners, calls for stakeholders to work together to improve drug plan efficiencies. But how? ***By Gabrielle Bauer***

To help answer the question, *Benefits Canada* organized its 2011 Face-to-Face: Drug Plan Management Forum around the theme of specialty drugs. Held at the Fairmont Royal York Hotel in Toronto on Dec. 1, 2011, the event drew an audience of more than 130 individuals. The following report highlights the forum's expert presentations, personal testimonials and panel discussion.

ERIC FORGET/THINKSTOCK

Best ways to save money on your drug spend

Steve Moffatt, senior vice-president of sales and marketing with Green Shield Canada, questioned plan sponsors' ongoing tendency to have their drug plans provide full coverage in today's financially constrained landscape. "On the one hand, it seems financially irresponsible," he said. "On the other hand, employers maintain that it's tax-effective compensation for employees, and plan members cling fiercely to their drug plans." So where is the "burning platform" for change?

As it turns out, the manufacturing sector has been leading the way. "The economic downturn of 2008 hit the sector particularly hard," Moffatt noted. By making modest changes in plan design, the sector was able to reduce its drug spend in the years since 2008—unlike other sectors, which saw a decline only in the rate of growth.

Specific changes included adjustments of co-pays, dispensing fee caps, generic substitutions and judiciously managed formularies for biologics. "Out-of-pocket expenses for plan members became much higher after the design changes," Moffatt said. Recognizing that "it's easier to implement plan design changes for younger people coming in," the sector focused on developing wellness programs to keep chronic diseases in check.

By communicating the economic rationale for dispensing fee caps to both members and pharmacies, one Green Shield client got buy-in and co-operation, said Moffatt. Forewarned about the impending $9 cap, "many pharmacists dealing with the company decided to limit their dispensing fee to this amount," he said.

Moffatt advised targeting a 54% generic penetration rate, using such strategies as generic or therapeutic substitution and maximum allowable costs. Biologic drugs— defined as drugs manufactured by an organism such as a bacterium or yeast—are best managed through an approval process to "ensure they reach only the right candidates," he said. As for vaccines, "make a decision as to whether you're in or out, because a lot of new vaccine drugs are coming down the pipeline."

According to Moffatt, "bread-and-butter" conditions such as hypertension, diabetes, depression and gastrointestinal disorders account for 80% of total drug costs. "If people are trying a new drug, make it available on a trial basis, then increase your prescription period so you're not dealing with as many refills," Moffatt advised. Effectively managing these issues while staying the fiscal course also requires a hard look at plan philosophy, he said. "Figure out where your obligations lie and what you want the plan to achieve for your members."

The employer's perspective: Mercer's survey of Canadian drug plans

Barbara Martinez, a principal with Mercer, reported on the findings of the organization's 2011 survey of Canadian private drug plans. The 420 employers that responded to the survey had workforces ranging from under 100 to more than 20,000 employees, with a median of 600.

Not only do more than 70% of respondents pay at least 80% of drug costs but "a large proportion also cover OTC drugs, which came as a surprise," said Martinez. What's more, only 14% of surveyed plans have an annual or lifetime maximum. "We think these features will become more prevalent, particularly for small employers," she said. The same goes for out-of-pocket caps. "Right now, only 28% of companies have them, but the feature is growing in interest." In the meantime, 39% of employers have no pooling protection, "which is very risky unless you have other means of protection, such as lifetime maximums."

Key findings of the survey also include the following:

- 86% of respondents have drug cards, almost always the pay-direct type;
- 37% have dispensing fee caps, with an average cap of $7.92;
- 51% of plans require drug substitution when applicable, but only 18% will not pay for the brand name drug if the doctor insists on prescribing it;
- 52% of plans share costs with employees;
- only 10% of plans communicate with employees on a regular basis; and
- 55% of respondents intend to change their plan design.

What if drug costs were to increase from 1% to 5% of payroll? "When presented with this scenario, more than 80% of respondents said they would change their plan design," said Martinez. Given that 62% of employees expect their employers to provide retirement coverage, "change is something every employer needs to face."

Living well with rheumatoid arthritis

One morning, at age 21, Jeff Aarssen found himself unable to get out of bed. A serious athlete at the time, Aarssen responded by scaling back his running from 60 kilometres to 40 kilometres per week. Within a few months, he could barely walk. A family doctor diagnosed Aarssen with rheumatoid arthritis and told him he'd be in a wheelchair by age 30. "I resolved to prove him wrong," Aarssen said.

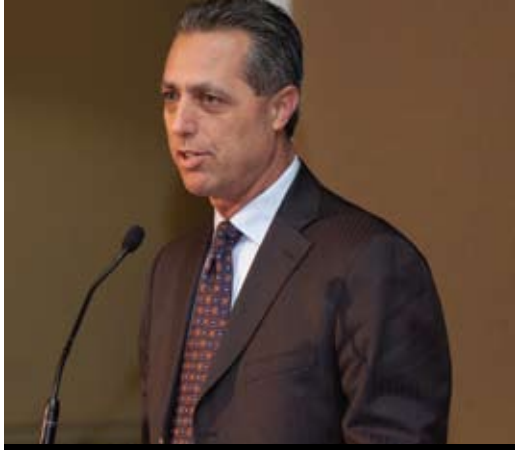

Steve Moffatt, Green Shield Canada

Aarssen hopped on the merry-go-round of treatments, starting with anti-inflammatory drugs and progressing to disease-modifying drugs such as methotrexate, which requires abstention from alcohol. "I became everybody's designated driver," he joked. Finally, Aarssen had the opportunity to try Enbrel, a biologic drug that targets the autoimmune dysfunction underlying rheumatoid arthritis. "I've been taking it for 10 years, and it's been a miracle drug for me," he said. "I travel 100 times per year, play 55 rounds of golf and lead a nearly normal life—all because I have access to the right treatment."

Now a vice-president at Great-West Life, Aarssen credits his employer for making all of this possible. "They've made modifications to my workplace, allowing flextime and virtual work, and they pay the full cost of my drug treatment," he

"With biologic drugs, we can halt the disease process before irreversible damage occurs, effectively buying many high-quality years for our patients"

— Dr. Lynn Hamilton, rheumatologist



Jeff Aarssen, Great-West Life

said. "This has enabled me to be productive and give value back to them, which I'd like to think is a good ROI."

The reality of chronic disease treatment: Panel discussion

Jeff Aarssen, vice-president, GRS sales and marketing and wealth management, Great-West Life
Sal Cimino, manager, pharmacy and professional services, Green Shield Canada
Tim Clarke, Canada's health and benefits innovation leader, Aon Hewitt
Dr. Lynn Hamilton, rheumatologist, Toronto
Lincoln Lee, pharmacy district manager, southwestern Ontario, Sobey's Pharmacy Group
Mark Rolnick, product director, pharmaceutical benefits, Sun Life Financial

Moderator Suzanne Lepage, a Toronto-based private plan strategist, launched the discussion by asking panellists what principles they followed when making decisions about drugs. In Clarke's view, "it's more useful to frame the issue around which drugs to prioritize rather than which costs to avoid." If a new drug passes the test, "perhaps we don't need to add another $100 to the visioncare plan," he said.

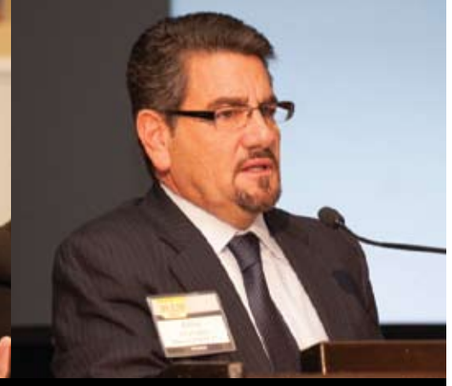
Where do biologic drugs fall along the priority continuum? Hamilton recalled "admitting our rheumatoid arthritis patients to the hospital for 'rest' because we couldn't do anything to help them anymore," when she began practising more than 20 years ago. "With biologic drugs, we can halt the disease process before irreversible damage occurs, effectively buying many high-quality years for our patients. This point cannot be emphasized enough."

Specialty drugs like biologics don't work on every patient. In this regard, Lee noted that the prior authorization programs used by most private payers "can help to determine whether a patient is likely to need or benefit from treatment." In Rolnick's experience, such programs offer a net savings of 1% to 2%. "About 30% of plan members don't complete the authorization form for a specialty drug, which tells us they're being treated effectively with another drug," he said. With more specialty products in the

"It's difficult for any one of us to absorb the costs. We need multiple stakeholders working together to find a solution."

— Tim Clarke, Aon Hewitt

Barbara Martinez, Mercer



Arthur Fabbro, Magna International Inc.

pipeline, "we believe savings of closer to 5% are possible going forward." Cross-industry and cross-employer poolings take further risk out of biologics coverage, Clarke added.

Still, the prospect of underwriting lifelong biologic therapy—not to mention combinations of biologic drugs—has plan sponsors understandably nervous. Hamilton allayed both concerns. For one thing, "we've found that using two biologics doesn't add anything to the outcome," she said. What's more, "the earlier we start treatment, the better it can prevent joint damage and disability. In selected patients, it may even be possible to halt treatment."

Cimino addressed the issue of sustainability—the "elephant in the room"—head on. "Our old sense of entitlement has to change," he said simply. Rolnick, in turn, boiled the challenge down to "changing plan design and educating members about the need for such changes."

While deeply grateful that his employer covers his treatment, Aarssen recognized the need for employees to absorb some of the costs if drug plans are to survive. "As long as I can afford it, I would not object to a $1,000 deductible for a $20,000 drug," he said.

Pharmaceutical companies have also stepped up to the plate with support programs (in some therapeutic areas) that assist patients with the costs of biologics or other specialty drugs. As Clarke put it, "it's difficult for any one of us to absorb the costs. We need multiple stakeholders working together to find a solution."

Subsequent-entry biologic drugs and the law

Biologic drugs are much larger than the small synthetic molecules used to treat most conditions. "I can synthesize a small ingredient in a test tube and rest assured it's the same as the original," said Lesley Rapaport, president of LRR Patent Law Office in Toronto. With biologic drugs, "there's a cell doing the work, so you can't ensure exact duplication"—which is why the copycat biologics in current development will be called follow-on or subsequent-entry biologics (SEBs) rather than generics.

While Canadian drug innovators have to follow an arduous process when filing for regulatory approval for traditional small molecules, generic manufacturers "don't have to prove as much, so the process is abbreviated—although they have to wait until the patents for the original drug and a data-exclusivity period have expired," Rapaport explained.

Because SEBs "may differ more substantially from the original than small molecules do," Rapaport said it is unclear exactly how much information SEB manufacturers will be required to provide. In 2010, the Canadian government issued guidance documents to help address the following questions: What safety and efficacy data will SEB manufacturers have to show? What differences from the original will be sufficient to justify data exclusivity?

An audience member asked whether these regulatory uncertainties, coupled with high manufacturing costs, might deter pharmaceutical companies from the SEB category. "While there may still be a question mark in terms of profitability," said Rapaport, "several companies have taken an interest in pursuing this market. Stay tuned."

Us versus the U.S.: Key differences in Magna's Canadian and American drug plans

Magna International Inc., a global vehicle part manufacturer and assembler with a workforce of 104,000, has a decentralized management structure that allows every division to run as a separate entity, said Arthur Fabbro, the organization's director of total compensation. Typically, drug plans in the organization's U.S. divisions have a three-tier design comprising generic drugs, preferred brands and non-preferred brands. "Most biologic drugs would fall in the latter category, meaning that plan members would have to go through an established process to get approval for these drugs," said Fabbro. In Canada, a two-tiered system—formulary and non-formulary drugs—prevails. Mail-order pharmacy, in its infancy in Canada, "plays a huge role in containing costs in U.S. plans."

According to Fabbro, Canadian drug plan providers might also learn from these common U.S. practices:

- adjudicating pharmacy claims;
- conducting safety checks and drug utilization reviews;
- negotiating preferred price and rebate arrangements with drug manufacturers;
- negotiating preferred pricing with retail pharmacies; and
- conducting regular reviews to discuss trends, explore and implement plan design strategies, and develop clinical programs.

Future plan design modifications may include out-of-pocket caps, electronic claims submission and automatic generic substitution. "If we could raise generic substitution by just 5%, we could cut major costs," said Fabbro, who also gave the thumbs-up to clinical and utilization management programs. "These programs hone in on where the costs are hitting our plans," he said, "and there's no question they lead to more cost-effective outcomes."

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TOP THREE TAKE-AWAYS

1| Frame the sustainability issue around prioritizing drugs according to their health outcomes rather than avoiding drugs simply because of cost.

2| Educate plan members about the rationale for therapeutic trade-offs and sharing certain costs with plan sponsors.

3| Develop a streamlined prior authorization process and explore pooling options to contain the financial risk of underwriting biologic drugs.