ConferenCe COVERAGE

High Price

Chronic disease is on the rise in the workforce and treatment can be expensive. How can plan sponsors cope? By Vicki McCullough

The specialty drugs for treating chronic conditions can be miraculously effective, but they come with a high price tag, and plan sponsors are pressured to both cover these drugs and find ways to achieve plan sustainability. At the first-ever Face to Face Drug Plan Management Forum in Vancouver on May 31, participants were encouraged to cross-examine drug plan management strategies for ways to alleviate costs. The half-day event—Changing With the Times: The New Face of Drug Plan Management—attracted more than 130 registrants to the Marriott Pinnacle Downtown.

The morning kicked off with the launch of the 15th annual Sanofi Canada Healthcare Survey, led by John McGrath, director of benefits with Great-West Life in Vancouver. According to the survey, only 10% of plan sponsors formally evaluate the success of their health benefits plan—a statistic that McGrath found “astonishing.” Of those that do evaluate their benefits, most report only on utilization and costs. This indicates that a majority of plan sponsors do not have meaningful data to support their management strategies or inform plan redesign.
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— Dr. Diane Lacaille, Arthritis Research Centre of Canada

On the drug claims front, Joanne Jung, director of pharmacy services with Pacific Blue Cross (PBC), made graphically clear the ascendency of biologic specialty drugs. Remicade, Enbrel and Humira—biologics used for inflammatory diseases—have all appeared in PBC’s top seven for amount claimed in the past two years. They also appeared in PharmaCare’s top 10 drugs paid for in 2010/11.

Biologics are more expensive than traditional chemical drugs because they are developed from living cells, making manufacturing more complex. They are also under indefinite patent protection because an exact generic equivalent is not possible due to the complex manufacturing standards.

The next presenter, Dr. Diane Lacaille, a senior scientist at the Arthritis Research Centre of Canada and holder of the Mary Pack Chair in Arthritis Research at the University of British Columbia, made a compelling case for funding biologics.

The Story of Arthritis and Biologics
Arthritis and musculoskeletal conditions are the leading cause of work disability (WD) in Canada. A recent study by Lacaille showed rheumatoid arthritis WD rates of 18% at five years and 27% at 10 years—significant rates, given that onset of the condition commonly occurs in your 30s to 50s.

Rheumatoid arthritis, ankylosing spondylitis and psoriatic arthritis are debilitating autoimmune diseases that cause pain, swelling and stiffness in joints and organs, resulting in fatigue. When there is persistent swelling, the bones and joints are damaged, which results in joint deformities and reduced physical function.

Unlike 20 years ago, when medical treatment aimed at merely controlling symptoms, the goal now is to eradicate inflammation. “We’re looking at remissions,” said Lacaille, “because that’s the only way we can prevent the joint damage and the physical disability.”

Using an arsenal of disease-modifying anti-rheumatic drugs (DMARDs), both traditional and biologic, the approach is to treat early and aggressively. “Cohort studies that have looked at instituting treatment within the first months of having symptoms actually show remission rates of a third and sometimes up to almost a half,” she said.

What does aggressive treatment mean? “We have to get to the patients with our DMARDs early on, reassessing them regularly and constantly modifying them—increasing, switching, adding—until we reach our target of no swelling, no markers of inflammation and no X-ray progression.”

The more expensive biologics are used only after failure of traditional DMARDs. In Canada, just 10% to 15% of rheumatoid arthritis patients are on biologics.

Not only are the biologic DMARDs effective in improving physical function, pain and fatigue, they can also arrest progression of the disease, Lacaille asserted. She acknowledged that for some patients it can take four to six months for the drug to take effect, but others describe it as “a miraculous drug, because with one infusion or one injection they feel like their old selves.”

The Experts Weigh In
A seven-member panel tackled the topic Making Room for Biologics and New Drugs. The panel’s high-spirited exchange brought myriad issues—including accessibility to preferred drug therapies and waste—to the surface for examination.

Gail Attara, president and CEO for the Gastrointestinal Society and chair of the patient-driven Best Medicines Coalition, was there to speak for patients—for Crohn’s disease sufferers, for instance, who are “crippled up in bed in extreme pain and bleeding rectally, have diarrhea, can’t function at all and then have to go through multiple complex applications with their physician to prove they need a biologic medication.”

In juxtaposition to Attara’s portraiture, senior account executive with Great-West Life Harold Gutovich’s charge that “everybody gets squeezed except the patient” seemed slightly inflammatory.

Attara pointed out that physicians, not patients, prescribe medications. Gutovich countered with the scenario of doctors prescribing per the coverage of a patient’s plan rather than following low-cost alternative protocols. Lacaille, also on the panel, rose in defence: “Sometimes the regulations are not in the best interest of the patient, and the physician is forced to give the patient a medicine where the benefit-toxicity ratio is unfavourable.”

Continuing the conversation about who gets “squeezed,” Mona Kwong—manager of the Howe Street Pharmacy and an award-winning community pharmacist—told of a patient who returned $30,000 worth of untaken medications to her pharmacy. Lacaille has had similar experiences—the patient who stopped meds because of side effects and brings back three months’ worth of a prescription. Waste due to non-compliance is a huge problem.

Kathy Sotirakos, senior manager of private insurance with Amgen Canada, the maker of arthritis biologic Enbrel, acknowledged that within six months of getting prescriptions, 50% of patients become non-compliant. Sotirakos says the Amgen patient assistance programs are crucial in helping patients understand what their drug is doing and in providing ongoing support.

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— Harold Gutovich, Great-West Life

Playing devil’s advocate, Gutovich asked, “How do we make people accountable for the dollars that we pay, so we can fund these magnificent new medications that make huge differences to people’s lives?” The ensuing discussion underscored the need for plan providers to be more accountable for their plan designs. Dorothy Steele, manager of compensation and benefits with London Drugs, noted that its employee benefits plan will only cover generics unless the doctor indicates no substitution. But, according to Jung, only about 50% of drug plans have mandatory generic substitution. Gutovich remarked that more than 90% of all plans are open formulary and will allow for PharmaCare limited-authority medications (which include Remicade, Enbrel and Humira) to be paid in full, without special authorization in place. He reminded the audience that, as Jung noted earlier, the majority of special authority applications for the high-cost biologics are approved. With approval, the B.C. government will pay a good portion of the cost of these drugs—essentially, all the cost once a plan member’s PharmaCare deductible has been reached.

Rob Taylor, a principal with TRG Group Benefits & Pensions, said, “The first plan I implemented to integrate with PharmaCare was about eight years ago. Eight years later, that plan sponsor has extended healthcare premiums that are half of the average, and it’s been able to enhance its plan three or four times.”

Navigating coverage is a challenge—and a burden both Kwong and Lacaille know well. Kwong spends 50% of her time helping patients understand their coverage, while Lacaille encourages her patients to sign up for drug company patient support programs, in which someone advises them on how to get costs reimbursed.

“Transparency and making your criteria available are critical,” Sotirakos said. “The patient assistance programs are challenged because the various carriers have hundreds of different plans within each insurer, so, at the end of the day, they can’t keep them straight.”

Lacaille stressed the need for flexible approval processes that “allow a physician to explain the exceptional circumstance to somebody with some medical knowledge, because there are some circumstances that don’t fit the criteria no matter how well-thought-out they are.”

Attara suggested reducing confusion by making plan coverage more inclusive. “I don’t want to arm-wrestle with another disease area to say mine needs coverage, not yours,” she asserted, advocating that physicians, not plan administrators, should be determining treatment. While acknowledging that this may sound simple-minded, she pointed out that “if you do give the right medicine at the right time for the right patient, then you’re going to have better outcomes and you’re going to have a plan that works for employers.”

Setting a Course

To effectively revise drug plans, plan sponsors need, as Taylor said, “to get on the bus of education and knowledge”—a bus, he noted, that’s moving faster every year.

Over the course of the morning, forum presenters urged plan sponsors to do the following:

- evaluate plans by tying the drug costs for a diagnosis to presenteeism, absenteeism and short- and long-term disability;
- improve private–public plan integration (as addressed by Gutovich and Taylor);
- find out about, and take advantage of, solutions now available in the marketplace, such as preferred pharmacy networks and preferred pharmaceutical wholesalers;
- ensure that plan members are educated to become more accountable in plan usage and to be better caretakers of their own health (the Sanofi survey indicates plan members are willing); and
- leverage existing community and government programs toward prevention, early detection and appropriate disease management.

Ultimately, employers need to promote a culture of health and wellness that will pay dividends for individuals, the employers and both the public and private healthcare systems.

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