With regulated generic prices about as low as they can go and the diminishing patent cliff, plan sponsors’ drug holiday is nearing the end. What can they do?

By Martin Chung

The unprecedented convergence of the brand name drug patent cliff, combined with progressive generic price regulations in most provinces, has resulted in a dramatic and prolonged drug holiday (lower than historical growth of drug expenditures) the likes of which has never been seen in Canada.

But in the absence of proactive and thoughtful approaches to drug plan management by plan sponsors, advisors and carriers, the underlying key metrics associated with drug utilization volume and cost clearly suggest this holiday will soon come to an end. In fact, most plan sponsors have a high probability of facing the post-drug-holiday blues by 2014.

How can they avoid it?

The Patent Cliff and Generic Price Regulations

Since 2008, approximately 180 drug identification numbers (DINs) have lost patent protection in Canada, according to data from Equitable Life. But it’s the drugs involved, rather than the number of patent losses, that’s compelling. The majority of blockbuster drugs are now off patent. This includes Lipitor, Norvasc, Nexium and, more recently, Crestor, Cozaar, Plavix, Oxycontin and Viagra.

Not long ago, Lipitor and Norvasc alone represented 8% to 12% of total drug plan expenditures for many employers. Despite this, the holiday is clearly coming to an end for plan sponsors.

Almost 200 additional DINs are expected to lose patent protection within the next two to three years, according to Equitable Life’s data, but few of those are considered blockbuster drugs—the notable exception being drugs for asthma and chronic obstructive pulmonary disease.

And Canada is seeing a dramatic increase in drug claims. IMS data indicate that, in 1991, an average of seven prescriptions were filled for every Canadian; in 2011, this number ballooned to 16, owing, in large part, to an aging workplace demographic.

According to Statistics Canada, in 1991, the average age of the Canadian working-age population was 38; in 2011, it was 44.

To illustrate how the savings are drying up, consider the dollars associated with patent losses within Telus Health Solutions’ block of business alone. In 2010, the organization estimated $300 million. That number dropped to $180 million in 2011 and is projected to be $87 million in 2013.

To further complicate matters, how much lower will provincial governments regulate generic prices? Ontario pulled back from a plan to move its generic price regulations from 25% of the brand equivalent to 20% in the fall of 2012. British Columbia is a notable exception, with its recent announcement to move from the current 35% to 25% in April and a further reduction to 20% by April 2014.

The majority of significant patent losses and generic price regulations have already occurred. With an aging workforce, ongoing increase in the volume of claims will continue.
**Disease Trends**

In Canada, chronic diseases (e.g., cardiovascular diseases, cancer, mental illnesses and diabetes) account for 67% of all direct healthcare costs and 60% of all indirect costs, which include lost productivity and income, according to the Conference Board of Canada. Disease risk factors and prevalence have implications far beyond just drugs.

In 2000, according to data from Telus Health Solutions, diabetes and rheumatoid arthritis did not even appear on the list of top 10 diseases by drug amount paid. Today, according to Equitable Life’s data, diabetes is No. 1 on the list and rheumatoid arthritis is No. 5. And, as these diseases become more prevalent, the drug innovation pipeline has become increasingly rich with substantially more expensive non-biologic drugs for diabetes and high-cost biologics for rheumatoid arthritis. Cholesterol disorders, depression and blood pressure remain prominent in the top five, but the majority of drugs used to treat most of the top 10 diseases now have a much lower-cost generic available.

High-cost specialty drugs (many being biologics) continue to command much attention, especially with the recent patent loss of Remicade and ongoing uncertainty of how subsequent entry biologics will be approved, interchangeable (unlikely) and priced (generic price regulations will not apply). With more than 50 specialty drugs in the pipeline for rheumatoid arthritis alone, and hundreds of others for rare (and not so rare) diseases, specialty drugs have high-cost impact potential. However, as quickly as the proportion of cost associated with high-cost specialty drugs is growing, according to Telus Health Solutions data, in 2011, 98% of claims and 83% of total drug plan expenditures were associated with regular drugs for common conditions.

**BOTTOM LINE** Despite there being a lower-cost generic alternative available for most common disease states, drug utilization and expenditures associated with treating common chronic conditions will continue to escalate. Cost pressure will be further magnified by high-cost specialty drugs.

**Unintended Consequences**

Pharmaceutical companies, however, have been rapidly adapting to these changes that threaten their financial top and bottom lines. Some have even established generic branches of their business in order to benefit from this growing segment.

In recent years, there has been tremendous growth in the availability of patient reimbursement support programs for both high-cost drugs and off-patent brand name drugs, sponsored by pharmaceutical companies in an effort to ensure continued business. (Compared with just a few years ago, there are now more than 100 brand name drugs that have a reimbursement support program.)

There has also been exceptionally high growth with respect to brand name pay-direct drug (PDD) cards (colloquially referred to as manufacturer coupons). These cards effectively serve as a means...
to facilitate co-ordination of benefits between the employer’s drug plan and the manufacturer’s reimbursement support program.

In parallel with the increasing availability of brand name PDD cards, many carriers have observed an increase in the number of drug claims submitted and adjudicated with no substitutions requested by the prescribing physician. Since many employer drug plans in Canada still maintain a voluntary generic provision, claims submitted as “physician request no substitution” in such cases would result in the employer paying the cost of the brand name drug—the manufacturer PDD card will not have a difference in ingredient cost to pay. The unintended financial consequence to an employer can be even more deleterious if it serves as the spousal plan (with voluntary generic) and the primary plan has mandatory generic. In this scenario, the spousal plan will, in fact, pay more, and, once again, the manufacturer PDD card will not have a difference in ingredient cost to pay.

**BOTTOM LINE** Drug plan design can impact opportunities and risks associated with the marketing strategies of healthcare providers.

**New Solutions Needed**

While it is naturally tempting to focus right away on solutions, it is usually far more productive for employers to have access to fact-based insights specific to their healthcare “ecosystem,” which, in turn, effectively prioritizes options (see “Easy Read” in Benefits Canada, September 2012).

Moreover, the decision tools used should not focus solely on drug metrics but also on other extended healthcare benefits and disability.

In order to best capitalize on drug utilization, marketing and distribution trends, employers should consider basic plan design elements.

- Include a mandatory lowest-cost alternative (typically a generic) provision in the drug plan.
- Convert reimbursement to a PDD plan, especially since there are now effective ways to mitigate concerns regarding potential short-term cost increase.
- Explore partnerships that will generate value to you and your plan members.
- Underpin all drug plan decisions with fact-based and actionable insights specific to your organization.
- Seek out partners in change management that can most effectively meet your administrative, communication, strategic and human capital management needs.

While the rapid pace of change in healthcare can be daunting and complex, it can be leveraged to your advantage while mitigating longer-term risk exposure. The post-drug-holiday blues are approaching fast for many employers. All stakeholders need to continue to evolve and work collaboratively in preserving a benefit that is important to employees and their families.

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