Your Plan on Drugs

Costs are increasing for drug plan sponsors...but not the ones you think

By Suzanne Lepage

Private drug plans are one of the most high-profile benefits plan costs, so it’s important to understand the factors influencing these costs. Many use the terms drug prices, drug costs, and drug plan costs interchangeably when, in fact, they’re all different.

Drug costs are the total drug claims paid by a plan and generally include the pharmaceutical company’s list price, the wholesaler and pharmacy markup, and the dispensing fee. In contrast, drug plan costs also include factors such as processing fees, data handling, and need intensive monitoring and frequent dosing adjustment.

In 2012, Canada’s Research-Based Pharmaceutical Companies commissioned IMS Brogan to forecast overall private drug costs for 2013 to 2017. Its report said Canadian private drug plan drug costs (ingredient costs, plus wholesale and pharmacy markups) should grow at a compounded annual rate of between 1.0% and 2.8%. Then, in 2014, IMS Brogan compared the actual costs to the forecast. Private drug costs grew 2.2% in 2013, in line with the prediction.

What Drives Drug Plan Costs?

Drugs are typically categorized as traditional or specialty medications. Traditional drugs—usually in pill form—are easy to self-administer, require less monitoring and treat common conditions such as high cholesterol and high blood pressure. Specialty drugs are injectable or non-injectable medications used to treat complex conditions such as rheumatoid arthritis (RA), multiple sclerosis and cancer. They are usually costly, require special storage and handling, and need intensive monitoring and frequent dosing adjustment.

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"Specially drug costs represent only 1.3% of claims but continue to grow as a percentage of total drug spending, steadily rising from 13.2% in 2007 to 24.2% in 2013," says John Herbert, director, strategy, product development & clinical services, with Express Scripts Canada. "[This is] primarily driven by the high treatment cost and increase in utilization. Factors contributing to the increase in specialty drugs include the shift to more in-home and outpatient administration and the introduction of new specialty drugs such as Tecfidera for the treatment of multiple sclerosis, Xandi for prostate cancer and Kalydeco for cystic fibrosis."

Plan sponsors may be wondering why there’s been such growth in specialty drug costs in recent years. The rise of new specialty medications has been spurred by improved scientific insights and techniques, allowing drug developers to reduce their high failure rate and take on some illnesses for the first time. For example, early trials of gene therapy (which involves replacing defective genes with healthy ones) were unsuccessful. Now, with improved techniques, there has been increasing success in trials.

Biologics, SEBs and Hep C

The year 2014 marked the first Canadian approval for a subsequent-entry biologic (SEB). Inflectra for the biologic medication Remicade (infliximab), used to treat RA and psoriasis. Priced at a 30% discount compared to the innovator drug, it may offer some cost savings for private drug plans. As the first of its kind, it also opened up the biologic market to further competition and may explain, in part, the announcement of several significant product listing agreements between Janssen and some major private payers to bring down the price of Remicade.

The challenge with SEBs is, highly sensitive manufacturing processes mean the SEB and the innovator drug aren’t interchangeable. It’s unlikely patients who are well established on the innovator can be easily switched to the SEB. For example, a patient taking Remicade to treat RA can’t automatically be switched to the SEB Inflectra. But there could be some savings with new patients who start on the lower-cost SEB before moving to the higher-cost innovator product if the SEB is ineffective.

While treatment costs for conditions such as RA, psoriasis, Crohn’s disease and ulcerative colitis continue to concern drug plan sponsors, “new hepatitis C medications on the market that address unmet treatment needs were a key area of focus in 2014,” Herbert explains. These new drugs offer far superior treatment with fewer side effects, but they’ve also had a major impact on drug plan costs.

“The pricing model for these drugs—on the order of $60,000-plus per member—was often rationalized as being less than the lifetime costs of previously available treatment regimes. However, plan sponsors were typically unable to cover these full treatment costs,” says Lisa Callaghan, assistant vice-president, group benefits product, with Manulife Financial.

“New drugs to treat this condition were only introduced in 2014, and already in 2015, we see them in the top five drugs in our block of business,” says Martinez. “Pooling is absolutely necessary to protect groups from catastrophic and unpredictable losses, such as high-cost claims for hepatitis C drugs that likely do not recur.”

But greater use of pooling is having a major impact on pool charges across the industry. “Our members indicate that although drug plan premiums have not increased significantly over the past couple of years, drug pooling charges have escalated considerably during the same period,” says Wayne Farrow, president and CEO of The Benefits Alliance Group (a network of 40 member firms and more than 100 advisors).

“Most small to mid-size employers couldn’t afford to pay without pooling; however, they continue to be concerned about the growing costs,” adds Cathy Fuchs, practice leader with White Willow Benefit Consultants. “We may see an increase in the number of plans with annual per-person maximums in order to avoid exposure to growing pool charges.”

Increased availability of specialty medications also puts more pressure on the drug stop loss pool. “While plan sponsors pay a pool charge to have their drug claims that exceed a certain threshold removed from the health premium renewal, they are not reimbursed by the funds pool for all other drug stop loss pool participants’ claims. With pooling thresholds hovering around $10,000, most of the costs and risks get pushed to the pool. Each year, thousands of plan sponsors benefit from pooling when it works as planned,” says Martinez. “Other firms continue to support the pool as protection from future liability. All plan sponsors will pay for the increase in specialty medications and greater use through growing pool charges.”

In 2012, Canadian health insurers established the Catastrophic and Unpredictable Losses Pool with the Canadian Drug and Device Pool (CDDP) to cover catastrophic and unpredictable loss. In 2015, the pool covered $148 million in unexpected losses, helping to reduce overall plan costs.

“Pooling removes the total amount of an individual’s claims that is greater than the pooling level from the group’s experience [and is used to predict the group’s future claims],” explains Martinez. “Pooling is absolutely necessary to protect groups from catastrophic and unpredictable losses, such as high-cost claims for hepatitis C drugs that likely do not recur.”
expensive and recurring drug treatments. Dan Berty, its executive director, says in its first year of operation, “insurers paid more than 4,000 claims—representing aggregate cost at the certificate level or total cost per family—for prescription drugs in excess of $25,000, doubling the number of claims from when the CDIPC was first established. Several claims exceeded $500,000, including one claim for more than $1.2 million.”

One proposed benefit of the CDIPC was improved portability of plans for employers, allowing them to switch providers without being penalized financially for existing large recurring drug claims. However, “too group with catastrophic claims is going to be received with open arms by any carrier,” says Farrow. “We still can’t move a case that has any significant stop loss claims.” Berty disagrees. “It remains a goal of the CDIPC to help facilitate movement within the market for fully insured plan sponsors with one or more recurring high-cost claims. Based on the most recent pool data, we know that more than 100 groups did, in fact, move between carriers, even though they had at least one claim over $25,000. This is an area the CDIPC board is following closely.”

Plan Sponsor Reactions
In 2014, many private drug plans were changed when carriers made mass amendments to all of their plans. These changes included adopting mandatory generic substitution—and, for high-cost specialty medications, increasing the use of prior or special authorization and case management—as well as introducing preferred pharmacy networks (PPNs). However, outside of this activity, most plan sponsors don’t intend to make plan design changes. In a fall 2014 TELUS Health Analytics survey of 100 plan sponsors, 91% reported a health premium increase of less than 10% over the last three years. Of those reporting increases, 70% chose not to change their drug plan. And most survey respondents said they didn’t intend to make plan design changes in the next three years.

While recent focus has been on specialty drugs, there are ways to manage the costs of medications for chronic conditions (e.g., diabetes and hypertension). Cost-sharing between plan sponsors and plan members, and there are also wellness programs that target a healthy lifestyle for chronic conditions such as diabetes or cholesterol.” Fuchs adds, “In the future, interest among employers on more actively managing drug plans will increase; there will be more focus on targeted interventions that drive behaviour. This could include focus on improving adherence to medications. An efficient delivery of services (such as PPNs, medication management and disease management programs). The reluctance to consider formulated medications is being replaced with the need to liberate savings on the day-to-day costs in order to fund biosimilars. As the number of biosimilars coming to market grows, more employers should be looking to find savings in other areas of their benefits plans in order to provide coverage for biosimilars.”

Balancing costs with benefits plan objectives is an ongoing challenge, however, “it is important for plan sponsors to re-evaluate the underlying objective of their drug benefit plan. Determine if their current plan design will sustain them into the future and choose the drug plan programs that meet their needs,” Callaghan adds.