BEYOND SPECIALTY DRUGS:
Drug plans taking a variety of
When Andrew Martin joined the HR department at Joey Restaurant Group eight years ago, the company hadn’t touched its paper-based, administrative services-only drug plan in many years.

Martin was quick to make changes, bringing in a flexible plan, drug cards, generic substitution and copayments based on dispensing fees. Still, he stopped short of reducing the 100% coverage across the board.

“I wanted to get more creative,” says Martin, now vice-president of human resources at the restaurant chain that has grown to 4,000 employees in four provinces and two states. “What was really concerning to me was biologics. I wanted to limit the company from uncontrolled exposure to biologics.”

Martin developed a two-pronged strategy. In addition to stop-loss insurance, the company capped its drug coverage. While Martin declined to state the amount of the cap, “it still provides a lot of coverage. If that’s not enough, we work directly with the provincial government to provide the rest,” he says.

The company has turned to that option a few times so far. Most recently, Joey’s plan provider secured additional coverage through Ontario’s Trillium drug program. “We’ve also worked with pharmaceutical companies to get financial help. We’ve had no problems,” he says.

The second strategy involved adopting a tiered plan that provides 100% coverage at the first level for drugs deemed to be clinically effective while also providing the best value for the payer.

“We want to eliminate financial waste, and the only way to do that is to put the decisions into the hands of employees,” he says. “The onus is on them to work through this with their doctors and pharmacists.”

To help make that happen, a website gives pharmacists and members access to what the plan covers and at what level. Martin also visited all of the restaurants to explain the tiered plan to staff. After three years, he says, the plan has worked. “We know it’s working because people are staying on [more cost-effective] Tier 1 drugs. We never got any pushback.”

Is the company’s story typical of what plan sponsors are experiencing today? Certainly, many employers are taking similar actions to address cost pressures. But the restaurant chain’s actions are only one example of the many trends in drug plans as both employers and their providers work to ensure they remain sustainable.

The centre cannot hold

Four out of five (83%) plan sponsors agree new drugs coming to market are too expensive for drug-plan sustainability, according to a survey of more than 200 employers by Benefits Canada in October 2015. And Express Scripts Canada predicts higher-cost specialty drugs will account for 35% of spending by 2018, up from 27% in 2014.

Yet drug-plan pooling, the traditional mechanism for dealing with high-cost claims, isn’t necessarily the best way to sustain that load. “Drug-plan pooling is really meant to address one-time catastrophic costs, but we’re seeing more drugs that cost tens or hundreds of thousands of dollars that are lifelong claims being put into that pool,” says John
Herbert, director of strategy, product development and clinical services at Express Scripts Canada.

Premiums are jumping by double digits as a result, and anecdotal reports suggest some plan sponsors are choosing to opt out of pooling insurance rather than continue paying and then capping coverage at $5,000 or $10,000.

According to the Benefits Canada survey, 30% of plan sponsors now have maximums on their drug plans. “We are beginning to see more plans going that route, which goes against the concept of insurance and can have a profound long-term effect. Are we moving toward an un-Canadian model, which may hold back access to medications when patients require them?” asks Herbert.

**Product-listing agreements on the rise**

While there are few options to address the flow of new higher-cost medications — many of which are also helping to prevent disability claims — benefits providers have been busy coming up with ways to ensure plan sponsors are getting value for what they spend. They’re turning to preferred pharmacy networks that deliver lower markups as well as case managers who work with members to support adherence and co-ordinate coverage.

More recently, carriers have been taking a page from the public sector and negotiating product-listing agreements with manufacturers, which are negotiated discounts on the ingredient cost of medications.

On the public side, the pan-Canadian Pharmaceutical Alliance has negotiated 89 product-listing agreements since 2010. Among private providers, Sun Life was among the first to openly enter the arena in 2014 with its discount for the arthritis drug Remicade, and activity picked up significantly in 2015, according to research by consultancy PDCI Market Access and H3 Consulting. Based on their study of 27 manufacturers, insurers and pharmacy benefits managers, 41% have negotiated at least one product-listing agreement and another 22% are interested in doing so.

“More [agreements] will be coming, yet they raise unique questions on the private side,” says Arvind Mani, director of market access and policy research at PDCI Market Access. For example, the increased number of stakeholders makes it more difficult to maintain confidentiality. At the same time, players will likely seek more transparency as they look to promote the agreement’s existence on the one hand and press for details on savings on the other. Size, of course, is another factor as Mani predicts such agreements “will be a challenge for smaller insurers.”

Among the largest carriers, Manulife got in early with the launch of its DrugWatch program in September 2015. The program entrenches product-listing agreements as part of a four-step process that vets all new drugs expected to make significant financial impacts on drug plans. It uses case management to monitor their use once reimbursement is in place.

“There has been a great deal of talk about the trends, and the pace of change has picked up dramatically,” says Lisa Callaghan, assistant vice-president for product group benefits at Manulife. “Without action, the rate of escalation of costs will quickly overwhelm many employers, putting their plans in jeopardy.”
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**New relationships emerging**

Perhaps an unexpected side-effect of all of the providers’ activities around specialty medications has been the deepening of relationships with other players that go well beyond discussions about price. “The pharma industry can be good partners in terms of chronic disease management and proper utilization,” says Theresa Rose, director for drug management solutions at Medavie Blue Cross.

“Pharmacists can not only offer disease management and other clinical services; they can help optimize drug plan performance.”

As well, input from health providers has contributed to the growing recognition that prior authorizations must evolve. The coming availability of new cholesterol medications, such as PCSK9 inhibitor drugs, adds urgency. The drugs are significantly more effective for a subset of people with high cholesterol but cost about $7,700 a year. That compares to less than $100 for existing generic drugs.

Given the prevalence of high cholesterol as a chronic condition and since most prescriptions come from family doctors rather than specialists, “exposure could be huge” from the new PCSK9 inhibitor drugs, says Herbert. “Prior authorization needs to be more than requiring physicians to sign off on a form. It has to ask the right clinical questions to make sure the medication is truly appropriate.”

Providers such as Rose agree, suggesting prior authorizations for all drugs — and not just specialty medications — will revolve more around

### A CLOSER LOOK AT ADHERENCE

Plan members aren’t taking medications as prescribed, and things worsen as the number of conditions increases

<table>
<thead>
<tr>
<th>NUMBER OF CONDITIONS TREATED</th>
<th>PERCENTAGE OF MEMBERS DEEMED ADHERENT</th>
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<tbody>
<tr>
<td>1-2</td>
<td>54%</td>
</tr>
<tr>
<td>3-4</td>
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<tr>
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<td>48%</td>
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<tr>
<td>7 or more</td>
<td>47%</td>
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Source: Express Scripts Canada’s 2014 drug trends report
clinical practice guidelines for the disease.

“Special authorization will evolve to recognize the importance of patient accountability in the appropriate use of drugs and ensuring positive treatment outcomes,” she says.

“It would also reassess outcomes over time.”

**Analytics playing a growing role**

Data analysis has come a long way in recent years, to the point where insurers and pharmacy benefits providers can give more meaningful information to employers. “Today’s analytics look at what is happening at the patient level rather than just the silos of drug by drug and therapy by therapy,” says Herbert.

For example, Express Scripts’ 2014 drug trend report considered how plan members with certain conditions, such as diabetes or high blood pressure, fare in terms of purchasing lower-cost medications. It also examined their rates of prescription refills and took a closer look at the outcomes for the highest-cost claimants.

For example, the report says average annual costs for the 1% of members who account for 28% of spending more than doubled over five years, a statistic that illustrates the impact of comorbidities and complications as a disease progresses.

Mike Sullivan, president of Toronto-based Cubic Health, says the availability of this type of analysis is one of the positive trends in drug plan management. “We have much more information available now and are able to make much more informed decisions, not just about costs but also about the impact on overall member experience,” he says.

Providers are also integrating different data sets, such as drug and disability claims information, he notes. “Insurers have also come a long way in their ability to adjudicate the kinds of plans employers need,” says Sullivan.

“Their frustration is they’ve put all this work into their systems to do that and, to date, plan sponsors haven’t been following through with different designs. It’s starting to change as more employers understand what they can and should do to manage their plans, and the good news is that providers are ready to go.”

**Wellness, disease management key to better outcomes**

The breadth of data also builds the case for better supports for plan members submitting the 65% to 76% of claims that aren’t for specialty medications, many of whom have chronic conditions.

“It’s important to focus across the full spectrum of employee health. You want to help them before
comorbidities add to costs,” says Callaghan, citing the importance of wellness programs.

In 2014, two insurers added chronic disease management support services as core benefits. Green Shield Canada’s cardiovascular health program reimburses community pharmacists with certifications to coach eligible plan members, and Medavie Blue Cross reimburses approved health-care providers through its chronic disease program to coach plan members with asthma, chronic obstructive pulmonary disease or diabetes.

“The studies have all been done, and the return on investment of disease management is clearly there,” says Rose.

“Now, we need to make it a standard of care that is accessible to employees. It’s no different than what we’ve done with occupational therapy or physiotherapy, which used to be available only in hospitals.”

Karen Wels is a freelance journalist who often writes about drug and other benefits issues.

**BIOSIMILARS STARTING TO TAKE OFF**

In December 2015, almost two years after getting Health Canada approval, the country’s first significant biosimilar medication finally received the green light for reimbursement from the pan-Canadian Pharmaceutical Alliance. Provinces will likely begin reimbursing the drug by March, and private plans may start seeing claims sooner.

Health Canada approved the medication, Inflectra (infliximab), to treat four of the six indications treated by Remicade, Canada’s top-selling arthritis drug. Inflectra is a subsequent-entry biologic, also referred to as a biosimilar, which means it came to market following the patent expiry of Remicade. Based on what’s happening in Europe, biosimilars cost 20% to 30% less than the originator, although there have been reports from consultancies such as PDCI Market Access of discounts as high as 69%.

But unlike generic copies of traditional medications, the interchangeability of biosimilars and originators has yet to be determined. Until that happens, most regulatory bodies, including Health Canada, don’t subscribe to automatic substitutions. So at this point, Inflectra’s use would likely be for patients who aren’t already on Remicade.

Inflectra, though, is just the beginning. “Pfizer has 11 other biosimilar products in development in all of the key autoimmune conditions, in oncology and to treat macular degeneration,” says Gerry Stefanatos, Pfizer Canada’s general manager for global established products.

Merck Canada also recently announced it was “preparing to bring to market a diversified portfolio of biosimilar medicines.”

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