As scientists successfully fill in the map of human genetics, pharmaceutical researchers are charting whole new territories of drugs, such as biologics, that can achieve unprecedented clinical results. People with rheumatoid arthritis, for example, no longer go on disability. People with hepatitis C can be cured. And those with high levels of “bad” cholesterol can turn those numbers around and thereby reduce their risk of heart attack.

Without a doubt, these are exciting times for modern medicine. The troubling question, however, is “How can we afford it?” There are no easy answers, and change management experts would likely describe the past and coming decade as the messy period of transition from one funding environment to another.
During that transition, there are gaps or barriers that need to be overcome, on both the public and private sides. Providers also bring forward possible strategies, though not all will lead to sustainable solutions.

What does this all mean for private drug benefit plans? Do plan sponsors have the right information to make informed decisions about the design, management and evaluation of their drug plan, with appropriate access to higher-cost specialty drugs? Here are some considerations as food for thought.

First, a look in the mirror
Spending on group benefits overall has climbed to represent six percent of the payroll, or an average of $4,745 annually, of which drug benefits represent the largest share. Yet aside from renewal times, when cost containment is usually the focus, are drug plans getting enough attention as far as management, evaluation and planning? Even in the area of cost containment, a survey of plan sponsors reveals that less than half have a strong understanding of the most common measures.

The evolution of medicine and the growing prevalence of chronic disease suggest that the time is ripe to clearly establish the objectives behind drug benefits. “Plan sponsors need to step back and figure out why they offer these benefits. Do they want to cover everyone for everything? Do they want to protect employees against undue financial hardship?” asks Sarah Beech, president of Accompass in Toronto. Once such guiding principles are solidly in place, they serve as a compass for all decisions going forward.

The right advice
Does the benefits advisor or broker make recommendations that support their clients’ objectives for drug benefits?

Consider the possibility of a capped drug plan, for example. What happens if plan members exceed the limit? Some advisors may indicate that public drug plans step in, but that’s not necessarily the case. “Probably the biggest negative with caps is that the drugs that you think will be covered by someone else, like the province, are not,” says Dave Patriarche, a broker for Mainstay Insurance Brokerage in Toronto. The impact on productivity and morale can be considerable, especially if a key employee is affected.

Caps on drug benefits may also limit exposure to important medical innovations. “The cap draws a unilateral line in the sand, where the world on the other side is changing in ways we can’t imagine. There will be new medications, and even new cures, that can improve performance or reduce disability claims,” notes Patriarche.

Questions for carriers
Plan sponsors and their advisors may also do well to pay closer attention to how insurance carriers are responding to specialty drugs. “We want insurers to help protect costs by giving clients a selection of options, but we don’t want them to mandate. Insurers are not paying the claims and yet they are imposing rules and changing contracts without permission,” observes Patriarche. Some carriers’ cost-management programs have raised debate over the extent of a carrier’s authority to make listing decisions, including exclusions, for drug plans with open formularies.

As providers continue to feel their way, the following questions may be worth asking:

How does the carrier integrate with public plans? “All Canadian provinces have some public drug coverage, be it universal, catastrophic, or specific to certain diseases,” reports the Conference Board of Canada. “Employers should confirm that their benefits plan is designed to account for this, and that it coordinates claims where appropriate.”
“More claims can be put on the province as first payer, through proper coordination, and private insurance would then pay for what government won’t,” adds Patriarche.

When it comes to higher-cost specialty medications, how does the carrier support access? Durhane Wong-Rieger, president and CEO of the Institute for Optimizing Health Outcomes, advocates to improve the prior authorization (PA) process. “It’s almost a crime that patients have to demonstrate they’re not responsive to older, cheaper forms of therapy, when in many cases the clinician already knows the patient should be on a biologic,” she says. “There can be months or even years of delay, and meanwhile the patient is experiencing progression of their disease.” Pharmacogenomic screenings can be practical tools for certain disease states, and can be incorporated into PAs.

What about the monitoring of patients? Most insurers provide case management—what are the results, and how is support adjusted for the individual? How do they coordinate with pharmaceutical manufacturers’ patient support programs? “These medications are getting more and more individualized; therefore, we have to change the system to accommodate that,” says Wong-Rieger. “The ideal scenario would be to have patient advisors on insurers’ committees to help determine measures for access and monitoring, which would include a simple feedback mechanism for patients.”

REFERENCES