SPONSORED SUPPLEMENT

Medication MANAGEMENT

SUPPORTING PLAN MEMBERS' AND EMPLOYERS' BOTTOM LINES

ABOUT

Medication Management is an educational series that takes a closer look at maximizing plan sponsors' investment in drug benefit plans, which includes supporting plan members to be healthy while continuing to protect plan sponsors' bottom line.

Specialty medications can significantly improve plan members' health, but may also have a large impact on private drug plan budgets. As more specialty medications become available for a wider variety of chronic conditions, the balance between appropriate access and appropriate coverage becomes more challenging. Through their patient support programs, pharmaceutical manufacturers seek to help maintain that balance by ensuring that patients meet Canadian clinical guidelines, by supporting adherence to medications and by helping patients navigate reimbursement options.

This installment of *Medication Management* seeks to prompt additional discussion about the evolution of drug plan design to better accommodate specialty medications, and the roles of benefits advisors and insurance carriers to help plan sponsors define and evaluate the objectives of their drug benefit plan.

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.

Brave new world

Is your drug plan keeping pace?

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.

> "Strategies exist to manage the financial consequences of specialty medications on employer-sponsored health benefit plans, but their impact on access to specialty medications must be weighed."
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> Specialty Medications: Background Information for Employers. The Conference Board of Canada. July 2016.

INSTITUTE FOR OPTIMIZING HEALTH OUTCOMES

The Institute for Optimizing Health Outcomes brings together individuals and organizations with the commitment, experiences and expertise to bring the vision of optimal health to reality.

The Institute serves as a catalyst and enabler for patient-centred programs, education, research and advocacy to improve care, treatment and support for all persons at risk for or living with health conditions.

For example, our Coaching for Health Management program for healthcare professionals supports patient self-management, drawing upon evidence-based best practices for health behaviour change.

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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.[1] 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.[2]

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."[3]

"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."

New option for people at high risk of heart disease

A new biologic drug delivers impressive results for a subset of patients who are unable to bring cholesterol under control using a standard of care. It has also added fresh fuel to the debate over coverage of higher-cost specialty medications.

PCSK9 inhibitors (short for proprotein convertase subtilisin/kexin type 9 inhibitors) are priced at about $7,000 per year. However, they are the first category of biologics to be associated with a highly prevalent chronic condition—in this case, hyperlipidemia (also referred to as high cholesterol).

The medications are not, however, intended for everyone with hyperlipidemia, nor are they a first line of therapy. According to the 2016 clinical practice guidelines, PCSK9s are for people with a genetic condition called heterozygous familial hypercholesterolemia and patients with clinical atherosclerotic vascular disease (people with heart disease, for example those who have had a heart attack). Within these subsets of patients, the drug is further limited to those who are unable to bring cholesterol down to a healthy level despite taking the maximum amounts of first-line statin drugs and efforts to maintain proper diet and exercise. Canada's Common Drug Review committee recently recommended that PRALUENTTM, a PCSK9 inhibitor, be reimbursed for patients with heterozygous familial hypercholesterolemia and patients with clinical atherosclerotic vascular disease.

How this translates into usage in the real world is the main topic of debate among public and private payers. For their part, manufacturers Sanofi and Regeneron have indicated that their patient support program will screen patients to ensure they meet the criteria for use.

Clinically, the drug's impact is impressive. Several studies show that PCSK9 inhibitors reduce levels of "bad" cholesterol by between 50 and 70 percent, to levels that are well within healthy targets.[4,5] The reductions of bad cholesterol in large clinical studies of numerous PCSK9 inhibitors also demonstrated significant reductions in all-cause mortality and the rate of myocardial infarction (heart attack).

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