face to face

Rewriting the Prescription

Experts offer creative ways to control drug costs at the Drug Plan Management Forum.



BY ELIZABETH GAREL

Drug plan management is certainly in the midst of changing times, from ever-increasing costs to drug reforms and innovations. On Dec. 1, 2010, more than 100 plan sponsors and other healthcare stakeholders met to discuss these and other drug plan management issues. The half-day conference, held at Toronto's Sutton Place Hotel, was one in a series of the Face-to-Face Drug Plan Management Forums presented by *Working Well*.

Generic Influence

Over the past year, it has seemed as though not a month passes without a drug reform announcement somewhere across the country. "We are in the midst of massive changes. These are exciting times," said Jamie Foley, team lead, drug plans, economic research, with IMS Brogan, in Kanata, Ont., as she detailed the new face of healthcare in Canada.

Many of the drug reforms coming out of the provinces relate to generic drugs. Although generics represent approximately 20% of the $25-billion pharmaceutical industry, they make up more than half of all claims, Foley said, and that share is continuing to rise as patents expire on many key products. Genericization of Lipitor—the biggest brand drug in Canada—will have a particularly significant impact on drug expenses as, for example, the 20-milligram brand price of $2.08 drops to its generic price of $0.52.

Looking at generic drug policies across the country, Foley confirmed that British Columbia, Alberta, Ontario and Quebec have all adopted best prices for both public and private insurers. However, "Private insurers should be asking themselves, Is this a wise decision to allow the public plans to dictate the prices that the private sector pays?"

Foley focused much of her presentation on Ontario's Drug System Renewal (DSR), noting that "Ontario's policies tend to ripple across Canada." Under the DSR, generic prices will drop to 25% of the original brand name product for both private and public insurers, for an estimated $900 million in savings annually by 2012.

PHOTOS: DAVE STARRETT

"Clearly, the public side has influenced private prices," she said. The result is an estimated $60 million per year, which, according to Foley, is a significant impact.

In Quebec, the application of the Most Favoured Nation legislation is being phased in so that by 2012, generic prices in Quebec will equal the best price across Canada, which will likely be equivalent to the price in Ontario.

Interestingly, brand manufacturers are now negotiating with provinces over brand prices, a new development. "Is there an opportunity for the private sector and brand companies to negotiate?" Foley asked. "It appears that some brand companies are interested."

Many of these drug reforms—including a reduction in pharmacists' professional allowances to 5% from 20%—have an impact on pharmacists. "I expect that pharmacy will go after additional sources of revenue to make up for these losses and develop a new business model to deal with this new world," Foley predicted.

She sees potential opportunities for brand manufacturers. For example, Pfizer's GenMed division has entered tendering bids for generics in Saskatchewan and Nova Scotia. "However, this is becoming less appealing as the generic prices decrease and there is less to gain," she said.

Evaluating Drugs

If all formulary managers look at the same scientific data when evaluating a particular drug, why do some formularies decide to cover the drug while others do not? Kitchener, Ont.-based private health plan strategist Suzanne Lepage outlined the challenges private drug plan formularies face when comparing similar drugs and establishing their relative value.

One significant factor is that some scientific studies evaluate *efficacy* rather than *effectiveness.* Although these terms seem interchangeable, efficacy refers to "the degree to which the use of a drug produces a predefined benefit under carefully controlled conditions of a clinical trial," Lepage explained. Known as randomized controlled trials (RCTs), these studies usually address safety and efficacy and are conducted to meet the standards of regulatory agencies such as Health Canada. Effectiveness, on the other hand, measures the benefits and harms of a drug in the real world. Comparative effectiveness research (CER) compares a drug with its commonly used alternatives, while an RCT usually compares the drug with a placebo.

Lepage used the analogy of buying a car to explain the difference between the two types of studies. While a car has to go through regulatory checks and approvals—comparable to RCTs—few people go to the Transport Canada website when deciding which car to purchase. "Most of us go to *Consumer Reports, Lemon-Aid* or *Edmunds,* which are like comparative effectiveness research, and look at what's happening in the real world," she said.

Both RCTs and CER have their own particular limitations. For example, RCTs are conducted in ideal patients, who may not represent the average patient population. Protocols limit who can be included in the study, and those who qualify must follow a regimented treatment. Lepage cited one RCT study that found only 18% of real-world early rheumatoid arthritis patients would have met the criteria to be included in RCTs.

Another challenging factor in evaluating drugs is how to establish their relative value. "If you consider that value can be derived by assessing the benefit versus the cost, then the value will vary significantly depending on what factors you include in your benefit-and-cost calculations," Lepage said. Government drug plans, for example, value the impact of a drug on hospitalization rates and the healthcare system, while private payers are likely more interested in workplace productivity and absenteeism.

When comparing the relative cost of medications, Lepage emphasized that price should not be the only factor; plan sponsors need to consider other health benefits, disability and absenteeism, as well as indication and how the drug is used. A more expensive drug may be more

cost-effective if it allows a patient to return to work faster or requires a shorter therapy period than a lower-priced alternative.

There is currently no best practice for evaluating drugs for private plans in Canada, Lepage noted, although there are a few standardized assessments in the U.S. One such example is the Format for Formulary Submissions developed by the Academy of Managed Care Pharmacy, which serves as a template for pharmaceutical manufacturers' submissions of drug products for consideration by managed care organizations. Lepage hopes that one day Canada will see the introduction of such standardized templates, which would allow formulary managers to "compare apples to apples" when considering new drugs.

Paying Drug Claimants

As the prevalence of employees with tens of thousands of dollars in annual claims increases, employers are looking for ways to best balance employee health needs and employer costs. Tim Clarke, Aon Hewitt's health and benefits innovation leader in Toronto, reviewed some of the approaches to managing prescription drug claims.

Claims adjudication traditionally focuses on whether an individual drug will be covered under the terms of the benefits plan. Once that decision is made, there is no separate investigation into other sources of coverage, and employer programs cover the cost almost by default.

Clarke suggested that alternative sources of funding for these products should be maximized before turning to the employer's plan. For example, automatic provincial programs, such as the Ontario Drug Plan, offer coverage for drugs on provincial formularies, albeit primarily for seniors. There are also conditional government programs that vary widely according to province and requirement (such as income tests). "One of the challenges," Clarke noted, "is to ensure that we are maximizing the government payment where it is willing to pay for these products." Before turning to their employers' plans for reimbursement, employees can also look to specialty programs (including government, quasi-government and charitable agencies) and patient support programs offered by manufacturers. Too often, however, private payers don't pursue these programs, even though they are available.

Picking up on Lepage's car analogy, Clarke asked participants, "If your prescription drugs cost as much as a car, shouldn't you negotiate the price the same way you would when buying a car?" To ensure that the price is reasonable at all stages of the chain, these negotiations should extend to pharmacies, manufacturers and insurers. For example, flat-percentage pharmacy markups and adjudication fees may not be reasonable for high-cost drugs such as biologics. Clarke acknowledged that value-added services should be reimbursed, but "the model needs to be structured in such a way to handle some of these high-cost drugs."

Claims management is another area where benefits programs can be improved. An ongoing adjudication model, comparable to disability claims management, requires that employee actions be taken for ongoing drug coverage. "Why is it that on a $30,000 LTD claim we have all this rigour, but on a $30,000 drug claim we have a one-shot authorization and then the person gets carte blanche drug coverage?" he asked. "Eventually, a model could evolve to one where benefits are regarded as a joint responsibility, not an entitlement."

Key Messages

Following the presentations, a panel of representatives from various sectors of the Canadian healthcare system discussed the conference's key messages and offered their insights.

The potential benefits of case management outlined by Clarke resonated with Leanne MacFarlane, senior director, business development, with MHCSI in Dartmouth, N.S. "Pharmaceuticals are only as good as the way they are used. Having the drug reimbursed is the first step; ensuring that they

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are used appropriately and that we are getting the full value is the next," she said. Continuing with the earlier car analogies, she added, "It's like an employer giving an employee a car without ensuring they know how to drive, or without putting in airbags. With case management, you make sure they know how to use that car and arrive safely at their destination, which is a healthy outcome."

Positive outcomes will also be aided by greater collaboration among healthcare professionals, said Paul Foley, director, private healthcare, with Shoppers Drug Mart in Toronto. "There is tremendous opportunity for pharmacists and other healthcare practitioners through collaboration and expanded scope of practice to play a much more dynamic role in employee health."

Foley also predicts considerable consolidations, mergers and acquisitions within the pharmaceutical, benefits and insurance worlds, with the result being fewer but bigger players. "With that will come possibly a more American-style medicine."

Frederic Lavoie, director, patient access, with Pfizer Canada in Kirkland, Que., suggests, "If anyone is contemplating rationing access to healthcare resources, it should be targeted in the right areas, by disease, not unilaterally to all benefits. Maybe rationing in rheumatoid arthritis is a worse idea than in other areas because the burden to the private sector in terms of disability may be greater—although to my knowledge, very little work has been done to rank the impact of different diseases on disability and productivity."

As new drugs come to market, public policy will need to catch up with science, said John-Paul Dowson, senior manager, external relations, with AstraZeneca in Mississauga, Ont. Using the example of new oncologics, he noted that Ontario's New Drug Funding Program still predominantly covers in-hospital infusions despite many treatments being available as oral therapies. "In the pharmaceutical industry, we recognize that while the good-news story of patients coming back to work is great [for sponsors], it places a strain on affordability and sustainability. Five to 10 years from now, we should see some method to support private access, since proportionally, private insurers are covering more of the bill for take-home oral therapies." **BC**

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