A DIFFERENT DRUG PROBLEM

Prescription drugs underlie a looming financial crisis in employee benefit plans.

by Michael Sullivan

CANADIANS ARE ESTIMATED to have spent close to $20 billion on prescription medications in 2006. Approximately half that amount was paid by the private sector.

Since the beginning of the blockbuster drug era in the pharmaceutical industry in the 1990s, Canadian employers have been facing a steady stream of double-digit annual cost increases within their drug plans.

A number of forces have driven plan costs higher, including the introduction of blockbuster products like Lipitor, expensive lifestyle medications such as Viagra, and the first wave of exceedingly expensive biological therapies like Remicade. In the next decade, containing drug-plan costs even more difficult, with:

- the continued aging of our Canadian workforce and increased per-capita consumption of prescription medications. Increases in age-related chronic conditions such as high blood pressure, high cholesterol and diabetes require indefinite treatment with medication and, in many cases, with multiple medications.
- the proliferation of expensive biological products with annual costs well in excess of $10,000 per patient. There are more than 800 biological products in late-stage clinical testing in North America.
- the changing paradigm of treating various forms of cancer as a chronic disease with oral therapies as opposed to a terminal illness that can be kept at bay only by injecting toxic chemotherapy agents in cancer clinics. Thus, the cost burden will shift from the public to private payers as these targeted oral therapies are purchased at retail pharmacies and taken by patients indefinitely.
- the introduction of novel, expensive medications to treat common disease states. For example, new therapies for diabetes and insomnia will increase the daily cost of treating these conditions significantly.
- the continuous downloading of the coverage of expensive new drugs to private plans. Claims will increase in any private drug plan that covers any prescription drug with a Drug Identification Number (DIN) written by a licensed doctor with very few exclusions (i.e. the vast majority of plans in Canada).

However, the biggest threat to universal cost containment in drug plans is that, in the Canadian system, there is no accountability. Patient A visits service Provider B (in this case the physician). Provider B acts as a gatekeeper, because a prescription is required for access to the drug. However, the cost for service is paid for by Third Party Payer C who is not involved in the prescribing decision. Physicians currently have no incentive to prescribe cost-effectively. They can select the therapy they choose without considering price. With physicians constantly detailed by the brand-name drug industry, it's little wonder that the rate of generic medication prescribing in Canada is roughly half that of managed plans in the United States.

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In the meantime, drug-plan management is becoming a much more critical issue for employers of all sizes in Canada. It can be defined as any activity that encompasses looking at immediate opportunities for savings within the drug plan without changing plan design; quantitative analysis of financial and utilization trends; strategic planning for future plan design change, and/or solutions that attempt to decrease the future inflationary trend within the benefit without adversely affecting plan members.

Figure One is an example of employers for whom we have recently completed work. It highlights their drug-plan experience, reasons for the trend, and the opportunities available for practical drug plan management.

Simply modifying existing plan designs in the face of poor financial performance is not always an option for groups. In the case of Employer A, it has union contracts in place preventing modification to its existing drug plan. Employer C recently made changes to its plan, and any further changes would not be well received by employees. In the case of Employer D, a lack of skilled workers has made management justifiably uncomfortable about modifying benefits with a perceived take-away by current employees.

With these practical considerations in mind, the first step in drug-plan management should be to assess whether there are opportunities for savings within the current plan design that do not require changes. Can immediate returns be found within the existing design? This allows the employer to answer the following questions:

- Are any costs caused by problems associated with the adjudication of the existing claims? Will the amount of savings available from resolving these current adjudication and plan performance issues significantly lower the cost trend?
- How long will the plan in its current

form allow for acceptable cost containment? When will some kind of plan-design change be required?

Figure 1

Employer	Description
A	Public sector employer, 2,300 plan members, drug plan costs in most recent year increased by 25% to $2.5 million
B	Private sector (manufacturing), 1,200 plan members, drug plan costs increased by 20% in most recent year.
C	Private sector (professional services), 400 plan members, drug plan costs increased by nearly 20% in the most recent year.
D	Private sector (health care), 250 plan members, drug plan costs of $248,000 in most recent year and a per claim cost of $111 (nearly double the Canadian average)
E	Non-Profit (advocacy association), 600 plan members, drug plan costs increased by $60,000 or 30% in 2006.

In each of these examples, the financial performance of the plan was poor but the reasons for the underperformance were different. In the case of Employer A, who saw a $500,000 or 25% annual cost increase, there are significant opportunities for optimizing the existing plan. The plan does not have appropriate limits in place for key drug classes that would help prevent abuse or overuse of expensive medications. This has cost the plan an additional $19,000. Medications for chronic conditions in a number of cases were being filled for monthly as opposed to quarterly supplies. This cost the plan more than $15,000 in excess dispensing fees.

There were also key adjudication issues with Employer A's plan: $55,000 was paid for claims for plan members who were no longer eligible for drug benefits, more than $50,000 was paid for over-the-counter (OTC) medications ineligible for coverage, and $12,000 was paid for drugs specified as exclusions in the plan description. Thus there are significant opportunities here to optimize the current plan before considering plan-design changes and strategies for longer-term cost containment.

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Employer B had a cost increase of $100,000 or 20%, but once again, there are numerous areas for optimization of the current plan that would have a significant impact on lowering that increase. The plan paid more than $16,000 for brand-name pharmaceutical products that had generic equivalents available. In other words, plan members were requesting the more expensive brand products at the expense of the plan, despite an identical product being available at 30%-50% less cost. This plan also incurred $25,000 in excess spending on dispensing fees for monthly supplies of maintenance drugs and $14,000 for OTC medications ineligible for coverage.

Employer C had some fascinating issues with expensive biological drugs. In its most recent year, specialty drugs accounted for only 0.8% of the number of claims but more than 16% of plan costs. The average cost of these specialty-drug claims was $1,822 per claim versus $49.70 for all other claims.

The situation with Employer D was equally as interesting. Spending on narcotic medications within this plan was nearly 14%, well above the national average. While 57 out of 250 claimants made at least one claim for a narcotic prescription (which is very common following dental appointments, acute injuries that require an emergency room visit, etc.), the top three narcotic claimants accounted for 95% of all narcotic spending. The top two claimants both claimed in excess of $13,000 each for narcotics in one year. This finding was even more concerning given that these top two claimants had no other claims on file indicating the presence of a chronic, debilitating condition such as multiple sclerosis, rheumatoid arthritis or cancer, and, in each case, the number of oxycodone-based narcotics (i.e. OxyContin tablets) greatly exceeded the quantity that would be considered appropriate even for someone with a chronic pain condition. (It should be noted here that all of the analyses completed were done using non-personally identifiable drug-claims data, ensuring that individual privacy was protected. The goal is to optimize plan design and ensure responsible utilization, not to identify high-cost individuals thereby breaching existing privacy legislation.)

Finally, Employer E faces a good news, bad news story. The good news: the plan's utilization was appropriate, there were no specialty drug claims or catastrophic disease states present, and the adjudication was extremely good. The bad news: there were no easy answers to explain the $60,000 increase in cost, a significant burden to a not-for-profit group of this size. It would appear that age-related chronic conditions are driving plan costs in this group, and the only path to long-term cost containment will be through a modified plan design.

Once the above issues have been identified and groups understand their situation in light of the financial and utilization evidence, those needing to modify their plan design can consider the following:

- examining existing drug utilization patterns to determine both the disease state and demographic profile of their plan population to select plan design modifications that will allow for long-term cost containment and sustainability;
- modeling the impact of proposed plan design changes using their actual claims experience to ensure that any modifications to the plan will achieve the goal of long-term cost containment without adversely affecting plan members, and
- establishing baseline metrics to prioritize their strategic focus and to evaluate the impact of possible wellness initiatives.

Employers need to continue providing a drug-benefit plan because they require healthy, productive employees. Furthermore, employees rate the prescription drug plan as their most important benefit.

At the same time, employers need to realize from the examples above that there may exist opportunities for immediate savings without altering the existing design. They have to design plans that will meet their financial and corporate goals and find ways to educate their employees about maximizing the cost-effectiveness of the drug benefit plan to ensure its sustainability.

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