

A MATTER OF TIME



Plan sponsors will have a break from high cost trends within their drug plans. The key is to use the time wisely to keep costs down in the future. **BY CHRIS VON HEYMAN AND MIKE SULLIVAN**

The next one to two years may bring better days for Canadian drug plan sponsors. The cost drivers that have contributed to double-digit cost inflation within these plans since the late 1990s are well documented, but there are subtle factors which may provide calm before the next storm. However, that storm will be far more detrimental to the financial viability of plans than anything we have seen to date. Therefore, plan sponsors who use this period of relative tranquility wisely and plan strategically for what is ahead should benefit significantly both immediately and over the longer-term.

The calming effect is coming from a few directions. There have been some major generic medication launches over the past year, with the potential for more in the year to come. At the same time, some significant product failures in late stage development recently have kept potential new blockbuster drugs off the market. Finally, increased scrutiny at the regulatory level has led to a decline in the emergence of new therapies on the market.

The clouds on the horizon feature new and expensive diabetic drugs, oral chemotherapy agents, innovative sleep disorder therapies, and a tidal wave of biologicals. While the future looks exciting for patients, it looks exceedingly bleak for payers who have not done the work needed to prepare for what's ahead. The next year or two is an ideal time for plan sponsors to focus on responsible cost containment through meaningful plan design change.

THE STARTING POINT

Many plan sponsors and advisors feel that if truly innovative and effective plan designs existed, cost containment wouldn't be such a concern. However, many stakeholders have been waiting for "innovation" instead of investigating practical and focused plan design changes available today. Innovation is seen as the remedy to our challenges in managing costs. Such an approach assumes we do not have the tools for the job, or that we have maximized all other solutions to date. This is not the case, and hence, a focus back to fundamentals is likely the best initial answer for most groups.

No plan design innovation will be successful unless we begin to focus on education and modifying behaviour within the plan. It has



been fascinating to see a vast majority of plan members have little or no idea what their drugs cost unless they are on reimbursement plans. If plan members knew there were very cost-effective options for most common chronic and acute illnesses, and that by better managing these costs, more resources would be available to pay for drugs for more catastrophic conditions such as cancer, rheumatoid arthritis, HIV, and MS, they would be more likely to do their part in managing their benefit.

The vast majority of spending (i.e. 90% or greater) in most plans is for non-specialty drugs that treat common conditions. A focus on becoming more cost-effective in this area will have profound benefits. According to data published by ESI Canada, less than 40% of groups in 2006 had generic substitution as part of their plan design. Not to suggest that generic substitution will solve all of our problems, but it is frightening to see how few groups automatically incorporate this into their plans, let alone educate their employees about the importance of making cost-effective choices.

The most apparent short-coming of existing plan designs, which needs to be addressed before any innovations can even be considered, is the inadequate contract wording and plan descriptions that currently exist. The marketplace is exceedingly dynamic and the Canadian landscape is further complicated by provincial asymmetries as they exist in key therapeutic classes like oncology. Public plans have been able to capitalize on ineffective design and contract wording and begin downloading to the private payer market. Current contracts typically do not adequately define inclusions and exclusions, nor are they set up to optimally coordinate with the public system leaving plan sponsors with material potential liabilities.

Expanding Limitations - Looking at the Bigger Picture

Given that groups currently have plan limits or exclusions for drugs used to treat conditions such as erectile dysfunction, hair loss, or infertility, it seems strange that there appears to be an industry-wide problem implementing annual limits on other classes that have the

potential for misuse or abuse such as narcotics. There needs to be better collaboration between plan sponsors and carriers to make some of these practical design changes a reality for a larger number of groups.

Managed Formularies – The Lost Innovation

It is interesting to consider why all prescription medications are treated the same way in a vast majority of plans. If a drug does not add any additional therapeutic benefit over a similar, less expensive medication, why should it be reimbursed equally? ESI Canada has published statistics for 2006 that indicate that only 6.5% of groups have some form of customized formulary. That compares to 90% in the U.S. marketplace where managed care is a staple.

Consider the vision care benefit: a plan sponsor is effectively saying that they want to ensure the plan member has adequate access to products that will correct vision impairment. Many plans will include annual limits to the benefit (e.g. \$200). If a plan member decides that he or she wants designer glasses that cost \$400, they are on the hook for the remainder. The \$400 pair of frames is no more effective than the \$200 pair of frames. What makes prescription drugs so special that they should be absolved of any value considerations? If we do not deal with these questions now with relatively basic pharmaceutical products, it will be exceedingly difficult to deal with targeted oral chemotherapy agents that benefit only specific patients or expensive adjunctive therapies for diabetes that look at other hormones besides insulin.

Canadian plans currently have generic penetration rates of just over one-third (by number of claims paid.) The figure is roughly half of the 60-65% generic penetration rates now seen in American plans. They accomplish this by incenting plan members properly. Simple tiered

plan designs that incent plan members towards the most cost-effective options whenever possible would make a world of difference.

This does not imply that there is no place for innovative products. This simply states that plan members should be financially incented and rewarded for making a cost-effective choice whenever the opportunity presents itself to ensure that the plan can afford coverage for those truly innovative products. If a plan has 80% co-insurance across the board, keeping brand-name co-insurance at 80% and moving generic coinsurance to 100% can still positively impact plan costs.

BRAVE NEW WORLD

With innovative drugs coming to market, and key changes emerging that will change prescribing paradigms (e.g. targeted oral chemotherapy agents), there will be a need to consider some novel approaches to the way plans are designed once the fundamentals have been addressed. Plans need to begin looking at viable ways of carving out specialty drugs from the general drug plan benefit, and move to a case management approach where the plan actively looks for financial support from both public and other private sector programs before becoming the payer. Private plans that are redesigned to involve case managers that seek reimbursement assistance programs to share the financial risk, and who are there to assist in optimizing therapy, could have a significant impact on containing costs and ensuring the sustainability of the plan as a whole. **BC**

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