

face to face



DRUG PLAN MANAGEMENT FORUM

Canadian medication costs are on the rise. In 2005, they reached almost \$25 billion, according to a report released by the Canadian Institute for Health Information (CIHI). This constitutes a staggering 11% increase over drug spending from the previous year.

Medication spending continues to be the fastest-growing category of health spending, and prescription drug costs account for a majority of overall drug costs. This growth trend is considered unsustainable by many critics and constitutes a growing area of concern for employers who are trying to contain their benefit costs while maximizing outcomes.

On November 29, 2007, in Toronto, *Benefits Canada* and *Working Well* joint-hosted the Face-to-Face Forum on optimizing drug plan designs. Professionals from varied backgrounds brought their expertise to the table to discuss the different issues facing drug plan managers as we move forward under changing economic and fiscal conditions. Panellists recognized

that drug plan managers struggle with the challenge of safeguarding employee health while containing costs. Key issues they identified included the importance of a solid business case for benefit investment, the effect of drug plan compliance on outcomes and how new public policy will impact private drug plans. An expert panel answered questions from the audience. We are pleased to present the highlights of the Forum in the following pages.

Building the Business Case for an Investment in Benefit Design Change

Drug plan costs are on the rise, due in large part to an increase in prescription drug use. **Mike Sullivan**, co-founder of **Cubic Health Inc.**,

has spent his career working within the benefits, insurance and pharmaceutical sectors. In the last 10 years, he's seen enormous changes in the drug plan landscape. Now more than ever, drug plan managers have to consider how to limit their drug plan costs while serving the health needs of their employees and supporting the core business of the employer. Collaboration among all departments, notably human resources and finance, is the key to success moving forward.

As Sullivan notes, "Reducing costs and improving employee health and productivity is an enormously complex question." Decreasing drug spending might not always be the answer. Increasing spending in certain areas could have a profound effect on a company's short- and long-term disability costs, especially in areas such as mental illness. Therapies for depression can cost as little as \$1 per day. Investing in these therapies could mean a slight increase in cost, but the overall impact on employee health and productivity could be enormous.

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Mike Sullivan



Michael Sokol



Beth Gearing



Alice Tseng

According to Sullivan, “If the drug spend is responsible, if it’s relevant, if it has value, then it can have a profound effect.”

He does, however, acknowledge that there are areas where costs could be better managed. Sullivan suggests a strategy that involves both human resources and finance professionals in any organization—small companies, mid-size organizations and large corporations alike. “Where I’ve seen the most success is where HR is aligned with finance,” he says. “As soon as we have the numbers on our side, then we can get the attention of the decision-makers and the plan sponsor.”

Together, human resources and finance can develop a business case that incorporates all the data available: short- and long-term disability data, absenteeism and any other data available at the plan sponsor level. Drug plans provide a wealth of data on which a solid business plan can be built. Drug claims data covers 70% to 80% of employees, depending on the company. “In situations where you have a pay-direct plan,” Sullivan explains, “you know every paid, every reversed, every rejected claim made to the plan. If you have a reimbursement plan, you still have information you can use.”

Once this data is collected and analyzed, companies have a framework for measuring and evaluating wellness programs, and health initiatives within the program. Using the metrics that have been isolated and measured, it’s possible to measure their investment in things

beyond plan design. “It is not perfect, but without any tangible model in place, nothing will happen,” Sullivan says.

Using this data, managers can create a predictive model to plan for the future. Plan managers can look at the current disease state and demographic profile of a group. Sullivan explains that it’s important to look at the factors that are unique to every group. “In most cases, in a group of a given size, cardiovascular therapies will be at the top of the list of spending,” he says. Across the country, about 20% of spending is in cardiovascular therapies, so it is reasonable to expect that this will be the case for most groups. However, as Sullivan cautions, “It’s not enough to build your business case on your knowledge of the top three or five disease states.” Even within the cardiovascular therapy group and certainly outside it, the rate of change of spending in disease states will differ.

The Impact of Drug Benefit Design on Medication Adherence and Outcomes

According to the World Health Organization, “increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments.” Getting patients to take their medication is a significant challenge. Medication compliance only averages 50% in the developed world. This results both in poor health of the patients who do

not comply and increased health-care costs for their employers.

A 2005 study shows that patients in the U.S. walk away from a doctor’s visit with a prescription almost two-thirds of the time. However, many of these prescriptions will go unfilled. As **Michael Sokol**, medical director of **Health Management Innovations**

explains, there are many factors that affect a patient’s choice or ability to take prescribed medication. These can range from difficulty getting the prescription filled to just forgetting to do it. Almost one in five patients did not get a prescription filled because it was too costly.

It might seem counterintuitive to assume that increasing the investment in drug coverage would save an employer money, but Sokol illustrates how this can be true. He poses a poignant question: “Is it really wise to initially have some savings by having patients pay more of the drug costs, when down the road this could actually increase your total costs?” A patient’s adherence to medication can have a significant impact on direct medical costs and indirect costs like productivity, disability and absenteeism.

To illustrate this relationship, Sokol turns to practical examples. Perhaps the most striking of these can be found in his case study of Pitney Bowes, an international company with over 35,000 employees. Concerned about the health of their employees, Pitney Bowes undertook an analysis of their employees’ health and compliance with medication. For them, Sokol explains, “Predictive modeling was a very accurate exercise.” They discovered that about half of their population had some kind of chronic disease, such as diabetes, asthma or heart disease.

Pitney Bowes began to examine their co-pays. Were they too high? They wanted to lower the barri-

ers that kept their employees from being healthy or adhering to their medication. This was a daunting task, to approach the CEO with the idea of increasing the company's burden of medical costs at a time when healthcare costs were steadily rising. The predictive modelling exercise turned out to be key, as Sokol says, "because they had good modelling data behind them, they felt strongly that they were going to see an impact."

The company took on a larger share of the costs for all medications to treat diabetes, asthma and hypertension. In some cases, this meant decreasing the amount the patient would pay from 50% to 10%. Surprisingly, the company's

2006, Bill 102, the Transparent Drug System for Patients Act, amended two pieces of legislation: the Ontario Drug Benefit Act (ODBA) and Ontario's Drug Interchangeability and Dispensing Fee Act (DIDFA). In February 2007, Quebec also set in motion a series of changes with 29 Ministerial Directions that spell out the province's drug policy and vision for the future.

Beth Gearing, partner in the Corporate Law group and Life Sciences group, and **Alice Tseng**, partner in the Intellectual Property group and Life Sciences group, both at **Blake, Cassels & Graydon LLP**, highlighted some of the key changes and what they may mean for private payers moving forward. As Beth

the original product. However, this pricing applies to the public system only. As Tseng explains, "this means the same drug will be sold for two prices, depending on which patient is going to be taking it—an ODB patient or a private payer patient."

Another key change involves rebates. Once permitted in Ontario, now rebates cannot be provided by manufacturers to pharmacies and wholesalers for drugs that are listed under the ODBA or designated as interchangeable with another product under the DIDFA. They cannot be accepted, either directly or indirectly, by pharmacies or wholesalers.

While rebates are prohibited, professional allowances, in the form of cash, services or educational materials for the purpose of direct patient care, are permitted. Examples of professional allowances are continuing education programs, clinic days or prevention initiatives. Under the new legislation, professional allowances in Ontario are limited to 20% of the drug benefit price for listed drugs under the public payer system. There is no limit on professional allowances for interchangeable drugs that aren't listed on the formulary.

Where once Quebec differed greatly from Ontario in its approach to rebates, now the two provinces are more aligned in their policies. One of Quebec's key Ministerial Directions permits professional allowances up to a 20% threshold, a move that's reminiscent of Ontario's legislation.

Tseng identified other trends shared by the provinces, including the emergence of more aggressive stakeholders (both provinces require paybacks and contributions in certain circumstances), increased accountability in the form of stricter reporting requirements for professional allowances and increased transparency.

A patient's adherence to medication can have a significant impact on direct medical costs and indirect costs like productivity, disability and absenteeism.

pharmacy costs went down, because patients could now take medications that were more appropriate for their condition. For example, asthmatics were more likely to take "controller" drugs to prevent an asthmatic attack, rather than "rescue" medications that would treat them only in the midst of an attack.

The most significant savings to the company came in the form of short-term disability costs, which were cut in half. Within one year, Pitney Bowes estimated savings of \$1 million. In three years, this figure was \$2.5 million, and after five years, it stands at \$4 million.

Examining Public Policy's Influence on Private Drug Plans

In the past year, legislation has come into effect that will profoundly affect the way private payers operate in both Ontario and Quebec. In

says, "there has been a huge change in business practices and business models of various stakeholders in the healthcare system. Wholesalers, generic manufacturers and pharmacies have really had to take a look at how they conduct business."

The changes brought about by Bill 102 include lower pricing on generic drugs, an expanded definition of interchangeability of drugs and a prohibition on rebates coupled with the permission of professional allowances.

Perhaps the change that will have the greatest impact on private payers in Ontario is the institution of a two-tier system of drug pricing. According to the Canadian Institute for Health Information, private insurers paid \$7.6 billion in prescription drugs in 2006, representing almost 36% of prescription expenditures. Under Bill 102, generic drugs will now be listed on the Formulary at 50% of the drug benefit price of

Minimizing Drug Plan Costs Q&A

Panellists for the minimizing drug plan costs Q&A included:

Kayte Fredrickson, Account Executive, Desjardins Financial Security; **Marilee Mark**, VP Marketing Services, Group Benefits, Manulife Financial; **Leanne MacFarlane**, Director, Business Development, Managed Healthcare Services Inc. (MHCSI); and **Paul Foley**, Director, Private Health Plans, Shoppers Drug Mart.



Kayte Fredrickson



Marilee Mark



Leanne MacFarlane



Paul Foley

Q What is the best way to approach employee benefits to save on prescription costs?

A **Kayte Fredrickson:** Most employers have a healthy population. There are always a few high users that have chronic conditions, but the expensive long-term medication comes in where there are risk factors that can be controlled—for example, smoking, weight, diet or exercise. When designing a benefit plan, you need to work on communication, education and letting employees know what they already have. An EAP program is critical. Often it is the first contact someone makes, because they don't want to go directly to their employer.

Q What evidence is there that managing costs through health management are paying off?

A **Paul Foley:** A lot of the evidence comes out of the U.S. They have the advantage of being able to capture not only drug costs, but the downstream costs associated with it. In Canada, we have a real challenge in terms of being able to identify an intervention as it relates to hospital visits, ER visits and other downstream costs. We need to rec-

ognize the validity of the data coming out of the U.S. and start to apply it here in Canada. We have to make some assumptions that if we do the right things and model it similar to what the U.S. is doing, we will start to see the outcomes here as well. The evidence is there, it's strong and it continues to grow.

Q We've heard several perspectives on investing in health to improve compliance and outcomes. How do you balance this with managing the overall drug benefits spend?

A **Marilee Mark:** First, you need to have a good idea of where your spend is going and what drives your costs. You can't manage what you haven't measured. And you have no way of knowing change over time. Then, determine your organization's intent and philosophy around benefits. This will also direct you in what you're prepared to support from a senior management level all the way down to what employees will accept. Then put in place some of the low-hanging fruit that aren't as invasive to plan members, such as communication and generic substitution. These things make us smarter consumers. How you proceed will depend on what you've found and your organizational strategy.

Q What is the role of the individual plan member in containing drug plan cost? How can employers get them more engaged?

A **Leanne MacFarlane:** It can be effective to give employees a statement of their account. Show them annually what has been invested in them with respect to their benefits plans. People are often unaware and it's an eye-opening experience for them to see those numbers.

Many plans make changes over the years. The ones that have gone well—whether it's a bad news story or a good news story—are the ones that have been well communicated to the plan members. If that's not done well, it's chaos.

Q Are employers ready to invest more with the expectation that they will see savings in disability costs down the road? If not, what information or assurance will they require?

A **Marilee Mark:** It's hard to put something in place and take it away if you don't see the results you wanted to see. Because of that, you see more pilot programs. Employers will take a specific approach to a disease state where they can more easily say, "we're going to put in place a comprehensive program and measure on this basis."

For those with a managed plan, it can be a good idea to decrease the co-pay or give an incentive—make it the path of least resistance. At the same time, combine this with some accountability on behalf of individuals participating to potentially take part in a health risk appraisal or a program, of which the medications would then be a part.