



Benefits ^{CANADA}

PA programs: missing the target

Mike Sullivan | March 03, 2011



Between 1998 and 2008, the most popular topic of conversation in drug plan management was the brave new world of expensive specialty (i.e. biological) drugs. As everybody knows, the fear was that these revolutionary new therapies would hit plans and drive costs to unsustainable levels. The only problem was that during that period, it never happened—at least not for a vast majority of plans.

The evolution of apathy

In some ways, a lack of significant growth in specialty drugs back then was the worst thing that could have

happened to plans because a focus on appropriately containing costs on the non-specialty side of plan experiences, and implementing meaningful and equitable prior authorization (PA) programs disappeared. It was as though the group benefits industry was “crying wolf” with respect to specialty drugs and we grew numb to the repeated warnings. Plans missed the opportunity to implement PA programs that could ensure appropriate use of limited resources. This was the beginning of the biggest missed opportunity for managing high-cost drug claims.

Then, a funny thing began to happen about seven years ago. These claims started to appear more commonly, but not at a dizzying rate. In most cases, specialty claims made up a fraction of one percent of all claims. The industry as a whole ignored the trend, offered new stop-loss pooling options to those who asked for it, and developed very simplistic PA programs that basically required a specialist fill out a form before a specialty claim was approved for the member.

PA programs became a rubber-stamping process because they evolved with no substance. Somehow stop-loss coverage seemed to be enough, and meaningful PA programs fell by the wayside—they were either too complicated or too burdensome, or the problem was apparently not significant enough to worry about.

What’s happening today

The wolf was more cunning than most ever imagined. As opposed to bursting onto the landscape 10 years ago and wildly inflating plan costs in a very short period of time, the growth of both biological (e.g. Remicade, Humira, Enbrel and Rebif) and non-biological specialty drugs (e.g. Gleevec and Sutent) was slow and steady, lulling the industry to sleep. The odd high cost claimant wasn’t a big deal if plans had relatively inexpensive stop-loss coverage.

Here’s where we are today.

Specialty drugs are far away the fastest growing segment of drug benefit plans, and now account for over 15% of

overall plan spending on average.

Specialty drugs are commonly responsible for at least 40% of year-over-year plan cost increases year-over-year in medium- to large-size plans.

Some of the blockbuster specialty drugs have gained even greater market share by applying for approval to treat additional indications (i.e. disease states) once approved on the market for an initial, specific purpose.

Clinical guidelines are changing in many disease states and more aggressive specialty therapies for catastrophic diseases are being used earlier, especially in younger patients.

There is greater public sector downloading of these products given their cost—hospitals and government plans are looking for private plans to pick up cost burden wherever possible to protect their budgets.

In 2010, 57% of new drugs approved south of the border were specialty drugs, and that trend shows no sign of slowing down.

Between 1980 and 2009, there were 20 oral cancer drugs brought to market in the United State and that number is expected to *double* by 2014.

Members are getting diagnosed much earlier with chronic diseases such as rheumatoid arthritis, multiple sclerosis, Crohn's disease and cancer. Advances in therapy have allowed members to live longer with these such conditions, the impact on drug plans is that the claims for these disease states are no longer one-offs on plan experiences. Many reoccur after year.

If stop-loss insurance is designed to insure against unforeseen, catastrophic claims at some point in the future – what will happen to stop-loss premiums moving forward (or stop-loss coverage altogether) given that many of these claims are no longer unforeseen and recur year after year?

Case Study: A lost opportunity

A plan sponsor with more than \$6.5 million in plan spending in 2010 saw its specialty drug spending increase more than 35% in one year to a total of 19% of plan spending. More than 70% of the plan's spending on specialty drugs was for chronic claims that are very likely to reoccur with the plan experience next year.

However, the plan does not have a PA program that considers the following items.

- Specific eligibility criteria for initiation of specialty drug therapies based on current treatment guidelines.

- Specific eligibility criteria for the continuation of specialty therapy in cases where benefit of therapy can be objectively measured.

- Preferential listings in key classes where there are multiple options with similar proven efficacy.

- Case management that involves coordination with manufacturer sponsored patient support programs.

Taking action

Plan sponsors are financing an ever-growing share of expensive specialty drugs without paying adequate attention to what could be done to adequately manage this burgeoning area of plan spending.

Here are some questions plan sponsors should be asking about their current PA programs to ensure they are adequately designed to meet their needs in the coming years.

- What products are covered under our PA program? How is this list determined?

- What clinical criteria (if any) are employed to determine member eligibility for a given specialty drug or does the current program simply require a physician to fill out appropriate paperwork?

- How often are these criteria updated given the new therapies that are coming to market and the rise in off-label (i.e. unapproved) use of specialty products?

- Does our existing PA program consider criteria for continuation of therapy or does it look only at the first claim?

Does our PA program offer preferential listing options in key classes of specialty drugs?
How well does our PA program intersect with existing patient support programs?

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