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Controlling Drug Costs And Meeting Claimants' Needs

By: Dan Clark

The growing cost of prescription drugs may be the most difficult challenge facing **benefit plan sponsors** today. For private **health** plan sponsors, drugs are the highest single cost category, accounting for 60 per cent to 85 per cent of all **health benefit** expenditures depending on plan design and demographic mix of the covered group. Year over year, drug **benefit** costs continue to increase at double-digit rates (14 per cent to 18 per cent in recent years) and that trend's not expected to improve, given the prevailing influences.

Research advances deliver a steady stream of new and better drug therapies, but can we afford the abundance of blockbuster, breakthrough, and specialty drugs coming to market?

In this article, we take a look at the risks that could affect the sustainability of your drug plan and some strategies for controlling future costs.

The Cost Drivers

A number of factors combine to maintain upward pressure on drug benefit costs.

◆ Population Aging

Simply put, as we age, more of us will need to use more drugs, more often. Many plans are experiencing the impact of aging along with the baby boomers.

◆ Biotechnology and Research Advances

It's estimated that there are 300 new biotech drugs in the development pipeline, many of which will be available by 2010. These new 'specialty' drugs carry bigger price tags than existing therapies and often gain rapid acceptance and use, which can have a significant impact on private drug plan costs. Express Scripts, a national pharmacy drug manager, reported that specialty drugs accounted for 19 per cent of U.S. pharmaceutical spending last year, which is projected to increase to 28 per cent of total drug expenditures in the next three years. We see similar patterns in Canada where access to some specialty drugs can be faster and easier under private plans.

◆ Primary Care Changes and Shorter Hospital Stays

Changes in treatment regimes have resulted in shorter hospital stays and more out-patient focused care, which means that, increasingly, private plans are paying for some high cost drug therapies that would have been covered by the public health system in the past.

One example is the proliferation of private infusion clinics set up to administer new intravenous (IV) drugs used in cancer treatment which are not covered by Cancer Care Ontario. Traditionally administered in hospitals, now cancer patients must purchase the drugs which are administered in a private infusion clinic. The cost of the drugs and their administration are the patient's responsibility and, to the extent they are eligible, the patient's private drug plan.

◆ Blockbuster Drugs

We've seen the impact of new 'blockbuster' drugs, such as the Cox-2 inhibitors – Celebrex and Vioxx – and erectile dysfunction drugs such as Viagra. They quickly became drugs of choice, placing in the top five or 10 drugs by cost under the majority of private drug plans. The cost impact of such drugs is unmistakable and significant, but the related health outcomes are less clear.

◆ Breakthrough/Specialty Drugs

Even the most standard private benefit plan covers a number of drugs for which annual costs exceed $20,000 for a 'usual dosage.' For many of these drugs, annual costs could potentially exceed $100,000, at higher dosages. The cost and increasing use of these drugs presents a serious risk to many private plans.

Chart 1 lists some drugs in this category, along with the related health condition, estimated annual cost based on usual dosage, and expected number of claims per 100 covered members (per capita) as reported by national pharmacy manager ClaimSecure, based on claims data for its total book of business.

Translating this data suggests that a plan covering 2,500 members can expect a claim for Remicade every year at an estimated cost of $24,000. In fact, claims for such drugs often occur in much smaller groups where the effect on costs and affordability is more dramatic.

◆ Specialty Drugs

Although not typically covered under 'standard plans, specialty drugs may be automatically covered under some private plans unless specific steps are taken to restrict or exclude them. Included in are some of the new IV drugs mentioned earlier, as well as very high cost drugs used to treat rare Gaucher and Fabry diseases.

Many provinces and/or hospitals have discreet specialty drug programs, which come into play when coverage isn't available under a private plan.

Exploring Effective Drug Cost Control Strategies

Predicting future drug costs and trends is increasingly difficult due to emerging developments and, clearly, the picture isn't rosy from a cost or risk perspective. In this era of increased personal choice, some flexible plan sponsors may want to review plan designs that include a 'gold standard' option with open access to all legally prescribed drugs.

There's no silver bullet. Controlling costs is near to impossible for drug plans that offer open access to all drugs, regardless of cost. In the longer term, what's needed is more focus on step therapies, appropriate prescribing protocols, health outcomes, etc. In the meantime, there are a number of blunter techniques which can help to limit the risk to drug plans – some restrict access, others deny access to certain drugs, some simply transfer costs to plan members, and others are more strategic – and can reduce total drug costs. Depending on an organization's priorities and benefits objectives, it may be time to take stock of the drug plan.

Here are some drug cost containment options to consider:

- Generic Substitution – This is a longstanding common practice whereby a drug plan restricts payment to the lowest cost available (generic) drug which is chemically the same or 'bioequivalent' to the prescribed (brand name) drug. Generic substitution has been in pharmacy guidelines in some provinces, including Ontario, for many years and its use is widespread. Generic substitution has no effect on the cost of newer 'single source' high cost drugs, many of which have no bioequivalent alternatives at this time, and represent a big part of drug plan costs.
- Therapeutic substitution – This approach substitutes a less expensive, but effective, alternative to a brand name drug (which is chemically different). For example, in the past, Losec generally ranked second or third on most drug lists. Gradually, new gastro drugs (for example, proton pump inhibitors) were introduced. Now Losec is further down the list, but three or four new gastro drugs appear in most plans' top 20 lists. Therapeutic substitution is generally used in conjunction with a modified formulary, discussed later.
- Dispensing fee caps – With these, drug plan reimbursement limits restrict payment of the pharmacy's dispensing fee to a specified amount and the plan member pays any balance. While this technique may reduce the overall cost of most drug plans, it has limited impact on very high cost drugs as the dispensing fee represents a small fraction of the total cost of such drugs. It remains to be seen what impact will result from the introduction of fees for cognitive pharmacy services.
- Drug formularies – Drug formulary options abound! Theoretically, benefit carriers/ pharmacy benefit managers can administer an unlimited array of formularies, which are simply lists (static or dynamic) of eligible drugs. Drugs not on such formularies are excluded, or approved only by exception.

New drugs are not automatically included, providing a barrier against many new high cost drugs, but plan members may not be able to afford an ineligible drug which is vitally needed. This disadvantage can be managed through a claims appeal process which considers the merit and expected impact on the plan of special cases.

'Therapeutic formularies' cover a defined list of drugs which is reviewed and assessed periodically for therapeutic effectiveness. As new clinical information becomes available, drugs are added or removed. Such formularies cover the majority of drugs found on typical 'prescription-required' drug plans. Excluded items include 'me too' drugs which offer little advantage over the existing (less costly) therapies. Lifestyle/ discretionary drug categories – such as smoking cessation, anti-obesity, or erectile dysfunction/fertility – are usually not covered. These drugs may be covered under a secondary benefit provision at limited or lower levels, or excluded altogether.

Multi-tiered reimbursement plans – Multi-tiered plans limit exposure by applying varying reimbursement levels. Tiers can be defined in a number of ways – by categories of drug dispensed, providers, or covered persons. Savings depend on reimbursement levels. Following are three examples:

◆ By Drug Dispensed

- 100 per cent for generics
- 80 per cent for brands, where there is no generic, but for which a similar drug exists
- 50 per cent if a brand is used and a generic exists

◆ By Provider

- 100 per cent for preferred provider network pharmacies
- 90 per cent for mail order pharmacies
- 75 per cent for all other pharmacies

◆ By Covered Person

- 100 per cent for employee
- 90 per cent for spouse
- 80 per cent for all other dependents

Two-tier reimbursement plans are more common than three-tier plans as described above which are rare – the likely reason being carrier-related system limitations. Most pharmacy benefit managers can accommodate two- or three-tier arrangements.

Pre-authorization – This process screens drugs subject to misuse and high cost 'multiple use' drugs to ensure access for appropriate use only. Designated drugs are clinically reviewed against set criteria to determine eligibility for specific plan members. This doesn't limit the financial risk for drugs which are appropriately prescribed. New drugs are reviewed by a pharmacy consultant to determine the need for pre-authorization.

Specialty drug plans – Alberta, British Columbia, and Ontario have introduced Specialty Drug Programs which potentially reimburse all or part of high cost therapies for designated health conditions (for example, some cancers, organ transplants). Such programs tend to be discreetly managed. Income testing is often included in eligibility criteria, but for some programs all residents are eligible regardless of income. Through a pharmacy benefit manager, such as ESI Canada, some carriers/ plan sponsors can structure plans to exclude drugs which are eligible under these specialty drug plans without an income test, whereby claims must first be submitted to the provincial program before being considered by the group benefits plan. Such plans are limited, so the number of claims affected may be few. However, the savings achieved on a single claim using this technique could be substantial.

Hospital drug plans – Ensure private plans are second payor for drugs normally only given in a hospital setting. This technique requires pharmaceutical expertise and monitoring. Again, carriers aligned with certain pharmacy benefit managers can structure plans to exclude drugs (for example, chemotherapy and antibiotics given intravenously) paid for under hospital plans.

Risk management/high amount claims pooling – Claims pooling can help to limit the risk associated with high cost drugs, without limiting or transferring costs to plan members. The amount of an individual 's claims in any year above the specified 'pooling' level is charged to the insurer rather than the plan. While protecting members against financial hardship, this can increase the demand and risk for high cost drugs, resulting in higher plan costs and increased pooling levels.

Plan member education and accountability – Plan sponsors should step up efforts to educate plan members and other influencers (such as unions) on these issues and engage them in finding ways to control costs that address their mutual interests. Make sure the 'value' of benefit plans is transparent. All stakeholders need to appreciate the challenges and responsibilities involved in good plan design.

Drug Cost Controls At Work

How well do these cost control features work? Some are too new to measure, but the following examples (based on two real plans) help illustrate the impact of some of these techniques.

Plan 1 – Multi-employer Members Plan

- Covers 3,500 members including active and retirees
- Benefits subject to adequate funding
- Shortfalls could result in member costs or benefit adjustments
- A drug card introduced in 2000 caused an expected spike in drug costs, leveling off in 2002

Priorities – Good value coverage for members

Drug cost controls at work:

- Generic Substitution
- Pre-authorization for specified drugs
- Dispensing fee caps
- Some preferred providers
- Review and limits on certain narcotic based drugs
- Claims pooling

Results, as reflected in five year drug cost trends – This plan (Chart 3) consistently experienced markedly better than expected costs, based on prevailing industry trends.

Plan 2 – Employer Sponsored Flex Plan

- Covers 5,500 active members
- Flex credits are provided to fully cover all health/drug options
- Members claim using a drug card

Priorities – Competitive benefits, member choice, good value, and sustainability Drug cost controls at work:

- Generic Substitution
- Pre-authorization for specified drugs
- Some preferred provider arrangements
- One flex option bases drug reimbursement on a 'national formulary'
- Claims pooling
- Considering specialty/hospital plan provisions

Results, as reflected in five year drug cost trends – This plan has also enjoyed consistently better than expected costs, compared to prevailing industry trends, as illustrated in Chart 3.

How do the results under your drug plan compare? If you are tracking or exceeding industry cost trends, this may be the time to take a closer look at some of these cost control options. A good first step is to carefully review the top 20 drugs under your plan and track the year-over-year trends to see what patterns emerge. Consider what changes are most important based on your plan goals and take advantage of appropriate cost control techniques.

As these issues gain momentum, benefit carriers would be wise to listen closely to their clients' needs. Suppliers who take the lead in developing robust cost control initiatives could gain a meaningful competitive edge. ■

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