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## Reference Based Pricing And Employee Engagement

By: Wendy Poirier & Karen Millard

Canadians spend more than \$20 billion a year on prescription drugs, with the private sector bearing more than half of this cost, either out-of-pocket or through private insurance plans. The magnitude of Canadian spending is staggering, but it's the cost trend – three times the general inflation rate – that shocks most plan sponsors. Private prescription drug spending has tripled in the last 10 years and could very well do so again over the next decade.

As costs increase, prescription drug plans are becoming a material aspect of not only **benefit** plan costs, but also of total **compensation** spending. Looking beyond cost control, the prescription drug plan is also viewed as a direct reflection of an employer's approach to wellness and management's interest in employee well-being – the number one factor driving employee engagement, according to Towers Perrin's 2006 Global Workforce Study.

Given the financial, operational, and motivational stakes involved, **plan sponsors** are starting to review the practical link between **benefit** programs and their business goals. In this article, we consider this link in the context of drug substitution opportunities and challenges.

### Generic Substitution

One of the key factors affecting drug cost trend is the shift to more expensive new drugs in place of older, less expensive therapies. Canadian brand name drugs generally enjoy 20-year patent protection. Once patents expire, manufacturers can produce lower cost generic versions.

Generics have the same active ingredients as brand name drugs. They must meet federal standards for chemical identity, purity, potency, bioequivalence (rate of absorption and elimination from the body), and labeling. They may differ from the brand name only in packaging, non-active ingredients, colour, and shape. While the original manufacturer may have invested years and hundreds of millions of dollars in testing and research, the generic has a much lower 'to market' cost and, therefore, can be priced lower than the original.

### Potential Savings

To take advantage of these lower prices, it is common practice for employer-sponsored drug plans to have mandatory generic substitution clauses. Few employer-sponsored plans, however, realize 100 per cent of the potential savings available from generic substitution. By volume, generic drugs account for roughly 40 per cent of all prescription drugs dispensed nationally, but from a total cost perspective, generics account for only about 15 per cent of the Canadian prescription drug spend. The other 85 per cent is still represented by patent and off-patent brand name drugs.

Brand name loyalty remains high in patients and physicians. Differences in the non-active ingredients can also be important. Physicians may have legitimate concerns that a patient will have adverse physical reactions to the non-active ingredients in a generic. Patients may simply be anxious about changing to a drug that looks different from a familiar brand name or believe the best drug must be the most expensive brand name in all circumstances. Despite the ability to monitor general rates of generic substitution in private and public plans, there is generally no mechanism to accurately capture why a brand name drug is dispensed when a generic is available. Most benefit plans requiring generic substitution waive the requirement where a physician has marked 'no substitution' on the prescription. Only rarely do plans limit reimbursement to the cost of the generic in all circumstances.

Generic substitution provides no assistance where there is no available generic for a prescribed brand name drug. It is not unusual to see more than 80 per cent of drug plan costs attributable to brand name prescriptions for which there is no available generic. To compound the problem, only some of the brand name drugs entering the market each year are 'breakthrough' therapies. Many of the new brand names, though heavily promoted, are 'me too' therapies that provide little to no therapeutic gain over existing drugs. The challenge for plan sponsors is to set reimbursement parameters that are prudent, but that also take into account the enormous value of new or expensive medications for certain individuals.

### Therapeutic Substitution And Reference Based Pricing

Reference Based Pricing (RBP) proposes that prescription drug plans cover an evidence-based standard of drug therapy. If there is no evidence that a higher-priced brand name or generic drug is more effective or has fewer negative side effects, the extra cost should not be covered. RBP programs recognize a list of drugs that have been proven to be equally effective treatments for the same conditions (therapeutic classes) and cover only up to the cost of the least expensive drug within the therapeutic class (reference drug price). RBP does not dictate to a physician or a patient which drugs they can and cannot have. Physicians can prescribe the drug that is best for the patient in their particular situation. The plan will only cover, however, the price up to that of the reference drug price.

British Columbia has had a Reference-Based Drug Program in place since 1995. While the program has drawn criticism from some quarters, it has arguably saved the government more than \$100 million while maintaining quality of care for BC residents. BC's program includes a Special Authority system to ensure that patients who cannot tolerate a reference drug can obtain special coverage of another drug within the therapeutic class. To date, BC's program has not been extended beyond five therapeutic classes.

The biggest critics of RBP are, understandably, research-based drug manufacturers who stand to lose market share and revenues. A drop in profits could trigger a drop in Canadian research and human capital investment and, ultimately, fewer innovative therapies and cures. Province governments, therefore, face a political dilemma. How do they secure low drug prices for public plans while maintaining a dynamic biopharmaceutical industry in the province? In the last 12 months, both Ontario and Quebec have confirmed that they will not introduce RBP to control costs within their provincial prescription plans. Private sector plan sponsors generally do not face the same political pressures and should not view the reluctance of provinces to adopt RBP as an indication that RBP is necessarily inappropriate for the private sector.

### **RBP For Private Plans**

RBP is a new concept in Canada and likely won't become part of mainstream private sector design for a number of years. Our U.S. experience tells us that, despite its challenges, RBP is too powerful a strategy to ignore. In the next few years, as pharmacy benefit managers (PBMs) develop more robust and effective private sector offerings, plan sponsors have the opportunity to:

- become familiar with the concept
- consider long-term strategies that may involve RBP or similar methods
- prepare plan members for this new approach

RBP won't be right for everyone. Here are some of the challenges and opportunities for private plan sponsors to consider.

**Robust Therapeutic Classes:** Plan sponsors must rely on PBMs to categorize drugs, propose therapeutic drug classes, establish the reference drug and appropriate reference price, and then assure appropriate clinical outcomes. Further, in order to enjoy long-term cost savings, PBMs must constantly consider new drug therapies and expand RBP into additional therapeutic categories. The most cost-effective programs target therapeutic classes where there is no generic substitution available. These classes must remain dynamic or savings will decline over time as patents expire and generics enter the market. These processes are complex and require extremely specialized and experienced pharmacoeconomic resources. We expect that the robustness of this aspect of Canadian offerings will improve considerably in the next few years.

**Responsive Special Authorization Processes:** Workable plan designs recognize that, even within generally recognized therapeutic classes, the therapeutic and clinical effects of various brands and generics vary on an individual basis. Physicians will criticize RBP if they believe it limits their ability to prescribe the right drug for a particular patient at a particular time. Patients who have been stabilized on one drug, for example, will be reluctant to switch to another, cheaper drug if there is a potential for negative health effects. Plan sponsors will need to exercise caution in introducing or changing therapeutic classes and reference drugs. Efficient and responsive special authorization processes should also be in place to ensure that patients and physicians can address coverage concerns quickly. Preferably, responses would be provided within 24 hours. However, the process should place a minimum administrative burden on health providers and their patients.

**Communication and Administration Costs:** As plan designs go, workable RBP requires the highest level of employee-informed consumerism and, therefore, employer commitment and administrative cost. Where it has been successful, significant pre-implementation communication is undertaken. Therapeutic classes should be introduced slowly, with just a few classes at first. New classes should be added once employees become more comfortable with the concept. Specialized booklets should be developed to explain all therapeutic categories and additional information should be made available for healthcare providers.

In the short term, plan sponsors wishing to control drug cost by restricting drug choice will likely opt for the arguably simpler managed formulary approach – a fixed list of drugs that either are or are not covered (either by drug or by drug category). Formulary plans can take an all-or-nothing approach or provide access to an extended list of drugs on a conditional or special approval basis, usually where certain clinical criteria are met or where a patient demonstrates that a lower cost therapy is ineffective or otherwise inappropriate. Tiered formularies apply different levels of co-payment or deductible to different categories of drugs (for example, generic versus brand name). Ultimately, the formulary approach differs from RBP because it precludes any amount of coverage where the drug prescribed is not listed on the formulary or approved on a conditional basis.

Encouraging Non-Prescription and Lower Priced Options: The best way to affect physician prescribing patterns is to work directly with the patient and the physician, knowing both the patient's diagnosis and the desired clinical outcome. PBMs generally obtain diagnoses through special conditions or pre-approval processes. Programs could be improved if employees and their health providers were willing to accept drug coaching throughout the diagnostic and treatment process. As treatment options become more numerous and complex, Canadian plan sponsors and employees may see great benefit from RBP programs coupled with independent drug coaching and disease management assistance. Coaching could help individuals understand all of their options, including non-prescription options.

### **Quebec-based Employers**

Employers that operate in Quebec and offer employees certain health and welfare programs are required to offer group prescription drug benefits meeting legislated requirements (special rules apply for employees over age 65). Any RBP design for Quebec plan members may need to comply with these special legislative requirements.

The success of an employer's drug plan management strategy should be measured not only by its ability to control costs, but also by its success in improving the health, satisfaction, and productivity of employees. Experience shows that RBP and formulary models are not wellreceived when the focus is on reducing plan costs alone. Employees need to understand the value of a sustainable drug plan and trust that management is committed to improving their health and well-being. The best drug plan is the one that allows employees to become engaged and knowledgeable consumers. This can be achieved through RBP designs that provide employees and their health providers with the means to consider all possible options that result in the same health outcomes as well as the different costs associated with these options. The significant educational challenges presented by RBP designs are an opportunity for plan sponsors to create a stronger alignment of employee and employer interests – achieving cost management and productivity goals while optimizing employee health. ■

Wendy Poirier is a managing principal and Karen Millard is a senior consultant with the Towers Perrin Canadian Health & Welfare Practice.