An End to Blank Cheques

GETTING MORE VALUE OUT OF EMPLOYER DRUG PLANS

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Foreword

Alarm bells are ringing about the soaring costs of Canada's healthcare system as it crowds out other valued public services and threatens ever-increasing taxes.

Drug costs are a prime culprit. Provinces are finally acting on their part through negotiating discounts, greater use of generic drugs and limits to the fees they are prepared to pay. But much of the cost of drugs is borne by private sector employers through their employee benefit plans. These employers feel and act as though they are powerless to rein in the cost increases that have been running around 10 percent per year. This hurts many interests as companies pass the cost increases forward to customers or backward to their employees through cuts to other benefits or wages. Companies passive reaction to soaring drug costs is understandable because the information they need to act is hidden in a deep fog.

After leading Ontario's charge against drug costs, Helen Stevenson has thankfully turned her attention to showing private sector employers how to cut through the fog. Her report is full of advice employers should absorb. Many new and extraordinarily expensive drugs provide little net benefit. As the provinces have learned, leveraging buying power can lower costs. Cheaper generic drugs are often a perfectly satisfactory answer to employees' health needs. It isn't necessarily cheaper to simply reimburse employees for their own purchases as opposed to acting more directly. These are but a few of Ms Stevenson's ideas on how employers can cut costs.

All employers with drug plans should study *An End to Blank Cheques: Getting more value out of employer drug plans.* Indeed, as it is customers and employees who are hurt by the inefficiency of these plans, everybody should pay attention. In the case of employees, they should heed Ms Stevenson's advice to take more responsibility for their health and wellness, including being more proactive in ensuring that drugs they are taking are clinically and cost effective. After all, the benefits and costs are ultimately theirs.

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INTRODUCTION

Everyone knows what a prescription drug is, and almost everyone has taken one. However, because a reported 98 percent of Canadians[1] benefit from some form of insurance plan that helps them absorb the cost of these prescriptions, very few people in this country understand how much medications really cost, who is bearing that cost, and how.

Canadian companies spend about

$200 million per week

on prescription drugs.

Drug prices are a concern across Canada. Academics, organizations such as the Conference Board of Canada, the Health Council of Canada, and the Competition Bureau Canada, not to mention newspapers, magazines, and trade publications, have all noted that drug prices have been rising steadily in this country for decades. In fact, drugs are the second largest healthcare expense, after hospitals. Drug costs have become the elephant in the room in health care. Unavoidable and unmanageable.

My goal for this paper is neither to criticize nor judge how drug costs have been managed in the private sector.* But as someone who transformed and managed the largest drug plan in the country, I am in a position to say with some confidence that prescription drug costs can be managed, that there are changes that need to be made in employer drug plans, and that, naysayers not withstanding, those changes can be made.

The simple fact is that until very recently the entire system of prescription drug insurance – be it public or private – has been shrouded in secrecy, devoid of transparency, and at times financially inscrutable.

Over the past five years, the public sector has been moved to action. Provinces have leveraged their purchasing power and law-making capability to impose a measure of restraint on the system, to make funding decisions based on evidence and budget considerations, and to bring prices under control, thereby incurring savings for the taxpayers who fund them. There is still a long way to go in this regard, but a great deal of progress has been made. More specifically, the Ontario Government has demonstrated that there are savings to be had that are already measuring in the billions of dollars.

Savings are available in the private sector as well, and they need to be found. Yet to date, employer drug plans appear to have been managed very lightly, or have implemented limited measures to control costs, such as cutting retiree benefits. I would argue that there are other, better measures that can be taken. This paper will explain what is wrong with the current system, and suggest doable ways to get more value out of employer drug plans. It begins and ends, as the title of the paper suggests, with putting an end to writing blank cheques.

A BIG, ACKNOWLEDGED PROBLEM

Canadian companies spend about $200 million per week on prescription drugs. In 2010, that translated into an estimated $10.2 billion[2] in costs incurred by employer drug plans. We are seeing more and more spending, and yet there is little evidence that the full $10.2 billion spent is justified.

* For the purposes of this White Paper, the terms 'private sector drug plans' and 'employer drug plans' are used interchangeably.

A recent Conference Board of Canada report expressed alarm about the situation in this way: "Benefit costs have escalated by 10 per cent year-over-year… if costs cannot be contained, the long-term sustainability of employer-sponsored benefit programs will be in jeopardy."[3]

The Canadian Institute for Health Information has also flagged the steady rise in prescription drug expenditures, as have the Competition Bureau Canada and the Health Council of Canada. Investment and benefit consultants of all stripes are eyeing the situation and suggesting that private plans need to adapt to changing times. Noted healthcare journalist André Picard recently wrote on this theme, "Consumers who use prescription drugs, and the drug plans that are the principal purchasers, need to start questioning the 'facts' and asking some tough questions."[4]

As this paper will demonstrate, the reasons for the steady increase in drug expenditures and the steady rise in the cost of drug plans have far less to do with the number of people in this country or how old they are, and a very great deal to do with how these plans are being managed.

SO WHY SHOULD WE CARE ABOUT EMPLOYER DRUG PLANS?

On the surface, it isn't readily apparent why most of us should care about how private sector drug plans manage their costs. They are, after all, private sector plans, operated by employers with the help of insurers, and offered to employees as part of their compensation. Why should we care? The reason: because continually rising drug prices are not magically absorbed by insurance companies. They are passed back to employers, who in turn may be forced to shift some of that burden – for example, through increasing prices of the company's products and services, or through cutting back retiree drug benefits, or possibly even by limiting salary and/or benefit increases to employees.

Ultimately that road leads to more people paying some or all of the costs of prescription drugs out of their own pockets. I believe as a society this is not the direction we want to go, because in the end more people will be forced to decide between buying the drugs they need and buying food. Or paying rent. This already happens in this country among the thousands of people who do not have drug insurance of any kind. And when you meet a person – as I have – who has just opted to go without diabetes medication so that she can buy groceries for her family, the question of cost containment in private sector drug plans becomes less an intriguing academic exercise than a matter of urgent public interest.

WHAT IS WRONG WITH THE CURRENT SYSTEM?

Drug costs are soaring, and there is every sign in the current Canadian drug landscape to indicate that the rise will continue. The Canadian Institute for Health Information (CIHI) offers this gloomy assessment:
"Drugs have been one of the growing components of total health expenditure in Canada. From 1985 to 2007, total health spending grew at an average annual rate of 6.6%. During this period, total drug expenditure increased at an average annual rate of 9.2%."[5] As a point of reference, Canada's real GDP growth rate in 2009 was -2.5% and 3.5% in 2010.[6]

In the face of costs that could soon make maintaining their drug plans

impossible, the private sector needs to take action.

From an outsider's point of view, it seems clear that the private sector has been slower than the public sector to deal with the problem of rising drug costs. In the past four years, **growth in private sector spending on prescription drugs has outpaced that of the public sector**. Private sector spending on prescription drugs reached an estimated $14 billion in 2009, representing an annual growth rate of 7.0 percent, while public sector spending on prescribed drugs reached an estimated $11.4 billion in 2009, representing an annual growth rate of 4.0 percent.[7]

Employers have historically been slow to take action to manage drug plan costs. The problem is not necessarily complacency. Rather, it is a lack of awareness. Until about five years ago, drug costs were not high on most radar screens. But recently, some very significant changes have taken place in the public sector, bringing drug costs and transparency into the public eye. And that means there is now a public policy framework in place to give the private sector the means and the moral authority to follow suit. **In the face of costs that could soon make maintaining their drug plans impossible, the private sector needs to take action.**

According to the Conference Board of Canada, 73.4 percent of employers surveyed report that the rising cost of drugs is the top factor contributing to an increase in annual benefit costs.[8] To repeat what I stated earlier, **these increased benefit costs to employers don't just disappear – they are often passed on into the economy through price increases on a company's products or services, or passed down to employees**. As a Health Council of Canada report explains, "Private drug plans are funded, in part, by employees, albeit indirectly.... Regardless of the mechanism, from the employer's perspective drug insurance is an additional cost of employing a person. Hence, it can translate to lower wages for employees. Some employee sponsored plans require the employees to share in the premiums… [and] out-of-pocket expenses through co-payments and deductibles."[9]

For obvious reasons, it is in the interests of both employer and employee to slow or reverse the rising cost of maintaining a drug plan.

What, then, are the factors that contribute to the steady rise in the cost of these plans? Plainly, the rise in the cost of drug plans is partially due to the increased use of drugs – both number of prescriptions and length of prescription. However, the steady rise is also due to factors that can be broken down into four main areas:

Any drug at any price

Almost every new drug approved by Health Canada gets added to the formulary of most employer drug plans. And the flow of new drugs onto the market is unending. **There is no question that the value of certain innovative new brand name drugs is nothing short of spectacular.** As examples, the death rate from cardiovascular (heart) disease has dropped 64 percent since 1981 thanks to cardiovascular drugs; and death rates due to HIV/AIDS have dropped by 80 percent over the past 30 years.[10]

However, a large portion of new drugs offer little in the way of added benefits that existing products do not already offer. One landmark study showed that 84 percent of all new drugs have minimal value or no new advantage.[11] And yet for the most part these new drugs are more expensive. More specifically, the problem is that "private drug plans' formularies welcome all new expensive drugs even if they are no more beneficial to patients than cheaper existing drugs."[12] In these cases, there may be little need for new drugs for certain diseases unless they are priced competitively with existing drugs.

For that smaller portion of new drugs that do offer benefits over existing drugs or target a specific group of the population, they may well justify a premium price.

Not making the most of our generic potential

It isn't hard to understand the attraction that generic drugs should have for drug plans. They offer precisely the same health benefits as their brand name equivalents, at a greatly reduced price.

If generic penetration increased by just **one percent** – to 58 percent – **drug plans would save** an estimated **$229 million** annually in Canada.[14]

Currently, approximately 57 percent of all prescriptions in Canada are for generic drugs, yet generic drugs represent only 25 percent of drug costs. In contrast, in the U.S., the rate of generic prescribing reached 75 percent in 2009 for all prescriptions.[13] **If generic penetration increased by just one percent – to 58 percent – drug plans would save an estimated $229 million annually in Canada.**[14] Despite this clear potential for savings, however, there are still plans that do not mandate generic substitution.* And for those plans that do require generic substitution, there is sometimes enough ambiguity built into plan designs that generic drugs are not always substituted.

An obvious example of this is Lipitor, the billion-dollar cholesterol-lowering drug. When a generic version of Lipitor became available in May 2010, employer drug plans should have realized savings in tens of millions of dollars, as employees taking Lipitor were simply given the generic version of Lipitor, at about 50 percent of the original brand price. Instead, a very significant number of people who had been taking Lipitor were switched not to the generic version of Lipitor, but to a completely different brand name cholesterol drug. The result: employer drug plans continued paying brand name prices rather than paying for the lower-priced generic version of Lipitor.

Pricing and dispensing fee antics

Public drug plans typically publish a price for each drug – sort of like a retail selling price. For private plans, however, there are vast differences in this price, many of which are devoid of transparency.

* Generic substitution requires pharmacists to dispense the generic equivalent of the brand name drug prescribed, where a generic version is available.

Case in point: the price of an expensive specialty drug differed by $2,528 ($6,664 compared to $4,136) for exactly the same dose dispensed at two different pharmacies in the same city. The $2,528 difference for just one drug for one person, or more than 50 percent difference, had to be absorbed by the consumer, the employer, or the insurance company.

In another claims review of a large employer, drug prices submitted by pharmacies for certain brand drugs ranged from 9.2 percent to 37.2 percent more than the manufacturer's list price; and certain generic drugs were priced between 45 percent and 102.9 percent more than the manufacturer's list price. In other words, some pharmacies charged 102.9 percent more for the same drug, in the same quantity, to the same drug plan.[15]

In addition, there are a concerning number of questionable practices and activities surrounding the buying and dispensing of generic drugs, which have inflated generic drug prices and created instability and confusion in the system. This is particularly true in the area of rebates paid to pharmacies by the makers of generic drugs.

In 2009, the Ontario Government took legal action against a number of pharmacies, generic manufacturers, and wholesalers, after a forensic audit uncovered a scheme under which drug products were being sold and resold several times in order to increase the 'rebates' being paid. The Ontario Government moved to eliminate rebates completely in the spring of 2010.

Just as the business of rebates has traditionally forced higher generic drug prices, with a resulting impact on health plans, so too has the practice of increasing the frequency of dispensing. Pharmacies get paid a dispensing fee for every prescription filled. Typically, people with chronic diseases – such as high blood pressure, high cholesterol, ulcers, etc. – receive a 90-day supply of their medications. It could be argued that it is in a pharmacy's interest to dispense more frequently. Occasionally it is in the best interests of patients as well. However, when it is not, it is simply a cost driver. And as the Ontario Ministry of Health and Long-Term Care reports, it is
a cost driver that is growing:

"…[T]he number of chronic medications dispensed weekly and more frequently has increased dramatically over the past several years despite a lack of evidence that such increases…are necessary…. In 2007, the Ministry paid almost $170 million in weekly dispensing fees and $7 million in fees for medications dispensed on a daily basis."[16]

Employee indifference – shooting themselves in the foot

The truth is that insurance companies, to paraphrase Rodney Dangerfield, don't get no respect. When it comes to drug plans, that lack of respect extends to employers as well. It seems that we all have enough of a sense of entitlement to assume that as long as we are not being handed a bill, we ought not to worry about the cost. Insurance company, employer – no matter. Somebody else is paying. It seems to be an assumption made by everyone. How often do doctors ask their patients if they have private drug plan coverage before writing a prescription? It is a considerate gesture on the surface, but actually shortsighted. Because in the long run, somebody else isn't paying: we are. Employees have to be aware that employers will not sit by forever, watching drug plan costs spiral upwards.

FOLLOW THE LEADER

As described in an article in *The Economist* last year, Canada's provinces have been leading the way in managing the costs of their drug plans through a series of sweeping reforms.[17] My own experience was in Ontario, where I first headed a review of the province's drug system, and then twice helped reform it.

The Ontario Government introduced Bill 102, or the Transparent Drug System for Patients Act, 2006 (Ontario). Bill 102 was the first major transformation of the prescription drug system in Ontario in decades. It lowered generic prices, attempted to control rebates through a system of professional allowances, and created an executive officer position responsible for managing the system and negotiating better pricing agreements with brand name and generic companies.

Because we continued to see abuses within the system in Ontario, the government moved to eliminate allowances altogether and further lower the price of generic drugs. The media called this latter set of reforms the "drugstore wars."

Similar reforms have swept across B.C., Alberta, Nova Scotia, and Quebec. The public sector in Canada is well and truly engaged. The private sector, however, is arguably not well engaged. We have yet to see a concerted effort by employers to better manage the costs of their drug plans, despite the fact that the trail has been blazed by the public sector. **In Ontario, for example, government reforms were hailed not only for their benefit to taxpayers but for their potential benefits to private plans.**

"[The reforms are the] single largest, most positive, change in employer sponsored benefit plan costs in decades."[18]

And yet, as the Conference Board of Canada bemoans, very little is being done. "Despite the current economic climate, most organizations (79 per cent) have not changed their organization's benefits strategy."[19]

This is without question at least in part because any attempts to lower costs, through negotiated agreements or by only funding preferred drugs, have been met with huge resistance by pharmacy and pharmaceutical companies. That being said, the public sector reforms successfully launched by provincial governments across the country were launched in the face of massive resistance, but they have by and large succeeded.

Employers need to know that the time is right.
There are solutions to spiraling drug costs

The truth is that the **private sector** has a **tremendous opportunity** here

To their credit, some companies in the automotive sector have been actively managing their drug plans; for example, the 'Big Three' automakers introduced a 'Conditional Formulary Plan' in 1993.[20] Yet where most employers have made changes, as noted at the outset, is in the area of retiree benefits. According to research conducted by Mercer in 2008, more than half of organizations with retiree benefits had already made reductions in those benefits, and another 26 percent planned to make them in the coming years.[21]

Employers need to know that the time is right. There are solutions to spiraling drug costs that do not involve curtailing benefits or flat-lining salaries, and employers should consider them – for the good of their organizations, and for the good of their employees.

PRACTICALLY RADICAL: DOABLE WAYS TO GET MORE VALUE OUT OF EMPLOYER DRUG PLANS

The truth is that the private sector has a tremendous opportunity here – it could even be argued that employers have a fiduciary responsibility to make changes.

The activities in the public sector have raised awareness about drug system issues, creating a certain undeniable momentum towards change.

How, then, should the private sector proceed? While it is not my intention in this paper to be overly prescriptive, I do offer an eight-point plan to help employers get better value out of their employee drug plans. They all have the general effect of putting a stop to the blank cheques that are being written in so many private sector drug plans.

1 Be clear on the purpose of your drug benefit plan

Employers should understand what they are trying to accomplish with their drug plans, and should regularly do a thorough review to make sure the plan is achieving its goals. Some obvious goals of a drug benefit plan would be to:

- attract and retain employees;
- provide access to specialty, high-cost drugs;
- promote good health and wellness; and
- support workplace efficiency by helping employees obtain the drugs they need to stay healthy.

In a perfect world, all plans would achieve all those objectives, but in reality most are weighted in one direction or another. Some plans, for example, have been designed specifically to attract and retain talent in competitive sectors. In other cases, employee drug benefit plans are legacy plans that were designed decades ago and simply evolved over the years.

Employers should require that their formularies are actively managed.

And just as companies do a critical review of the effectiveness of different strategies within their organizations, so should they critically review the effectiveness of their drug benefit plans. For example, is the plan achieving maximum potential savings? Is the plan benefiting from generic substitution? These questions should be asked, and if employers are clear about the answers, they will be well on the way to extracting better value from their plans.

2 Get good data for great decisions

Most companies do detailed analyses as part of the decisions in their day-to-day operations. **Yet too often it seems, with respect to plan design, employers have very little information at hand to inform their decisions.** Having the right information is critical to making good decisions. Plans should be carefully monitored – by employers, insurers, or third party organizations. You can't fix what you can't measure. In fact, you might not even know it needs fixing. Good data for great decisions.

3 Better manage formularies

No more blank cheques. It really is that simple. As mentioned above, most private sector drug plans seem to have an open formulary door policy, which includes funding drugs that cost more, but offer little or no clinical benefit than drugs that are already being paid for. **Employers should require that their formularies are actively managed** – in other words, employers should mandate that drugs be evaluated based on clinical and cost-effectiveness evidence and, more specifically, whether they have added benefit over existing drugs.

In addition, there is much to be said for what is known as an incentive-based formulary. An incentive-based formulary implies that drugs are included under different tiers – most drugs are covered, but employees pay different co-payments depending on which drugs. For example, employees may have a higher co-payment or co-insurance should they insist on a more expensive drug that provides no added benefit. These types of incentive-based systems exist and are effective the world over.

Finally, **employer health and drug plans should provide comprehensive clinical programs to help employees better manage chronic conditions**, and particularly as it relates to prescription drugs and adherence. Programs such as a diabetes care program or a pain management program, among others, will drive better outcomes for employees and help manage prescription costs.

4 Promote appropriate use of both brand and generic drugs

Clearly, there are times when the best and only drug is a new brand name drug, and in those situations it is right and proper that plans should pay for those drugs. But again, these **decisions should be based on clinical and cost-effectiveness evidence**.

At the same time, employers should mandate paying for the lowest-cost product – typically the generic drug – and they should ensure that this is enforced. To put numbers behind this opportunity: the generic drugs expected to be launched in 2011 would generate $1.275 billion in savings for public and private drug plans if they mandated paying for (substituting) the lowest-cost drug. In 2012, the savings could be $1.2 billion, and in 2013, the savings are estimated to be $541.7 million. The cumulative three-year savings for generic products launched between 2011 and 2013 are estimated to be $6.774 billion.[22] By comparison, in the U.S., the savings are estimated at a staggering $70 billion over the years 2011 to 2014.[23]

There is a small but growing number of brand name drugs that are maintaining their position on formularies post-patent, competitively priced compared to the generic drugs. This would imply that brand name pharmaceutical companies are taking an innovative view on the lifecycle of their products and are prepared to negotiate discounts in exchange for long-term, predictable formulary listings.

5 Build buying power

One of the reasons that provincial governments have been able to make the changes they have is that some – such as Ontario – have extraordinary leverage as buyers of prescription drugs. While individual companies do not enjoy that luxury, there is leverage to be had. Some insurers have attempted to negotiate agreements with pharmaceutical companies and have met fierce resistance at the pharmacy level. That resistance would be easier to overcome **if several employer plans banded together to negotiate pricing agreements with drug companies** – the Competition Bureau Canada cautiously identifies bargaining power and incentives needed to support the deployment of alternative delivery models.[24] They would, in fact, have a real chance at success. This already happens in the United States, and I am aware that some insurers in Canada are contemplating moving in this direction – employers should jump on board as quickly as they can.

6 Implement pay direct drug plans

Drug plans work in one of two basic ways – reimbursement or pay direct. With reimbursement plans, employees pay for their prescriptions up front, and submit receipts to the insurance company for reimbursement. For pay direct plans, the pharmacy automatically submits the claim to the insurance company, leaving the employee to pay whatever amount is not covered.

Some employers have assumed that reimbursement plans are less expensive, primarily because employees sometimes forget to submit their receipts – this 'shoe-boxing' effect amounts to on average four percent of total plan spending, so it is by no means insignificant.[25]

The fact is, however, that pay direct plans are really the way to go. When pharmacies submit the claim directly to the insurance company, as they do under direct pay, the amount they can charge is fixed. However, they can and do charge more when the employee is on a reimbursement plan. As a result, employers end up paying much more for drugs under reimbursement plans, and, in future, would forfeit any ability to benefit from buying power described above.

7 Drive consumerism

Employees – consumers – should be more aware of the notion that some drugs cost much more than others and yet have virtually the same clinical impact. To relate it to everyday life, one gas station charges $1.40 per litre and the other gas station charges $1.10 per litre for virtually the same gas, and we frequently hear about the line-ups for the $1.10/litre gas station…why not with drugs? Part of the answer, of course, is drugs are insured so people often don't care what they cost. That's why it is **so important that employees be educated about the price of drugs and the resulting effects on benefits**. It is probably only when they understand that they really do eventually end up paying that they might be encouraged to do a better job of comparison-shopping.

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Ultimately, **we need to shift people's minds from a mentality of entitlement to a mentality of empowerment**, the latter implying greater self-responsibility and behavioural change – for example, exhausting non-drug treatment options before starting drug treatments.

8 Reinvest savings in benefits

Every good business understands the importance of reinvesting savings, and this is as true when it comes to employee drug plans as anywhere else. **Better-managed plans will yield significant savings to employers.** This in turn will give them the opportunity to create a better and more desirable work environment for existing and potential employees, by reducing out-of-pocket expenses, and **investing in value-added initiatives like wellness programs**.

Conclusion

Economists talk about a burning platform as being a necessary impetus to change. It is not for me to yell "fire," but I would certainly suggest that employers who run drug plans start sniffing the air for smoke. Because I can state for a certainty that if nothing is done, the steady rise in the cost of these plans will continue. The shifting of benefit costs from hospitals and governments to employers, which has been underway for decades, is not going to change.

Employers have a real opportunity here to improve benefits for their employees, introduce accountability into their plans, and save themselves money in the process. Anyone doubting that should do the math on what a 10 percent cost reduction would yield on a $500,000, $10-million, or $50-million plan. In many ways, the public sector has done much of the heavy lifting. Certainly, it has demonstrated what can work. If employers can now pick up that ball and run with it, they will have better-managed plans that are much more sustainable. Time to take action.

No more blank cheques.

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