DRUG-MIX EFFECT ADDS TO COST

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CONTROLLING PLAN COSTS AND NEW APPROACHES TO DRUG PLAN MANAGEMENT

Barbara Martinez, National Practice Leader, Drug Benefits Solutions at Great-West Life Assurance Company; Dr. Richard Heinzl, Global Medical Director at WorldCare International Inc.; and Mark Rolnick, Vice President, Payor Partnerships & Plan Spon-sor Innovation at Shoppers Drug Mart; provided their insights into drug cost challenges.

Drug-mix Effect Adds To Cost

The end of pull effects which brought drug plan costs down, the tremendous potential of biologics (and their high cost), and how one of Canada's drug stores redesigned its drug benefit plan were the areas of focus at the Benefits and Pensions Monitor Meetings & Events 'Controlling Plan Costs and New Approaches to Drug Plan Management' session.

Barbara Martinez, National Practice Leader, Drug Benefits Solutions at Great-West Life Assurance Company; Dr. Richard Heinzl, Global Medical Director at WorldCare International Inc.; and Mark Rolnick, Vice President, Payor Partnerships & Plan Sponsor Innovation at Shoppers Drug Mart; provided their insights into these challenges and offered solutions for plan sponsors.

The Patented Medicine Prices Review Board digs deeply into the drug price trend in Canada and the forces that drive it, namely, those that "pull" costs down or "push" them up, says Barb Martinez, National Practice Leader, Drug Benefit Solutions at Great-West Life Assurance Company.

Pull effects are related to generic drugs. When patents expire, generic drugs bring prices down, which reduces the trend. On the push side, there is the demographic effect. "As we age, we tend to need a greater number of prescriptions, which results in a larger volume of claims," she said.

However, the greatest impact on prices is the drug-mix effect. Over 10 per cent of the trend increase is due to a tendency of some doctors to prescribe new drugs over existing drugs that are equally effective and typically more economical.

Dominating Today

The push effects are dominating today and will continue to in the future. The net effect in 2015/16 was a 12 per cent increase. Patented drugs, in particular, had an 18.8 per cent trend increase over the previous year, representing 58 per cent of drug spending. "If 58 per cent of spending increases by 18 per cent, and if that happens every year for the next five years, where are drug plans going to be?"

Even more important, there was a 60 per cent increase in spending on drugs that cost $10,000 or more per year. In 2011/12, there were 42 drugs that cost $10,000 or more per year, representing one-tenth of spending. "This has now doubled; in 2015/16 there were 81 new drugs that cost $10,000 or more, and those drugs represented one-quarter of the spending," she said.

Take, for example, a new eczema drug soon to enter the market at $720 per tube. "If we're prescribing that $720 tube for somebody who has a mild form of a condition, that's completely going to bankrupt drug plans.

"We have to start to ask ourselves burning questions in this environment such as does it make sense to rely on Health Canada's approval as the basis for deciding whether or not to include a particular drug in a drug plan? Health Canada approves drugs essentially on 'Is it safe?' and 'Does it work better than a placebo?' There's no study to compare a new drug to an existing drug and there's absolutely no look at the cost. Does it make sense to list a drug without taking the time to look at it from every angle," said Martinez.

Newer Drugs

Then there is the preponderance of doctors who shift prescribing towards newer drugs. "I can't explain to you how costly this is. A new drug

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costs $150 and because it's new there's no generic. The older drug might have been $100, but it has a generic at $18. So you might have been paying $18 for a condition and all of a sudden now we're at $150 and we have a 20-year patent before there's any generic," she said.

The reality is that the Patented Medicine Prices Review Board says almost no new drugs are breakthroughs. Typically, they're categorized as a slight improvement, moderate improvement, and "basically a 'me too' drug. If two drugs really are going to work the same, why are we prescribing the new drug first?"

Plans have to be designed using a bottom-up approach and this starts with the doctor. Cost is not part of the decision-making process at the doctor's office because drugs are not consumer goods. "You might take a drug, but the doctor chooses it and the plan pays for it."

The most important thing is to get "employees to understand how to answer that question about who pays at the doctor's office. 'Yes, I have a drug plan, but I have to pay 20 per cent. Is this going to be expensive?' The minute you have that conversation with the doctor, they're going to go: 'Oh, let me check that out.' Doctors do care whether their patients can afford to take a drug. If we teach our members to explain this to their doctor, then we wouldn't get that new drug switching happening when there is not extra value. Then we'd get a bottom-up approach to prescribing."

"When we think about medicine, we look for important cures – a cure for cancer or AIDS. I'm hoping it's going to happen, but as a year goes by and then five years, you get a little despondent and think it's not going to," said Dr. Richard Heinzl, Global Medical Director at WorldCare International, Inc.

Then, all of a sudden, there's a breakthrough in one area of science and another technology is invented. These people come together and they stack these on top of each other and suddenly they're able to create something new and "we have our breakthrough, our cure."

Today with cancers, the absolute standard of care is biologics – they are part of the conversation every single time. There's been an explosion of biological therapy for cancers in the last five years. What used to be done – chemotherapies or cytotoxic therapies – were rather blunt instruments. "They were small chemicals that you'd hope would hurt the cancer cells the most, but also hurt a lot of normal cells as well," said Heinzl.

Increased Cures

Biologics are much more precise, they're much more about personalized medicine and they're only going to get more specific and more targeted. This is going to lead to greater remission rates and increased cures.

Worldwide, it's big numbers as 325 million people have received biologics and there are 200 approved biotherapeutics on the market today.

"Now let me give you my doctor perspective on this stuff," he said. A traditional small molecule non-biologic drug like Aspirin is always the same. It isn't targeting one specific area; it's hitting the whole body. It's a blunt instrument, but an effective one. "The thing about it is you can make it many ways," he said.

Biologics are different. The first biologic, even before penicillin, was insulin – "made right here in Toronto about 100 years ago now." They can be a vaccine, they can be a blood product like a white cell or a lymphocyte, they can be actual tissues or cells, they can be an antibody, they can be part of genes, they can be a hormonal agent, and crucially they can be part of recombinant DNA, which is where DNA is manipulated to grow things. It also takes a minimum of $200 million to take a biologic to market.

Because they're from a living microorganism, they're complex. They're made in huge bioreactors and are carefully controlled.

An example of the process is the TNF (tumour necrosis factor) alpha. It is a protein that regulates how much inflammation is given to various parts of our body. It can be "beautiful, but when it gets out of hand, diseases like rheumatoid arthritis and Crohn's can occur and we want to suppress that," said Heinzl.

This is done by making a biologic, like Remicade. Antibodies are primed, then put in a syrup and fed the molecule of TNF alpha. These antibodies know how to recognize that TNF alpha. "So we put that DNA into a cell and let it start replicating. Inside the cell, an engine is created that pumps out a protein that recognizes TNF alpha. This is a pre-biologic that we adjust by putting sugars in, add-

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ing extra molecules, and changing the pH the pressure. This is done very carefully until we get biologics," he said.

'Fundamentally New Way'

It's a big, complicated process which is fundamentally a new way of doing things in medicine. And the results "are really totally dramatic. You can cure people; you can totally lessen their disease," he said.

However, "if we're thinking about how to make drug plans work, and how to make them affordable and effective, it can't just stop at the drugs we're talking about and the biologics because there's new things coming. Regeneration medicine where we're going to be rebuilding organs is coming. Personalized medicine is going to get more precise for therapies so they are unique for each individual. Nanotechnology and genetics are new frontiers and targeted genome editing (CRISPR and Cas9) are mind-blowing possibilities in the future. The potential is tremendous, but brings with it tremendous issues."

Shoppers Drug Mart is a large employer and, like many organizations, found that the rising costs of drug coverage were a challenge, said Mark Rolnick, Vice President, Payor Partnerships and Plan Sponsor Innovation, at Shoppers Drug Mart.

The company was also questioning the value for its investment. However, Shoppers Drug Mart is a bit different from a typical employer. It is the one of the largest purchasers of pharmaceuticals and as such it has deep insights into the industry pipeline.

"We saw that the savings to the drug plan from more products coming off patent and lower cost generics was getting smaller over time. With that backdrop, we took a look at our own drug plan. We had what they call an open-ended program, so it was a core plus options benefit plan," he said. The plan paid for many things including over-the-counter medications and there were little controls around generic substitution or prior authorization for high-cost drugs. It was funded by the organization, not by the employees, and there was very little co-pay.

Something Different

"We knew we had to do something different to afford the specialty innovation that's coming. When we look at spending in our stores – we see about a quarter of the spend in Canada now is specialty drugs. Yet it's still only two per cent of claimants. We needed to incorporate a specialty prior-authorization program that was very straightforward," said Rolnick.

But once that specialty piece is covered off, "what do you do for the other 98 per cent of claimants?" Managed plans were an option, but "Our view was that the private formularies available were very focused on cost savings, less on members.

"As pharmacists, we believed we could do better. We developed a simple two-tiered design that focused on best coverage for the best value medications on tier one. The team was able to find the right balance between savings and minimizing the impact to plan members," he said. On tier two, there's multisource brands which already have a generic and other brands where there's lower-cost drugs available. On the not listed group, there could be over-the-counter or other good-value alternatives.

The goal was to get as many people on that first tier where the clinical value is the highest to save money for the plan.

"While it was important for us to look at the business case for cost savings, the plan had to align to the benefit philosophy and benefit strategy, which included incenting employee behaviour for good-value medications and cost-effective and good-value therapies across the tiering that optimized productivity and were well supported at the store level.

"We made sure that we didn't focus on cost alone, but also considered member impact," said Rolnick.

"Essentially we took a disease-by-disease approach where we identified over-the-counter options that would be less likely to impact productivity which would have options on the first tier," he said.

Unique Position

Shoppers Drug Mart leveraged its unique position and insights into the pharmacy space and, being a large employer, was able to get "some pretty considerable savings year over year in a way that really managed the employee experience and kept engagement high."

What's next, he said, was getting into a responsible employee productivity-oriented tiering of some of the higher volume non-specialty products. "The pharmaceutical industry does a lot of research, they do bring a lot of innovation forward, and we want to make sure that if the innovation is of good value, we find ways to pay for it." **BPM**

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