Expensive biologics are driving up drug claims costs...but how can employers choose between saving a life and saving the drug plan for everyone?

I Want a New Drug

By **Brooke Smith**

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Employers offer benefits plans to attract and retain employees but also to keep them healthy. In the 2014 *Sanofi Canada Healthcare Survey,* 57% of plan sponsors said the main purpose of their health benefits plan is to attract and retain employees, and 52% reported their plans' purpose is to keep employees healthy and productive. And 83% of plan members consider the drug plan very important.

"Employers recognize that drug plans are an investment in the health and wellness of their employees, and that they help to keep those employees healthy and productive at work," says Barb Martinez, practice leader, drug solutions, with Great-West Life (GWL).

However, 70% of plan sponsors surveyed raised concerns about the sustainability of their drug plans. This isn't surprising, since many drug claims—such as those for cholesterol-lowering medications, blood pressure meds and antidepressants—are related to chronic conditions. Ongoing conditions may not always need a drug; some can be improved through lifestyle changes alone, such as exercise and a healthy diet.

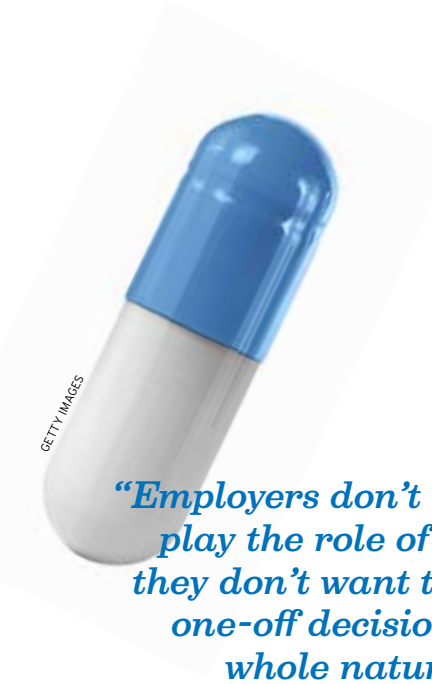
But other conditions—including cancer, rheumatoid arthritis (RA) and hepatitis C—may require more expensive

treatments to save employees' lives or significantly improve their quality of life. Remicade, for example (used to treat RA as well as Crohn's and colitis), can cost an employer an average of $29,000 per patient, per year.

Driving Up Costs

The growth of biologics such as Remicade is costing employers. Martinez says many employers in GWL's roster have a high-cost specialty medication at the top of their drug benefits spending. Although incidence of these diseases is rarer among employees, she continues, they're still a major cost driver. "There might only be a small number of people with a claim for these specialty medications, but the higher cost per claim adds up to a large amount covered by employers."

For example, the Public Health Agency of Canada reports roughly one-quarter of a million Canadians are infected with hepatitis C, but one in five don't know they have it. Many who are infected show no symptoms. If those who are asymptomatic are eventually diagnosed, that would introduce more claimants, upping employers' drug spend.



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— Sarah Beech, Accompass

Furthermore, certain lifestyle activities (e.g., sharing needles or engaging in unprotected sex) contribute toward contracting hep C. While the new drug Sovaldi has been promoted as a cure, if patients don't take the medication as required or don't change their lifestyle, they could contract the disease again.

The Benefits 360 Health & Welfare Trust, representing 1,750 Canadian employers and 70,000 employees for the Canadian Automobile Dealers Association (CADA), is currently paying six claims for Sovaldi. And the drug comes with a high price tag: about $55,000 for one 12-week treatment. Currently, CADA does not have a limit on the number of treatments per patient, but it will be considering plan options in the future.

The trust also has one claim for Soliris (an infusion for a genetic disorder affecting a small number of Canadians). That treatment costs a staggering $500,000 per year. The CADA plan is paying the whole amount, which was reduced to $435,000 through its insurer's health case management process.

"About four or five years ago, our high-cost drugs were around $3 million," says Catherine Jay, director, governance & plan management, Benefits 360 Health & Welfare Trust, with CADA. "We're now at $6.5 million."

It's not the average cost of the drugs that has increased, she explains; it's the number of employees taking the more expensive drugs. In 2014, there were 455 claimants for high-cost drugs, compared with 342 in 2013.

But, insurers argue, that's what insurance is for. "The drug plan is doing what it's designed to do: help people get medications they couldn't otherwise afford so they can be healthy and productive at work," says Martinez.

David Willows, vice-president, strategic market solutions, with Green Shield Canada, agrees, comparing health insurance to house insurance. "Most of us will never use our house insurance; for most of us, our houses aren't going to burn down," he says. "But there's an exception. When it happens to you, there's insurance there for you.

"There are occasions when we've got these new drugs," he continues. "They may be expensive, and we may debate whether we pay too high a price for them. But they're making amazing medical advancements for people with serious medical conditions."

The Trade-offs

But employers—whose primary focus is their business—also have to look at the bottom line. For CADA, the dealerships decide on their individual plan designs, and almost all have open formularies.

"Employers ask, 'How can we continue to afford these increases?' " says Jay. "We have concerns that employers will start to react by putting low maximums in to lower costs—or, down the road, if things get too expensive, eliminating coverage altogether. It's not at the tipping point yet, from a cost point of view—and I'm not sure what the tipping point is—but we could get there. There is no doubt that our current model will become unsustainable unless there are significant changes in the marketplace."

And if a drug *isn't* covered, there are other costs to consider. "If I'm curing hep C versus that person ultimately being so sick they can't work or ultimately dying, is paying for it a better trade-off than paying out a big disability or death claim?" asks Sarah Beech, president of Accompass.

"Employers don't want to play the role of doctor; they don't want to make one-off decisions," she adds. "The whole nature of an employee benefits program is that there's equal access." With Sovaldi, Beech says one option may be for the industry to set some limits, such as paying for one course of treatment per plan member.

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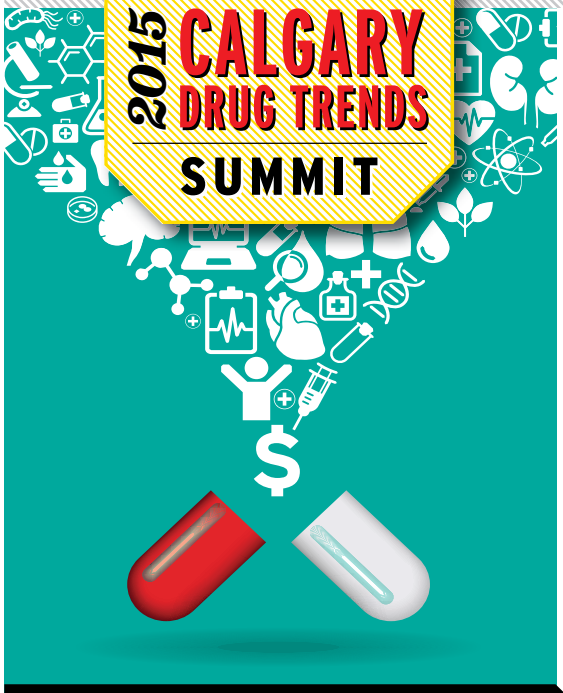

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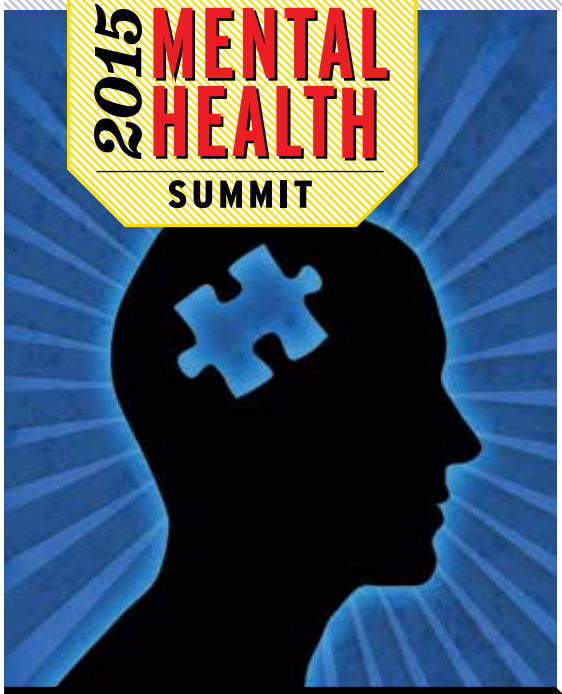

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Green Shield Canada does cover Sovaldi, but, as Beech noted, only for one treatment (of 12 to 16 weeks). However, patients need to take the medication as prescribed, says Willows.

"We can't have plans paying for this two or three times because [a patient] is not adhering to the treatment," he says. "I don't think that's fair to the broader population and the financial health of a plan if an employee is going to have this drug reimbursed at a very high cost. The onus is on the plan member and their physician to make sure it's used properly."

Not Enough Data

Employers want the numbers to show that offering an expensive drug—or any drug, for that matter—will give them a reasonable return on investment (ROI). And insurers are trying to provide those numbers. But the ROI of a drug will vary depending on the condition, the stage of the condition and the person taking the drug, says Martinez. "It's not like there's one answer for all drugs."

Jay says the statistics she receives aren't specific enough. "It's much the same thing as trying to decide what the ROI is on a wellness program—it's very, very elusive," she notes. From her perspective, the trend statistics aren't correlated with disability or disease states, so it's difficult to determine how the drugs help people stay at work. "We know RA medication…is keeping people at work, keeping them off disability. But the correlation hasn't been really identified clearly from a financial point of view—which would make sense to an employer," she explains.

Willows adds that because the drugs are new and not exposed to a large number of patients, there's nothing definitive or evidence-based in the ROI studies.

Employers do have some tools and controls to help them save on expensive drug costs. Pooling can help, but it isn't the full answer. "Pooling is designed to protect plans from catastrophic risk and is particularly helpful for small groups, helping them to cap their liability at a certain dollar threshold," Martinez explains.

In 2010, the Canadian Life and Health Insurance Association pledged to protect private drug plans from the financial impact of high-cost drugs. Twenty-three insurance companies across Canada agreed to mandatory pooling and a joint industry pool for large and recurring claims.

Historically, pooling was designed for one-time catastrophic costs, such as an

6 OF THE
top 10 drug classes in 2013 were used to treat conditions related to cardiovascular disease and the nervous system
Source: Canadian Institute for Health Information

$28.8 BILLION

The amount Canadians spent on prescription drugs in 2014

Source: Canadian Institute for Health Information

out-of-country car accident, but that's not the case these days. "Think about chronic RA medications that can cost $25,000 or $50,000 a year and that you may need to take for life," says Martinez. "Those kinds of claims are falling into the pool and putting more stress on the cost of pooling."

Jay says CADA is always looking at pooling thresholds. "Naturally, there's pressure to increase those thresholds. [But] all that does is move more claims into the claims experience of the employer, and that drives [its] base costs up. Where's the proper balance?"

Many employers use prior authorization in their drug plans. "You're asking the physician and the patient to say why they absolutely need this particular drug, and why other drugs aren't going to work. It's a validation for it," Beech explains. "An employer should put those measures in."

Willows says employers also need to look at their overall health benefits spend, especially for paramedicals. "The number of people using massage and chiropractic services has really increased in the last number of years without a lot of evidence on their long-term health impact," he notes. And while employees may use the services, only about one-quarter of respondents to the Sanofi survey saw both massage therapy and other paramedicals (e.g., acupuncture and naturopathy) as a very important benefit.

From an ROI standpoint, it just doesn't add up. "We're concerned we don't have enough money to pay for a drug that cures hep C or to get someone with RA from their bed back to work," says Willows. "We tend to be spending a lot of money on things we like and want rather than on these more expensive drugs—which, it could be argued, we really need."

For her part, Jay would like to see a national catastrophic drug program to relieve some of the pressure on employer-sponsored plans.

"The federal government becomes a huge purchaser of drugs and would be able to buy them at a somewhat lower cost, or at least have influence over the pricing," she explains. "That would be a better way to spread the cost, spread the risk. It's probably Utopian—the political will of actually going there is hard to imagine. But that, to me, is a solution."

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