Presented by Benefits Canada

CANADIAN LEADERSHIP COUNCIL
DRUG EVALUATION



THE RIGHT DECISION

NUMEROUS FACTORS COME INTO PLAY WHEN CONSIDERING MANAGED FORMULARIES FOR PRIVATE DRUG PLANS

CHRONIC DISEASE AND HIGHER-COST SPECIALTY drugs appear to be putting plan sponsors into a corner, as many feel their drug plans can no longer afford to cover all drugs. Yet the move to managed formularies comes fraught with unknowns: How do we choose which drugs to cover? Does there need to be a separate drug evaluation process for private plans? What role can public formularies play? Do we have the tools and systems in place to know we are making the right decisions?

Industry leaders addressed these and other questions as participants in the 2012 Canadian Leadership Council on Drug Evaluation, which met formally in Toronto in late June. While private managed formularies are still in the early days in Canada—the council estimates that no more than 20% of private plans are managed—it's past time to address how to close significant gaps in understanding, information gathering and process.

Education on the value of drugs, rather than just their costs, is at the top of the list. "Plan sponsors want to move to a model where their drug plans pay for only effective and affordable drugs," says Suzanne Lepage, private health plan strategist and moderator of the council meeting. "What we often hear is, 'If two drugs are equally effective, then why not pick the cheapest one?' The challenge is that 'effective' and 'cheapest' do not always mean the most cost-effective."

Cost-effectiveness is a reflection of value, and "that is more difficult to assess," continues Lepage. "For example, if drug X will get your employees ▶

PHOTOS: JOHNNY LAM, JLP

back to work faster compared to drug Y, we have to assess the value of work time saved versus the relative value of the medication."

Positioning a drug in terms of its impact on the disease is an important first step. "Average employers today are never going to see a submission for drug coverage, nor should they," says Martin Chung, council member and assistant vice-president, strategic health management, Equitable Life of Canada. "Yet employers need to understand that we're not just talking about 'this drug.' We're talking about its impact on the disease. We need higher-level, relevant, practical Canadian facts about the disease. It could be a one-page fact sheet attached to the submission."

It will also be useful to have a concise summary of the economic evaluation so it is easily understandable by stakeholders, says Kathy Ho, council member and pharmacist, pharmacy services and formulary management, TELUS Health Solutions. "Let's say we recommend a favourable formulary decision for a drug that is efficacious but does not appear to be as cost-effective on the surface compared to other common therapeutic alternatives, although the data around productivity or absenteeism indicate otherwise," says Ho. "The actual economic evaluation is often pretty complicated. It's worth it for pharmaceutical manufacturers to invest in an easy-to-understand executive summary that PBM managers and insurers can adapt and share with their clients, including plan sponsors, where appropriate. It will also be worthwhile if pharmaceutical companies can provide a good economic analysis from the perspective of the private payers, with relevant costs and benefits listed clearly, for some of their important drugs."

BETTER INFORMATION

Substantial changes to data content and integration are also in order. "If we don't take meaningful steps to start changing some of the data and people's understanding of it, my fear is that this level of very informed discussion isn't going to be applied practically," says Mike Sullivan, council member and president, Cubic Health Inc.

For example, drug claims currently do not necessarily indicate the conditions treated, which makes it difficult to assess the drug's impact on the disease and its value for the workplace (for example, its ability to reduce absenteeism). As a result, drug claims analysis is largely retrospective and uses assumptions that may be inaccurate. "I see reports all the time that misclassify drugs or the classifications are too simplistic," says Sullivan. "You can't do anything with that from an integrative perspective. In fact, you can make some profoundly big mistakes."

Gathering post-market data, or real-world evidence of effectiveness, is also essential for private-payer analysis. There is a dearth of such information in Canada, particularly when it comes to group-specific data.

Multi-stakeholder collaboration is the key to building such knowledge. "The more we integrate with pharmacy, with pharmaceutical manufacturers, with advisors and others, the better the solutions we



can ultimately bring to plan sponsors," says Ben Harrison, council member and manager, group strategic relationships, Great-West Life.

NEW PARTNERSHIPS

For their part, pharmaceutical manufacturers appear ready. "We want to move into that space of showing the real-world value of our products in the workplace. But we can't do it alone," says Priscilla Nykoliation, council member and external affairs manager, private payers, AstraZeneca Canada. "Right now we can't just phone an employer and ask if we can track productivity data for employees on drug X. We need to build new partnerships to figure this piece out. We may have a variety of goals as stakeholders but at the end of the day we want to get to the same place, which is optimal health and productivity outcomes."

Pharmaceutical manufacturers' patient assistance programs represent another "good opportunity to collect vital post-market data," suggests Godfrey Mau, council member and pharmacist consultant, Medavie Blue Cross. "They are able to collect more information than just claims patterns or claims fills; for example, assessing medication adherence and tracking health outcomes for those patients who have enrolled in the assistance program."

Community pharmacies can also serve as a link to patients in the collection of real-world data. A growing number are providing medication management reviews, funded by provincial governments. Private payers and manufacturers could build upon that, enlisting the services of pharmacists to provide additional, ongoing adherence support with documentation that includes simple questions to measure the impact on performance and absenteeism at work.

REMOVING BARRIERS

Insurers and pharmacy benefits managers (PBMs) on the council are also stepping up to do more with existing systems and data. "As an industry, we've been guilty of looking at drug costs in silos," says Connie Wong, council member and director, pharmacy benefits, Manulife Financial. "We have addressed this so we can now measure the total cost per disease state, including drug costs, disability, absenteeism and paramedical costs, based on group-specific data. However, it's resource-intensive and hence an expensive process. We'd love to be able to push this data out more broadly but right now cost is a barrier for some groups."

Similarly, insurers and PBMs recognize the need for collaboration amongst themselves, since many employers spread their benefits across multiple providers. "We can address that, but it takes a lot of time and extra cost," says Wong. "Mechanisms have been put in place to facilitate such non-competitive collaboration. The use of multiple providers is no longer a barrier."

Acquiring the right information is a long-term commitment to partner on many levels. The results, however, are worth the effort. "When we assess aggregate data that include disability, absenteeism and productivity, sometimes you get a ▶

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– BEN HARRISON, GREAT-WEST LIFE

very different perspective on what conditions are impacting your bottom line," says Lepage. "For example, based on drug plan data alone you might focus on rheumatoid arthritis; however, when you look at the aggregated analysis you realize you have a much bigger problem with diabetes."

THE PUBLIC DISCONNECT

While drug evaluations for public drug plans can save private payers considerable resources regarding clinical information and, to some extent, cost considerations, the leadership council cautions against using them for decisions on coverage.

Public plans primarily cover the lives of seniors and low-income individuals, and use a health-system perspective to assess the value of drugs; for example, the drug's potential impact on surgery and doctor visits, explains Lepage. Private plans, on the other hand, typically serve an active, working population and need to consider a drug's value from the perspective of productivity and profitability; for example, its impact on absenteeism and return to work.

The emergence of provincial product listing agreements (PLAs) has further widened the gap between public and private plans. "PLAs create an 'illusion of value' with prescribers," says Mark Jackson, council member and pharmacy services consultant, Green Shield Canada. A provincial plan can make a coverage decision based on a PLA's lower confidential price, but this price does not extend to private plans. "The provincial PLA can drive utilization on our book of business, at a higher price tag, and as a result it's conceivable that those PLAs may present a barrier to private sector coverage at some point."

PLAs have "basically changed the whole analysis on cost-effectiveness," agrees Priscilla Po, council member and manager, clinical services, Express Scripts Canada. "When plan sponsors say, 'Oh, we used to follow or we can start to follow the provincial formulary,' we reply that the landscape has changed. We need to look at different aspects and arrive at our own decisions."

SETTING STANDARDS

In light of public-sector reforms and the unique value assessments of drugs for the private sector, the industry needs to consider how pharmaceutical manufacturers can put together formulary submissions tailored to the needs of private payers, suggests the council.

"Drug submissions today are very rigorous and technical. We forget the 'HR factor' that needs to take into account workplace-related healthcare costs," says Bessie Wang, council member and director,

PUTTING DRUG BENEFITS INTO PERSPECTIVE

MANAGED FORMULARIES MAY BE THE FUTURE OF private drug plans, but it's important to put drug costs in their proper context to avoid coverage decisions that do more harm than good, advises Thomas Parry, president, Integrated Benefits Institute in San Francisco.

The institute accesses large-plan member databases to build business impact models that break down cost silos and "help employers understand what's really at risk," says Parry, one of several guest presenters at the 2012 Canadian Leadership Council on Drug Evaluation. A recent model for automakers, for example, found that the pharmacy benefit accounted for just 15% of costs, versus a staggering 46% linked to lost performance productivity (also referred to as presenteeism). Wage replacement (26%) and absenteeism (13%) made up the remaining costs (note that medical costs have been removed from this breakdown, since they are not applicable for Canadian employers).

Another study on drug plan design found that adherence to medications for rheumatoid arthritis dropped as copays increased, leading to a "significant negative impact on disability costs," says Parry. As well, the overall adherence level was well below levels considered critical to drive improvements in disability and productivity.

"Regardless of how healthcare is financed in your country, the health of the workforce is a critical business strategy," states Parry.

professional services, TELUS Health Solutions. "It's difficult for pharma companies because they don't know enough about that environment. Now that there is more attention to drug coverage in the private sector, it would be worthwhile for manufacturers, perhaps through Rx&D [Canada's Research-Based Pharmaceutical Companies], their advocacy body, to get together with pharmacy benefits managers to standardize submissions for the private sector. For example, to determine criteria to measure the impact on disability."

Off-label use (that is, when a drug is used to treat a condition not listed on the product monograph) is also "something that we always talk about but that's never in the submission," says Leanne MacFarlane, council member and senior director, business development, Managed Health Care Services Inc. "How is this drug going to be prescribed in the real world?"

"Currently, off-label use is a risk," agrees Jackson. "It doesn't even have to be off-label; there can be indications in the U.S., for example, that aren't in Canada. The bottom line is that it has the potential to undermine any pharmacoeconomic or budget impact analysis that we get in our submissions."

Canadian law (under the *Food and Drugs Act*) dictates that pharmaceutical manufacturers can address only the indications approved by Health Canada and contained within the product monograph, says Mark Ferdinand, council member and senior director, health and economic policy, Rx&D. In the U.S., the Food and Drug Administration permits manufacturers to share off-label uses when specifically asked.

A submission format for private drug-plan evaluations is worth exploring as an industry, concludes the leadership council. The overriding objective is to close the gap between the academic, clinical content and "how things are going to work in the real world," says Tim Clarke, council member and senior vice-president, Aon Hewitt. "There are a number of different aspects of that, from adherence to physician behaviour to off-label use and future indications. It's a big challenge, and there is no easy solution, but we need to begin."

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