BENEFITS PLAN VALUE CREATION EVOLVES
Benefit programs were once a one-size-fits-all approach—but this is changing,” said Paul Kennedy, an actuary and principal in Mercer Canada’s Health Business practice who specializes in employee group benefits.

While historically employer-provided healthcare coverage has concentrated on traditional benefits, like hospitalization and prescription plans, to attract and retain the best employees, many started adding more areas of coverage, like paramedical, vision, and dental. “These benefits were always offered in a bundle, equally to all employees without choice,” said Kennedy.

“This had a two-pronged impact for employers. While this was changing,” said Paul Kennedy, an actuary and principal in Mercer Canada’s Health Business practice who specializes in employee group benefits. While historically employer-provided healthcare coverage has concentrated on traditional benefits, like hospitalization and prescription plans, to attract and retain the best employees, many started adding more areas of coverage, like paramedical, vision, and dental. “These benefits were always offered in a bundle, equally to all employees without choice,” said Kennedy.

“This had a two-pronged impact for employers. While the additional benefits kept employees happy, in some cases the full suite of benefits were not being utilized.”

Today, “while employers have injected significantly more financial resources into their benefit programs,” employee satisfaction towards those programs has continued to decrease,” he said. The workforce has changed and today most households rely on two sources of earnings, which means they have access to two sources of benefit coverage.” He also noted “Millennials will soon dominate the workforce, but Baby Boomers are not quite ready to retire.”

Kennedy believes a new approach is needed to increase employee engagement among the multi-generational workforce. “The market is trending towards a flexible approach to benefits and compensation that allows employees to tailor their benefits to their personal situation.” While “we’re already seeing a bit of this today,” he believes the evolution will be “greater than today’s typical flexible benefits plan,” giving employees more power to decide what sort of coverage they want. “Millennials in particular want flexibility,” said Kennedy. “Today’s flexible plans remain rooted in tradition by offering a generous level of base coverage, but in the future we’ll see employers give their employees more options when it comes to benefits and compensation.”

“First failure” in the medical world is when you try a drug, you intend for it to work, and your doctor intends for it to work, but it actually fails to achieve the expected results, said Zahra Sakkejha, Director of Marketing of Personalized Prescribing. That failure can come in many forms. It can be a side effect, it could be no effect, and it could be a toxic effect or an overdose. The rate of first failure across all categories is about 50 per cent.

What causes medication failure has a lot to do with genetics which is why a new field of personalized medicine has emerged called pharmacogenetics, also known as drug compatibility testing. It’s all about determining the right dose of the right drug for the right person.
before the patient actually takes that pill. It falls under the umbrella of what is being called personalized medicine, a term used to describe this new era of patient-centric healthcare which seeks to find the best possible treatment and the best possible health outcome for one particular patient.

With a one-size-fits-all method, doctors look at different things including age, health condition, weight, and any other drugs being taken. But there’s “no genetic piece of the puzzle and that’s a really critical piece that we’re missing,” she said. It means three individuals who are all very similar on paper in terms of their health characteristics could be treated exactly the same with three different outcomes – a toxic effect, no effect, and the intended effect. But, said Sakkejha, the third person got lucky. “It just happened that their genetics happened to be in that population that responds really well to this drug.”

Pharmacogenetics disrupts the system at the point of prescribing. It allows the doctor to understand which drug is going to work optimally for each patient. Currently there are two major types of offerings in the market. The employee benefit format is set up similar to the way an EAP is set up and those who need it can get it. The other is a pay-as-you-go format where the employer is invoiced per test. Used more by smaller plans, its downside is that the cost can be much higher for each test, which is why most employers prefer the employee benefit format.

Employers need to do their due diligence when looking for a program, she said. There may be concerns around privacy issues, discrimination, and because pharmacogenetics seems like a new science, although it has been around for over five decades.

However, there is a real return on investment. “In terms of cost savings, the biggest area that we see is in the reduction of absenteeism and disability. We’re actually not expecting to see a big reduction in drug costs because one ineffective drug is being replaced with a more effective one,” said Sakkejha. “There was a paper published in 2013 that actually showed employees who were on genetically incompatible drugs were three times more likely to be absent from work and four times more likely to go on disability.”

And while it may seem like “this is the future already, there are lots of ways that this technology can go,” she said. Employers will definitely be hearing more and more about this leading-edge new technology in benefits. And “schemes have become much more sophisticated with today’s technology and, in many cases, are very highly organized,” said Voin.

One of the questions Karen Voin, Assistant Vice-president of Group Benefits and Anti-Fraud at the Canadian Life and Health Insurance Association, frequently gets is: ‘What’s the cost of fraud?’ Studies estimate that “two to 10 per cent of healthcare dollars are lost to fraud,” she said. “Annually insurers pay healthcare benefits totaling about $32 billion so even at a conservative level of two per cent, you’re talking big dollars.”

With employers concerned with the sustainability of plans, fraud and abuse of benefit plans can add to these cost pressures. This may create a need for an employer to make difficult decisions such as adding or increasing a co-pay or deductible, decreasing coverage, and, the “worst case scenario, potentially having to stop offering a benefit plan to their employees.”

Fraud is essentially where someone intentionally provides false or misleading information for the purposes of financial gain. Abuse is when there is exploitation of the plan. An example is plan member or their dependents using all the annual maximums in their policy every year, even if the products and services are not medically necessary.

The reality is that benefits fraud is not going to disappear, she said. “There’s too much money at stake.” Prevention is key to mitigating fraud. She offered three key messages – sponsors need to help plan members recognize how to protect themselves and the benefit plan; reject it before it happens; and if you suspect it, report it,” said Voin.

The average student today will have 10 to 14 jobs before the age of 40 and employers will be providing benefits to employees who are likely coming in and out of jobs every few years. “This will have a big impact on benefit design because employers will need those benefits to attract and retain the best and the most talented,” said Todd Nelson, Toronto Leader for the Willis Towers Watson Investment Practice and Co-leader of the Canadian Defined Contribution Team.

It is also important for employers to recognize that there will be at least three generations in the workplace – each with a different set of values and financial lens through which they view the package of career, benefits, and compensation.
The key message for employers is that employees across all generations value health and retirement benefits. They simply value those benefits in different ways. “When you spend the time and money to get it right for each generation, that’s when the value becomes most clear,” he said. But that’s not enough. Employers have to ensure that the program evolves to keep pace with changing workforce demographics.

Employers also need to balance the needs of a multi-generational workforce while delivering an ROI for the company. “In the past, benefit program management was generally focused on compliance-driven management – employers made sure they were compliant with the laws, checked their usage and cost figures, and monitored the dollars spent,” said Nelson. But there is more to creating a positive ROI. “Employers must design a program and communicate the benefits of that program in a way that is meaningful for that organization’s unique workforce,” he said.

This can often be achieved by treating employees like consumers. “When companies think of their employees as consumers, they can begin to gather immense data to help them better understand the needs of their workforce,” said Nelson.

Taking a closer look at drug plan utilization at a patient level shows the majority of patients suffer from multiple conditions and need assistance in managing treatment complexity, said John Herbert, Director of Strategy, Product Development, and Clinical Services at Express Scripts Canada. Specifically, over half of claimants suffer from two or more chronic conditions and a “staggering” 19 per cent of claimants suffer from four or more chronic conditions.

Those who suffer from four or more conditions account for 53 per cent of spend, require an average of 36 claims per year, and their average annual spend was almost five times that of other claimants. “It’s quite clear that these patients need help making better decisions to optimize their drug spend and to reduce waste. Waste is highly prevalent within their drug spend, we estimate for an average claimant that is suffering from multiple conditions around $436 is wasted and this could be reduced by making better pharmacy choices and better drug choices,” he said.

Increasing claims volume illustrates probable disease progression and increasing complexity of treatment. This represents “a challenge for these patients as our researchers found that medication adherence declines as the number of conditions being treated increases,” said Herbert. Only 54 per cent of patients that have one or two different conditions were deemed adherent. However, this drops to 48 per cent for those using four or more medications.

Given this, he said it’s clear that patients require a holistic approach as well as tangible solutions to drive better decisions.

Solutions to help patients begin with leveraging actual data to drive better decisions. Data analytics can be used to identify opportunities to make those better decisions. Solutions can then be tailored to influence patient behaviour, addressing poor pharmacy choices and poor drug choices as well as poor health choices. Strategies to drive lower costs and healthier outcomes must include aligning physician and patient goals, engaging patients to influence better decisions and better choices, building trusted relationships with patients as well as their prescribing physicians, and finally helping patients implement their decisions once they’ve made them.

One solution is ‘Active Pharmacy.’ It makes it easier for patients to make the right choices and for them to execute upon those choices as well. The Express Scripts Canada model closes gaps in care and reduces waste by acting as a concierge service which engages patients and helps them identify and implement better choices. The model itself is a circle of care built around the patient which effectively engages patients, aligns physician and patient goals, and builds trusted relationships. This can increase adherence across multiple therapy classes by about 20 per cent.

Innovative solutions can drive healthier outcomes at lower costs. “This is where we see data-driven solutions helping to close gaps in care in the case of individual patients and reducing waste to ensure plan sustainability in years to come,” said Herbert.

The Patented Medicine Prices Review Board identifies effects driving drug spending – push effects that push drug spending higher, and pull effects that pull drug spending lower, said Barb Martinez, National Practice Leader, Drug Benefits Solutions, for The Great-West Life Assurance Company.

The pull effects are around generic drugs. The number and price of new generics pulls spending down, but these are diminishing dramatically. Patents will continue to expire, but not in the billions of dollars seen over the last number of years. “Going forward, there’s not going to be much pull effect, but there is going to be a lot of push effect.”

Demographics and volume are among the push effects. An aging population means that, over time, we’ll see an increase in the amount of drugs Canadians are taking, she said.

The biggest push effect for the future is around the drug-mix effect where doctors are prescribing newer drugs over older drugs. While newer drugs are sometimes thought to have better value, work better, and have fewer side
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effects, some of the waste in the system is because doctors are choosing more expensive drugs when less expensive ones can achieve similar health outcomes for many people.

For example, PCSK9 inhibitors are biologic drugs prescribed to treat high cholesterol at a cost of about $8,000 a year. Some people need these drugs as, without them, they’d have a high likelihood of heart attack. But many people can take the existing statin drugs that cost about $400 a year without increasing their risk of heart attack. For this reason, “… we need to ensure we’re paying $400 a year, not $8,000 a year wherever it’s appropriate,” said Martinez.

Much focus is on high-cost drugs even though that may not be where the big problems really are.

Great-West Life partnered with Sanofi, the pharmaceutical company, and Cubic Health, a data analytics company, for a study that looked at disability data and drug spending to determine the real burden of illness. In terms of dollars spent, diabetes was number one and most of the drug spend was on high-volume, low-cost medications. “Lots of people have diabetes, but per-prescription treatments costs are low,” said Martinez. “It’s different for rheumatoid arthritis and cancer. A much smaller number of people suffer from these conditions, but per prescription costs are high.”

Yet, the evidence is clear that while certain drugs are expensive, cutting them out of a benefits plan could mean a big increase in disability costs. Without coverage, many employees wouldn’t be able to afford the medications they need and could potentially end up on disability until they’re 65 years old.

“So we really have to think about where our priorities are to manage this. It’s not all about high-cost drugs,” said Martinez. “This is really an effort to turn on investment for health and wellness programs. So much great data available on the return on investment for health and wellness programs.” “We know that 70 per cent of illness is preventable. The World Health Organization estimates that 80 per cent of all heart disease, stroke, and type-2 diabetes and 40 per cent of all cancers would be prevented with education and treatment. There are powerful numbers that speak to the importance of health and wellness programs and their impact on costs,” said Martinez.

“It’s very important to be strategic about balancing cost and health, and to avoid knee-jerk reactions that cut things out of the plan and reduce access for plan members who truly need the coverage in order to be healthy and productive at work,” she said.

“Fifteen years ago, most of the top drugs in terms of cost would have been small molecules,” said Brad Millson, a Principal of the Health Access and Outcomes Consulting Group at QuintilesIMS. Today, close to half of the top 10 selling drugs in private plans are biologics.

One major difference between biologics and small molecule drugs is in what happens once they lose patent protection. For small molecule drugs, there is very predictable timing and discount for generics entering the market. “For example, once a typical small molecule loses exclusivity, generics tend to quickly enter the market at a fixed percentage of the brand price, and take market share from the brand rapidly,” he said, largely because many payers have policies encouraging the use of generics and generics are interchangeable with the brand. “What you see from that is a large savings for payers as patients get switched over from the brand to a generic.”

That’s not the case with biologics. To start, biosimilars are not interchangeable with the brand, hence the word “similar.” This means the pharmacist is not allowed to switch to a different biosimilar as they do with generics. They have to maintain the prescription as it was written. In addition, there is no fixed price discount with biosimilars as there is with generics, so we see varying degrees of list discounting by product.

As a result, the majority of biosimilar patients are coming from “new starts.” A lot of public plans are now mandating new patients starting on a particular biologic to use the biosimilar rather than the brand. Patients already on a biologic are grandfathered in and not forced to switch from the brand to the biosimilar. “One of the key things that we quickly learned about the uptake and adoption of biosimilars is that it’s likely going to be very different product to product, market to market,” said Millson. “There are therapy dynamics at play and a very different adoption curve.”

Regulatory decisions will be a key driver. Right now, there is no therapeutic substitution and how interchangeable these products are is still an unknown. No one is willing to take the risk of switching a patient if it means an adverse outcome.

Competitive strategy is another factor shaping this market. Innovators are at work to retain market share, but also provide savings and value to payers. “We’re seeing a lot of negotiation that’s happening between the innovator and the payers. While the details of these agreements aren’t public, if individual payers are negotiating lower net prices, this could be translating to quicker savings to the plans,” he said.
Physician behaviour is going to be a big driver as well. So far there’s still very little clinical practice or clinical experience in this area in Canada. As physicians get exposed to and used to using biosimilars, their level of comfort and knowledge may evolve.

The payer influence is obvious. Payers are looking for ways to generate savings and biosimilars is an avenue they’re looking at closely.

Finally, how the biosimilar manufacturers approach the market will have a big impact. The types of manufacturers in this space are very diverse, from innovative biotech through to established generic manufacturers and everything in between. They may take different approaches for their products, and depending on what they do or how they do it will obviously have an impact on how well their individual products are received in the market, how well they’re adopted, and what level of savings the payers can expect.

To quote John F. Kennedy, “Change is the law of life, and those who look to the past and present are certain to miss the future,” said Andrea Frankel, of Janssen Inc. So while they are fully supportive of cost containment measures, “we cannot be complacent. We need to realize and understand that cost management is important and necessary to the sustainability of drug plans.”

However, cost management may impact plan members’ health and incur added expense to the plan member and a plan sponsor. “So, implementing blanket solutions is not necessarily the answer. For certain therapeutic classes, there may be unintended consequences of implementing cost containment measures.

Cost containment measures typically include prior authorization, generic substitution, tiered formularies, therapeutic substitution, case management, and preferred provider networks.

However, in certain therapeutic categories, generic substitution can result in unintended consequences on the plan member’s health. For example, with organ transplants, immunosuppressant drugs are essential to prevent rejection. Generic immunosuppressants exist and pharmacists can switch without the physician or patient being made aware. This may lead to an imbalance between efficacy and toxicity with potentially harmful patient outcomes, even death. The risks are not limited to a switch from brand to generic, said Frankel. It can also be a switch between generics or a switch from generic to brand. “So caution needs to be exercised at the level of drug plan design when it comes to blanket mandatory generic substitution policies for certain therapeutic classes.”

Potential risks also exist with implementing mandatory generic substitution for mental health products. Looking at one particular product to treat schizophrenia, when patients were switched to the generic, 28 per cent developed psychotic symptoms and in mental health, a switch in medication could result in suicidal ideation, so this is “life and death that we’re talking about,” she said.

Employees who have destabilized because of a switch of medication will likely not discuss it. Ironically, employers invest heavily in mental health so their drug plan designs should be consistent with this large investment to result in positive health outcomes.

This makes it “critically important to exercise caution in certain therapeutic categories such as transplant and mental health when it comes to mandatory generic substitution,” she said.

Cost management needs to be maintained and perhaps even expanded, said Frankel, “but we need to sharpen our old tools.” Providing blanket policies for mandatory generic substitution may not be in a patient’s best interest and it may ultimately result in increased costs for plan sponsors. Similarly, biosimilar blanket policies may not guarantee best possible patient outcomes or plan sponsor savings.

To ensure the best possible patient outcomes, “we need to ask our insurers and PBMs for creativity with regards to drug plan design. This could include loyalty cards, manufacturer agreements, and approaching pharmacy to determine whether their profit model can change to ensure that once a patient initiates on a drug, they are able to remain on that particular drug for the duration of their treatment,” she said.

“The tools and approaches developed 20 years ago cannot be applied as a blanket solution to the complicated medicines of today and they don’t fit with the evolution of patient care. We mustn’t be complacent and we don’t want to miss the future, so we need to be creative and innovative to ultimately ensure best possible patient outcomes,” she said.