BARGAINING BENEFITS

CUPE RESEARCH

DRUG COSTS

Drug costs are rising rapidly. From 1998 to 2002 the costs of prescription drugs increased a whopping 61% in Canada. (See 'The Facts on Bargaining Benefits: Overview' for the reasons why)

Drug costs are the greatest contributor to overall benefit cost increases, so they are the primary target for employers seeking to lower their benefit costs. Employers' solutions for reducing drug costs include:

1. limiting access by managing drug formularies, and
2. controlling how available drugs are used.

1. Managing Drug Formularies

A formulary is the published list of all of the drugs that a drug plan payer will pay for people who are covered under that drug plan.

An "open" formulary, where all drugs are covered, is the preferred option. Until recently, any drug formulary restrictions tended to be "rules-based" - for example drugs that require a doctor's prescription are covered while "over-the-counter" (OTC) drugs are not.

"Managed formularies" is a new trend imported from the U.S., which imposes rules that limit access to drugs, or guidelines that encourage certain prescribing practices. Managed formularies exist to save money. They are usually developed by a benefits management company for the health insurance company.

There are several ways in which managed formulary approaches show up in employer proposals:

Restricted Formulary List ("Customized Formularies")

- This option limits the drugs covered by the insurance company, usually based on cost.
    - New drugs, that may provide significantly greater success in prevention and treatment, are among the highest priced.
    - This option allows the insurance company to override a Doctor's decision about what drugs are best for the patient.
    - Employers use historical drug usage data ("plan experience") about employees to propose restrictions that limit costs and affect only a minority of members.

- One outrageous example of such a "Customized Drug Formulary" was recently shown to a CUPE local in Ontario. All of the drugs (eg., Prozac, contraceptive pills, etc.) consumed by full-time and part-time members of the local were listed on the formulary produced by a carrier called "Shared Health Network Services Ltd". This document was a clear violation of employee privacy. The employer used it to try and pressure workers to negotiate the formulary based on illnesses that were "more important" and cheaper to treat!

- CUPE opposes this option because it overrides the Doctor/patient relationship and can violate employee privacy.

Multi-Tiered Formularies

- Many insurance companies are now promoting a tiered formulary (often three tiers) where each tier requires employees to pay a different percentage.

  - Employees must pay a larger share of expensive drugs and/or "lifestyle drugs" such as Viagra.

  - Employees pay a smaller share of the cost of generics and lower priced drugs.

  - The intent of a multi-tiered system is to encourage patients to pressure their physician to prescribe less expensive drugs.

  - CUPE promotes the use of generic drugs but opposes multi-tiered formularies, because they increase costs for employees and treat employees differently depending on the kind of drugs they require.

Electronic Drug Cards

- Electronic drug cards allow employees to directly purchase drugs at their local pharmacy.

  - The advantage is that employees do not have to pay the total cost of drugs and then wait two to three weeks for reimbursement from the insurer. This approach increases the likelihood that the prescription will be filled because the requirement to pay up front often acts as a deterrent for those who are less able to pay.

  - The disadvantage is that the advent of Electronic Data Interchange (EDI) allows pharmacists who submit employee claims electronically to interact directly with the insurance company's claims adjudication system. Insurers have taken advantage of this technology to further restrict access to drugs by building into the system new cost-containment measures that can further restrict access to certain drugs.

The more drug costs are passed on to individuals, the more people will face difficult, and often unpalatable, choices as to whether to fill prescriptions. A recent survey conducted by Price Waterhouse Coopers discovered that one in ten Canadians did not fill a prescription in the past year, with cost being a major factor.

The consequences of not filling prescriptions or skipping doses are

significant of course, as heart disease, diabetes, and hypertension can worsen. In the end, the savings realized by downloading costs to employees is transferred in even greater proportion to health expenditures borne by governments to deal with medical conditions that were poorly treated.

2. Controlling how available drugs are used

Employers and plan providers can implement other ways to contain drug costs such as:

- **Pre-approvals** – For certain medications, the physician must submit information to an independent reviewer, justifying the "medical necessity" of the medication.

- **Trial Prescriptions** – Under a trial prescription program, pharmacists dispense small amounts of a drug the first time it is prescribed. If the treatment is successful, the remainder of the prescription is dispensed.

- **Step Therapy** – In this case the plan only covers drugs when they are used in accordance with a standard treatment protocol i.e. a specific drug must be used first, and if it is not successful then another (more expensive) drug may be used.

However, these measures:

- Make cost as the determining factor, rather than a doctor's judgement.

- Allow insurance companies to control costs by directly involving physicians and pharmacists.

- Challenge doctors' clinical judgment, and burdens them with extra documentation. Spending more time on administration and paper work can threaten the time and energy that many doctors argue takes away from patient care.

- Put doctors and pharmacists in the middle between insurance companies trying to reduce costs, and big drug companies trying to directly promote their products.

- Risk increasing the influence of drug manufacturers on what drugs are accessible to plan members.

What are the alternatives?

Both employers and employees have an interest in controlling the costs of benefit plans. Employers may attempt to achieve this goal through managed formularies, but there are alternatives such as:

1. **Preferred Provider Networks (PPNs)** –require a pharmacy or group of pharmacies to provide service at a fixed, lower fee for both ingredients and dispensing.

    - The pharmacies will also dispense up to 90 days of a medication for one dispensing fee.

    - The arrangement with the PPNs is negotiated between the insurer and the pharmacy or pharmacies.

    - The pharmacies must be easily accessible to employees, geographically and in terms of hours of business.

2. **Direct Delivery (Mail Order) Pharmacies** – For long-term medications, direct delivery or mail order, pharmacies offer low dispensing fees and controlled drug cost mark-up.

    - Medi-Trust, is one bulk supplier of drugs can be used to supply some drugs. Its dispensing fee is 1/3 of that of most pharmacists. Their costs are lower because they are warehouse operations selling larger quantities of product than retail outlets.

    - It is important that the wording of Master Policies is clear as to how and when mail order pharmacies are to be used. For example, if there are delays in receiving mail order drugs, employees should be allowed to buy their drugs locally at no extra cost.

    - The use of mail order pharmacies like Medi-Trust should not be embraced in such a way that it puts the local pharmacist out of business.

3. **Risk-Pooling** – Wherever possible, locals should look for opportunities to join with other CUPE locals and other unions to bargain group insurance agreements.

    - Larger plans reduce costs by increasing the scale of plan participation and reducing administration costs. For example, within the Nova Scotia school board sector, CUPE, NSGEU, SEIU and the employer group are discussing the possibility of moving to a single, province-side, jointly-trusteed structure for group benefits.

4. **Government Involvement in Achieving Economies of Scale** – Locals can impress upon employers the need for them to join together to lobby provincial governments to use their "economies of scale" power to negotiate lower drug costs with drug companies.

    - The government could act as a kind of broker, passing on the negotiated savings in drug costs to consumers by selling drugs at a cheaper rate to retailers.

    - As well, both the federal and provincial levels of government should be lobbied to develop policies that encourage the development of generic drugs.

5. **Negotiating formularies** – By negotiating the formulary, locals can exert some control over how cost savings are achieved while protecting members from the problems highlighted in the above section on formularies.

6. **Use of generic drugs** - Generic drugs should be used whenever possible. Substituting them for the higher priced patent drugs is a very efficient cost-saver. It is important to remember, however, they cannot be substituted in all cases and that physicians will sometimes insist on the patent brand of drugs.

7. **Coordination with other benefit plans** where a plan member's spouse is covered by another plan can reduce costs. The total combined coverage should be maximized in favour of the employee and the arrangement should be bargained and put in writing.

Until we have a national Pharmacare plan, workers will continue to pay directly for their drug costs. The above proposals can help reduce costs plan by plan, but CUPE will continue to pursue the bigger picture solutions needed address the real sources of drug cost increases: the federal government's drug patent legislation that favours the giant drug companies, and provincial governments that de-list services to save themselves money.

For further information see: cupe.ca - Speakers Notes for a Presentation on Prescription Drugs to the House of Commons Standing Committee on Health, October 2003.