

Why focus on generics?

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“Why is there a focus on generic drug reform?” asked Barbara Martinez, a principal with Mercer, speaking on December 1 during a Mercer webinar entitled “Drug Reform—What’s Next?”

According to IMS Health, 54.3% of prescriptions in 2009 were filled with a generic. And, while these may be lower cost than the name brand, generics in Canada cost much more than they would south of the border. And as more brand name drugs patents expire in the next few years, many more generics will enter the market, she said.

Also, biologic (drugs synthesized from living organisms) spending has increased in the last five years. These drugs are very expensive, typically thousands of dollars annually, said Martinez. Most biologics are funded by private group insurance plans, unless they are administered in a hospital.

In 2000, 5.5% of employer drug plan money was spent on biologics. In 2009, this increased to 15.9%. “But that’s nothing compared to what’s going to happen in 10 years,” said Martinez. By 2019, 50% of all money on biologic drugs will be spent by the employer.

Provinces have been making attempts to help manage drug costs. All the provinces (except for Nova Scotia, Newfoundland and P.E.I.) have fixed generic pricing to a percentage of the brand. In B.C., Alberta and Ontario prices for public and private drug plans have been regulated.

But as brands come off patent, the potential savings may not be sufficient to offset associated increases. There is a significant increase in pooling charges from carriers, and this is expected to continue, she said. Generics account for 25% of the costs, and biologics and brand names represent a much larger share of the spending.

What’s an employer to do?

With drug plan costs not decreasing any time soon, employers need to consider some changes to their drug plans.

Some traditional approaches include implementing a generic substitution, a dispensing fee cap, a dispensing fee deductible, a managed formulary or a tiered formulary. But are employers using the tools? asked Martinez.

According to the Mercer Plan Design Database, 76% of employers in the database do *not* have a dispensing fee maximum. And 40% of employers still reimburse 100% of their drugs—that is, there is no co-insurance. “Those are going to be the plans that will be most susceptible to costs in the future,” she said, adding that companies with these plans are also vulnerable to hiring people who have high drug costs.

The database also reveals that 83% of employers don’t have a per prescription deductible, 30.7% don’t use a pay-direct drug card and 54.5% do *not* mandate the use of generic drugs. Some employers say that pharmacists might automatically offer the generic, but that definitely is not common practice.

Employers need to look at the tools that they have themselves, she said, in addition to lobbying the government.

New approaches

If an employee needs a \$300,000 drug treatment a year for the rest of his life, can you pay it? asked Martinez. Do you have a management process for high-cost drug claims? What pooling arrangements are in place? What is the pharmacy strategy in place?

Employers, Martinez said, are reluctant to bring in new approaches when the old ones don’t have a high uptake. But it’s up to both consultants and plan sponsors to understand what the available tools are and see if they fit the organization’s needs. Only then can you look at the new solutions.

Plan sponsors should update or implement a formal pharmacy strategy because of the combined financial impact of the recent drug reforms and the growing availability of expensive specialty drugs, she said.

And, she continued, employers need to communicate to employees and demonstrate the value of the drug plan, and educate employees on how they impact the cost of that plan