Redefining the Meaning of Lifestyle Drugs in Your Benefits Plan

by | Gordon Polk and Robert Fong

Plan administrators have to juggle the dual aims of improving member benefits and containing plan costs. Taking a broader view of health and lifestyle when it comes to drugs for smoking cessation and weight loss, among other categories, could help in achieving both goals.

As pharmaceuticals evolve over the years, so too must benefit plans adapt to find new ways to improve the health of members while containing costs.

Given the dramatic changes we’ve seen to the pharmaceutical landscape over the last decade, including changing views on medically necessary treatment, it is clear that challenges and opportunities for benefit plans remain a moving target. This article will examine the potential for plans to redefine their coverage of lifestyle drugs in order to streamline claims procedures, improve member experience and produce cost savings. Lifestyle drugs are prescription drugs used to treat categories such as smoking cessation, obesity, erectile dysfunction, infertility or cosmetic problems that are not always considered medically necessary—and thus often are not covered by benefit plans.

As it applies to certain treatments, the term lifestyle can be considered an anachronism in today’s world. The boundaries between an individual making a personal choice for a drug versus a physician prescribing treatment are not always clear in terms of what medicines are medically necessary to support health, wellness and job performance.

Today, most of us in the benefits industry have heard of innovative biologics, a new class of medicines derived from living cells. These drugs have the potential to improve health, and some even cure previously untreatable conditions, with corresponding decreases in employee sick days and disability costs. These drugs come with a price, and it’s up to benefit plans to find the optimal balance between costs and benefits.

This holds true for more than biologics, of course. And with the recent attention on biologics and the benefits they can provide, this could be a good time for plans to revisit other drug categories such as lifestyle drugs. Instead of using a narrow definition of medically necessary treatment that requires benefit plan personnel to parse through individual cases and exceptions to the rules, perhaps plans should take...
Narrow definitions of medically necessary treatment often require benefit plan administrators to make case-by-case decisions and exceptions—even though this may be beyond their level of expertise.

Consider the case of an employee who contacts a plan administrator to appeal a rejected claim for a specific drug. This employee has a history of rheumatoid arthritis (RA) that, in addition to physical impairments, causes her anxiety. She took a short-term disability leave in the past to deal with RA. She tried first-line oral therapies and found they were not effective for her. Now she requires further therapy and needs approval to go on an injectable biologic as requested by her physician. What should an employer do if its benefit plan does not cover the prescribed biologic drug?

Now consider the case of a different employee who has a smoking history of 20-plus years, which has had negative impacts on his cardiovascular and respiratory health, and who is now motivated to quit. He is seeking administrator approval because the prescribed smoking-cessation treatment is not covered by the plan. It turns out this treatment, though recommended by his doctor, was deemed a lifestyle drug by the insurer and thus was not eligible for coverage. Once again, what should an employer do?

These two examples help illustrate the conundrum facing benefit plans as they try to navigate through complex employee issues. Consultants and advisors can be of great assistance in these scenarios since they see them more regularly via different employers in their book of business, but the reality is that employers and plan administrators might not have the time or expertise to deal with exceptions to the rule or the complexities of individual cases when it comes to approving or denying a unique patient’s drug claim. This is where it can be helpful for a plan to better identify and define categories such as lifestyle drugs.

To Cover or Not to Cover—What Was the Reason?

The impact of plan design criteria on claims procedures and plan member health and wellness manifests itself when some drugs are covered and others are not. The reasons for these decisions are not always clear and can get lost when plan members submit claims that are subsequently rejected. With the help of advisors, plan sponsors can try to implement an overall benefits plan philosophy that seems reasonable and consistent while at the same time precluding the need for an intervention for every potential exception to the rule.

In the RA example above, so long as the patient has met predefined clinical criteria and has tried earlier step therapies, most insurers would approve the RA biologic. An in-the-know plan administrator probably would too, because he or she realizes that the therapy can prevent absenteeism, possibly prevent another disability leave and keep the employee optimally productive at work. This can be good for the plan member and good for the business.

When it comes to the smoking example above, it is quite possible—and fairly common—for all smoking-cessation therapies to be excluded from plan member benefits because these therapies are deemed to be lifestyle treatments. But this is a case where a rejected claim might not be good for the plan member or the business.

Today, we know that smoking is an addiction and the associated health issues are complex, often requiring multifactorial interventions including drug therapy over time in order for a person to have a fighting chance of quitting. From the plan standpoint, it is important to consider the health consequences of a member continuing to smoke, including the potential costs of cardiovascular medications like blood pressure or cholesterol pills, regular inhalers for longtime smokers who assist in the control of asthma, and the potential severe downstream costs of a lifelong smoker continuing to smoke.

Takeaways

- **Lifestyle drugs** are prescription drugs used to treat categories that are not always considered medically necessary, such as smoking cessation, obesity or infertility.
- Taking a broader view of medically necessary treatment could help plans reduce overall costs and enhance member benefits.
- Cost/benefit analyses indicate plans might find savings by covering smoking-cessation interventions that prevent down-the-road costs of members continuing to smoke.
- Sexual health and weight-loss medications represent other areas in which plans might find benefits such as prevention of more serious diseases, improved mental outlook and increased productivity.
- Technology can help plans to control quantity limits and enforce prior authorization requirements, reducing concerns for misuse or overuse of certain drugs.
develop chronic obstructive pulmonary disease (COPD) and lung cancer therapies. A cost/benefit comparison performed by insurers or pharmacy benefit managers (PBMs) might find there is a benefit to paying the modest cost of a smoking-cessation intervention—even if this intervention is repeated two or three times for the same plan member—versus the potential health costs of a member continuing to smoke.

For example, the Conference Board of Canada estimated that organizations face costs of $3,396 per year for each employee who smokes. In contrast, the cost of a typical 12-week course of prescription drugs for smoking-cessation therapy such as Champix® or Zyban® is approximately $400. Although the majority of plans do cover smoking-cessation drugs that are prescribed, many of them also implement limits such as dosage and/or annual or lifetime maximums. Given the nature of smoking addiction, such limits might be counterproductive for the patient trying to be free of smoking over the long haul. When it comes to nonprescription therapies like nicotine replacement patches or gums, which are recommended first-line treatment options, plans are even less generous. Less than half provide any coverage at all, and those that do are subject to similar annual and lifetime maximum restrictions.

When rethinking a policy, perhaps the broader issue to consider is whether a drug should be considered a lifestyle treatment or a health treatment.

**Modernized Drug Plan Philosophies**

In today’s context, very few plans would consider denying oral statin treatment to a patient diagnosed with high cholesterol. In fact, instead of receiving a claim denial, a patient may be targeted for followup treatment to track other common comorbid conditions such as high blood pressure or weight gain. Treatment of these conditions may help prevent the onset of more serious diseases such as diabetes or heart attacks.

But then consider the very similar situation of a patient presenting as overweight. It’s well established that being overweight is a risk factor for high cholesterol, high blood pressure and the development of diabetes. But weight-loss medication prescribed by a doctor can be denied because weight loss is viewed as a lifestyle treatment instead of a health treatment.

To illustrate further how the lifestyle label can be ambiguous, let’s look at vaccines. Historically, childhood vaccines have been covered by public health plans. But coverage wasn’t automatic for human papillomavirus (HPV) vaccines for preteen and teenage girls and boys. More recently, provincial government plans have been covering HPV vaccines as a way to prevent further treatment and higher costs down the line, but there were time intervals before provincial coverage in which plan sponsors had to decide if they would cover this vaccine.

Vaccines will continue to present conundrums to plan sponsors as new products are introduced to treat both existing and yet-to-be-discovered diseases. Case in point is the vaccine for shingles. If a plan doesn’t know the probability of an individual getting this condition without a vaccine, it is difficult to assess the cost benefit of covering the vaccine. Adding another layer of complexity to the decision is that patients suffering from shingles usually fall within the age group for retirees. While it might be an easier decision for an employer to exclude this vaccine from retiree coverage, the issue of coverage will remain pertinent for active employees between the ages of 50 and 65. Defining the shingles vaccine, and others like it, as a lifestyle treatment or a health treatment could make a big difference in coverage for members—and costs and benefits to the plan.

Sexual health presents another area of potential change for benefit plans. As with smoking cessation, maintenance of mental health is multifactorial because there are many facets to overall well-being. Sexual health can have an important impact on mental health. In that context, a plan should consider whether the savings of not...
covering sexual dysfunction drugs outweighs the costs related to stress, anxiety and a decrease in mental well-being such that an individual’s performance on the job is negatively affected. There also can be a middle ground. In the case of medications promoting healthy sexual functioning, many plan sponsors have addressed this issue by implementing quantity or dollar caps per month or per annum. For example, many plans implement dollar caps, such as a $500 annual spending limit, on erectile dysfunction drugs.

**Moving Beyond Lifestyle**

The above examples illustrate the difficulty in broadly defining lifestyle drugs. They also highlight the importance of reviewing drug categories in determining plan costs and benefits.

If we go back ten years, the issues and concerns that first arose with lifestyle drugs involved the fear that inappropriate use or overuse of certain drugs would contribute to unnecessary plan costs. In today’s world, many of those fears can be alleviated. PBMs employ technology that can accurately control quantity limits on certain drugs and enforce prior authorization requirements. Such controls can curb the potential threat of runaway costs.

Viewed in another light, those drugs that have been described as supporting lifestyles instead of medical conditions can be an opportunity for benefit plans to save on total costs. As with the smoking-cessation example, in which smoking-cessation drugs are far cheaper than potential medical costs for untreated smokers, it can make business sense to spend money on drugs earlier in order to save on costs down the road. As another example, the issues around drugs that assist with weight loss may be subject to greater debate; however, regardless of the employee’s reasons for seeking weight loss, there may be downstream medical benefits for both the employee and the employer. The vast majority of patients being prescribed drugs for weight loss are obese, and obesity comes with well-documented medical issues, most notably diabetes and high blood pressure. Members who lose weight before incurring costs related to diabetes or high blood pressure could be a tremendous source of savings for the plan.

With that in mind, it might be a good time to take another look at the drug categories in your benefits plan. Check to see if there are opportunities to streamline claims procedures, improve the health and well-being of your members and reduce expenditures by providing access to treatments that produce the best overall cost benefits.

This may require close collaboration and dialogue with your advisor and insurer, but the end result could be a well-considered policy that benefits members and the plan.

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**BIOS**

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