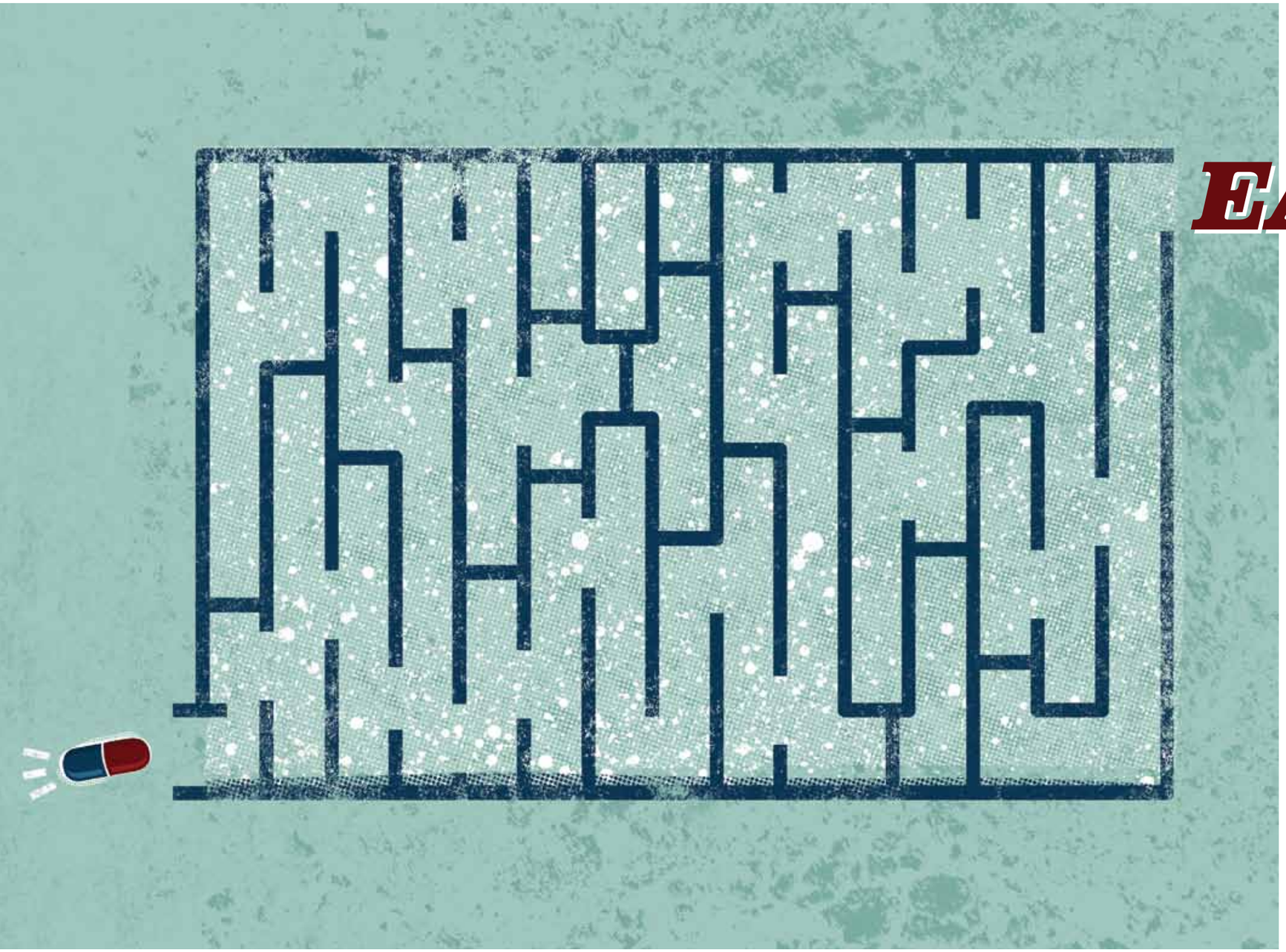

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NO *EASY* PILL

Understanding claimant needs is key to ensuring the sustainability of group benefits plans

By ***Eric Shen***

In 2011, the amount paid toward drug coverage by Canadian private drug plans reached $7.6 billion, an increase of $1.8 billion over the past five years, according to IMS Brogan's Private Drug Plan Database. The corresponding increase in cost to plan sponsors has spurred discussions on the sustainability of group insurance plans and the need for a long-term perspective on potential solutions.

Specialty drugs have become a key focus in recent cost-containment discussions, due, partly, to their inherent high cost and increasing availability over the past decade. In 2001, there were only eight such products on the market with an annual treatment cost of more than $10,000 per user, only one of which cost more than $25,000. By 2011, this number had increased to 76 (with 25 over $25,000 and two exceeding $250,000). As manufacturers increasingly focus their research and development efforts on these costly specialized medicines, this trend is expected to continue. It's no surprise, therefore, that group insurance providers and intermediaries are concerned for the affordability of some drug plans and are questioning the long-term impact to their own solvency.

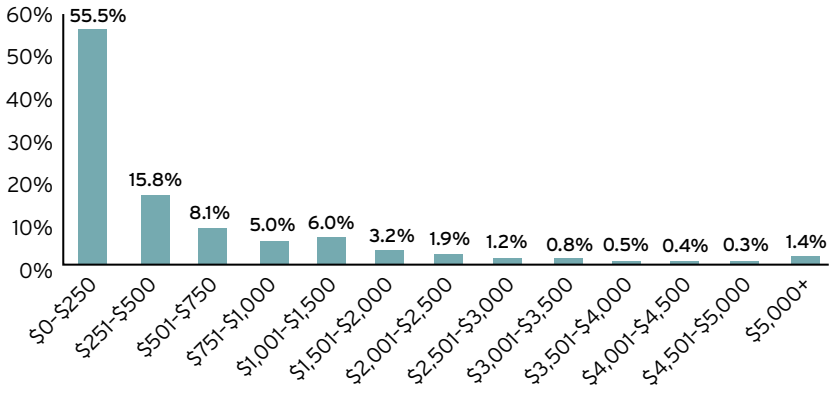
Pooling Efforts

Most private drug plans have long mitigated their risk from catastrophic events and that of plan sponsors by spreading the risk of high-cost claimants over a pooled group. This is accomplished through either stop-loss pooling for non-insured groups or large-amount pooling for their insured business. The increasing availability and subsequent use of high-cost treatments (the number of claimants who had more than $25,000 in annual cost has jumped from 5,800 in 2007 to 13,400 in 2011, according to the Private Drug Plan Database) have, however, put increasing pressure on these existing pooling strategies.

The Canadian Life and Health

FIG. 1 - SHARE OF CLAIMANTS BY ANNUAL DRUG COST RANGE, 2011

CANADIAN PRIVATE PAY-DIRECT DRUG PLANS



Source: IMS Brogan Private Drug Plan Database

Insurance Association recently formed a pooling network across 23 Canadian insurance companies (representing 100% of the market for insured plans) in response to this threat. This new agreement becomes effective in 2013 and should better position qualifying plan sponsors (i.e., a certificate that exceeds a claim in excess of $50,000 for two consecutive years) to sustain their fully insured drug plans in the event that high-cost drugs are claimed. This, in turn, will benefit employees by ensuring they continue to have access to expensive drugs should they need them.

Provincial Help

Additional coverage for high-cost drugs may also be available through provincial catastrophic drug coverage programs, which are used to help individuals with high drug costs relative to their incomes. These programs often kick in when a resident's out-of-pocket expenditure reaches a defined deductible. At that point, the plan sponsor is no longer responsible for any cost, and the employee will only need to pay a nominal portion. One example of provincial catastrophic drug coverage is the Ontario Trillium Drug Program, which is available to residents with a valid Ontario Health Card. Once the patient's out-of-pocket prescription cost is greater than 4% of family income, he or she would only need to pay $2 for subsequent eligible prescriptions. Similar programs exist in most provinces to protect residents from high drug costs. The exceptions are New Brunswick and Prince Edward Island, but some effort has been made to address this situation. In New Brunswick, an advisory committee is working on the outline of a new catastrophic drug program. However, the government is struggling with budgetary challenges and has only committed to having this program in place sometime during its mandate, which expires in the summer of 2014. In Prince Edward Island, the Liberal government had hoped the federal government would provide funding for catastrophic drug coverage in a new health accord—something that appears unlikely. During the October 2011 election campaign, the governing Liberals promised $1 million over the next two years to help seniors with high-cost drugs.

Claimants and Utilization

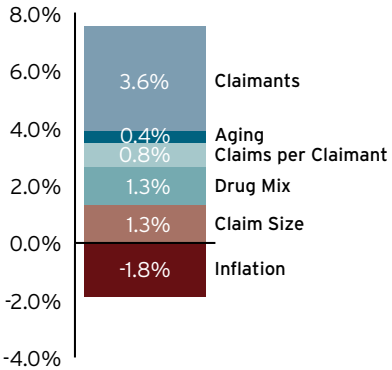
While the possibility of a catastrophic claim is daunting for plan sponsors, incidence rates for conditions that require these high-cost treatments are extremely rare. In Canada, in 2011, 98.6% of claimants had an average annual cost of less than $5,000, and most (71.3%) were under $500 (see Figure 1, above).

Although it is easy to lose sight of this when confronted with an annual claimant cost of more than $1 million, long-term sustainability of private drug plan insurance will be achieved, in part, through a continued focus on the masses of relatively lower-cost claimants.

The main driver of Canadian private drug plan cost increases is utilization. This is a combination of the number of plan members making claims and the frequency with which they are made (see Figure 2, below, for the average annual growth rates of key cost drivers). Over the past four years, the average annualized cost increase was 5.7%; however, this increase slowed in 2011 to 4.3%. Growth in the number of individuals actively participating in private drug plan coverage accounted for 3.6% of this annualized increase, with a corresponding increase in the average number of claims per claimant of 0.8%. Notably the price of drugs, or inflation, had a negative impact on spending over this time period—thus highlighting the importance utilization has from an overall drug benefit-expense growth perspective.

FIG. 2 - DRUG PLAN COST DRIVERS, AVERAGE ANNUAL GROWTH, 2008-2011

CANADIAN PRIVATE PAY-DIRECT DRUG PLANS



Source: IMS Brogan Private Drug Plan Database

In 2011, 67.6% of spending by private drug plans was associated with just 15% of claimants

The utilization trend is partly a result of an aging population. Claimants are becoming more concentrated around ages that are correlated with the incidence of chronic conditions such as hypertension and high cholesterol. There is a tendency for these claimants to take multiple medications to treat co-morbid conditions, which increases the number of claims being made by a single claimant. In 2011, the Private Drug Plan Database showed that more than half of claimants in Canada were taking three or more different medications, and nearly 7% were taking 10 or more. The expected continuation of this trend will place further upward pressure on drug costs.

Interestingly, most drug plan spending is concentrated on a small percentage of plan members. In 2011, 67.6% of spending by private drug plans was associated with just 15% of claimants. Any attempt to increase the efficiency of a drug plan should focus on this group of claimants. This group had roughly six times more claims (35 claims versus six) compared with the rest of the population, and the claims were largely concentrated among older individuals with chronic conditions, according to the Private Drug Plan Database.

Designing Solutions

For those claimants who have already been diagnosed with a chronic illness, traditional plan management strategies (e.g., mandatory generic substitution, therapeutic substitution and lowest-cost alternatives) are necessary to ensure the adoption of cost-effective treatments. Drug plans must continuously adapt to the challenges presented by potentially unproven treatment options. Despite lack of evidence of additional benefit, many patients may choose a newer drug as opposed to an older and potentially equally effective—but less costly—option. Esomeprazole (Nexium) and omeprazole (Losec) are good historical examples. Esomeprazole is a derivative of omeprazole and was clinically shown to be just as effective; however, the former comes with a higher price tag. In these cases, incorporating guidelines and tiered formularies into plan design can result in less expensive treatment options being selected by claimants.

Although the figures above seem sufficiently alarming to warrant action, prudence is needed to ensure that sustainability measures benefit plan sponsors without compromising employees' quality of life, which can have a significant impact on the healthcare plan and the plan sponsor. Healthy, happy employees generally use fewer sick days and are more productive. There is good reason why an increasing number of plan sponsors are investing in wellness initiatives and promoting an overall healthier lifestyle. Plan sponsors realize encouragement of a healthy lifestyle translates to lower chronic condition incidence and severity, and, therefore, a reduced average lifetime cost per claimant, if implemented correctly.

Initiatives encouraging medication adherence can play a significant role in reducing the deterioration of claimants' health and limit the future progression of illness. One study in the *Canadian Medical Association Journal* found that almost one in 10 hospitalizations in Canada is caused by mismanagement of medication. According to data from the Private Drug Plan Database, almost half of patients with type 2 diabetes, cholesterol and hypertension were not persistent with their medication after 12 months of therapy. And a surprising two-thirds of patients with depression/anxiety were not persistent. The need for intervention is evident.

Lastly, the expected benefit of improved drug management needs to extend beyond the cost of drugs only, to include a more complete health benefits perspective. Though the direct correlation between effective drug treatment, wellness initiatives and lower rates of disability or absenteeism, for example, is logically anticipated, the current lack of requisite data integration between these benefit types makes the precise measurement of the return on wellness investment difficult. Rather than the present systems of collecting data for separate benefit areas, data need to be gathered on the actual total cost of looking after a plan member. Building bridges across benefit types offers a promising avenue in the sustainability of group benefits, and helping employers create healthcare plans that work for themselves and their employees.

The cost of new drug treatments continues to rise. In order to guard against large rate increases and to ensure employees continue to receive care at sustainable costs, plan sponsors will need to look to plan design for sustainable solutions. It is unlikely that sponsors and members will contribute ever-increasing dollars into their plans, so it will become increasingly important to ensure that money available is spent wisely.

The process of reforming the status quo model in Canada will involve improved oversight and leveraging of available data.

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