Cost Drivers Analysis of Private Drug Plans in Canada 2012-2016

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INTRODUCTION

Innovative Medicines Canada (IMC) engaged IQVIA in 2016 to create an annual **Private Drug Plan Drug Cost Forecast** which included a baseline analysis that projected forward using actual historical private drug plan drug costs. An updated forecast will be released later in 2018.

This analysis takes a closer look at the private market claims data in order to highlight the key drivers of private drug plan cost growth for the period between 2012 and 2016. Often the total growth of the private drug plan market is simply reported without any details on what factors in claimant behavior are influencing total plan costs. Prior reports have identified significant growth due to greater utilization of drugs, however they did not provide details explaining utilization growth. This report will clarify the underlying drivers of cost growth, including utilization, in private drug plans in Canada.

It is important to note that the cost of a drug plan to a plan sponsor includes much more than the drug claim cost. Section 2 includes discussion on some of the other costs that influence the cost of a drug plan.

Methodological Notes

1. **Analysis is based on IQVIA Canadian Private Drug Plan (PDP) Claims Database**
   - The largest, national private drug plan claims database in Canada, comprised of 9 of the top 10 private insurance carriers, 3rd party administrators, and benefit plan managers.
   - Represents approximately 70% of total private drug claims in Canada. (Figures in this report have not been adjusted to represent 100% of the market).
   - Captures more than 12 million active claimants with over 129 million drug claims.
   - Represents only members that have claimed, not all covered members. TELUS Health Solutions data indicates that 63% of beneficiaries are claimants.
2. **Claims costs are based on submitted amount** including both the plan paid and the patient-paid portions and represent drug ingredient costs and pharmacy and wholesaler mark-ups (dispensing fees not included except in Quebec).
3. **Growth is measured using Compound Annual Growth Rate (CAGR)**. Because actual growth may vary from year to year, CAGR defines the mean annual growth rate for the entire period, and adjusts for volatility and compounding.

Executive Summary

75% of the private drug claims growth is driven by increased utilization and 25% is attributable to the cost of drugs

The total private drug claims market grew by 4.7% CAGR between 2012 and 2016, with the number of claimants (2.1% CAGR) and cost per claimant (2.6% CAGR) growing at a similar pace. The cost per claimant was driven both by growth in number of claims per claimant (1.4% CAGR) and in cost per claim (1.2% CAGR).

3.5% of the 4.7% growth is attributable to increased utilization (number of claimants, 2.1% and claims per claimant, 1.4%), whereas only 1.2% is due to the increased cost of drugs (cost per claim), often referred to as drug mix.

FIGURE 1

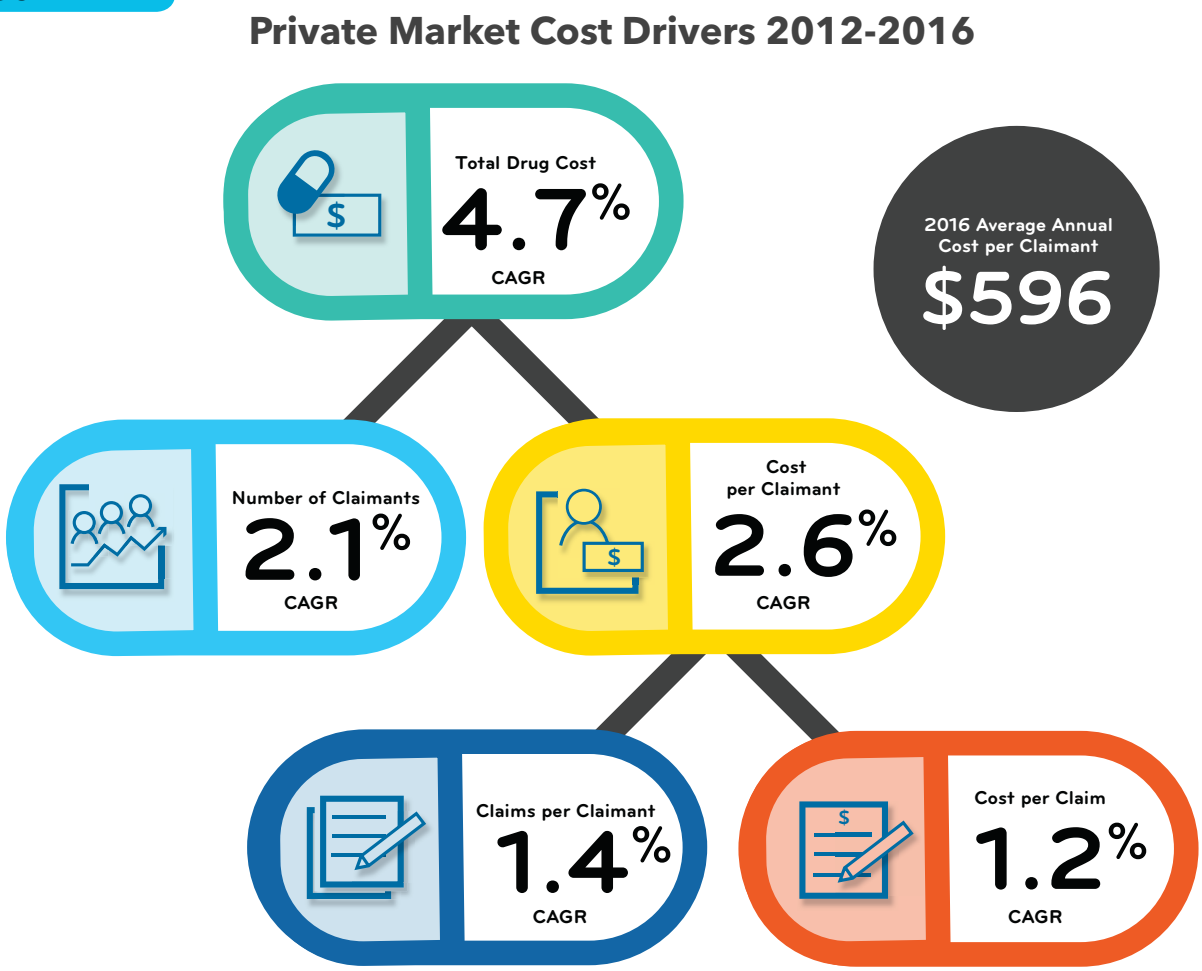


Figure 1. Source: IQVIA Private Plan Claims Database.

SECTION 1
Cost Drivers Analysis

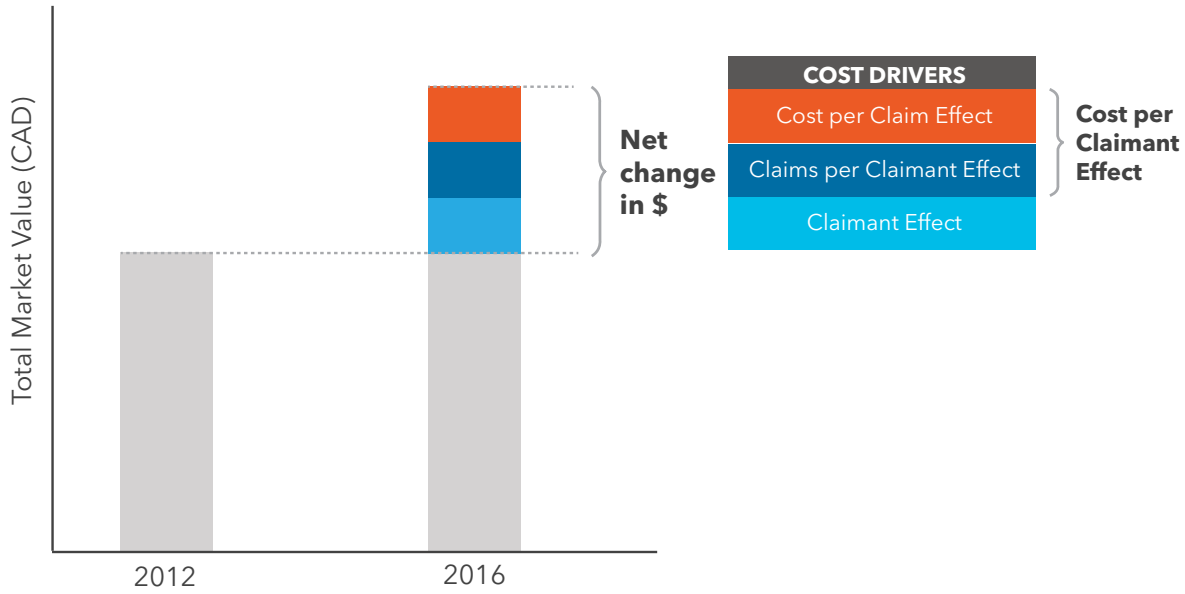
Background

Methodology

The Private drug plan (PDP) market growth was examined by separating the growth into three independent drivers: claimant effect, claims per claimant effect, and cost per claim effect.

Claimants	What was the impact of changes in the number of plan members on the PDP market growth? What was the impact of different age groups?
Cost per Claimant	What was the impact of cost per claimant growth on the PDP market?
Claims per Claimant	What was the impact of changes in the number of claims per claimant on the PDP market growth?
Cost per Claim	What was the impact of changes in cost per claim on the PDP market growth?

FIGURE 2



NOTE: not to scale, only for illustrative purposes.

Total Cost Growth 2012-2016

From 2012 to 2016, total private drug plan drug costs increased by 4.7% CAGR (Figure 3). Of note the increase seen in 2014 and 2015 can be largely attributed to the introduction of new hepatitis C treatments and the warehousing effect seen with patients who were waiting for the more effective treatments. By 2016 the costs of these medications had dropped to 2013 levels in private plans.

FIGURE 3

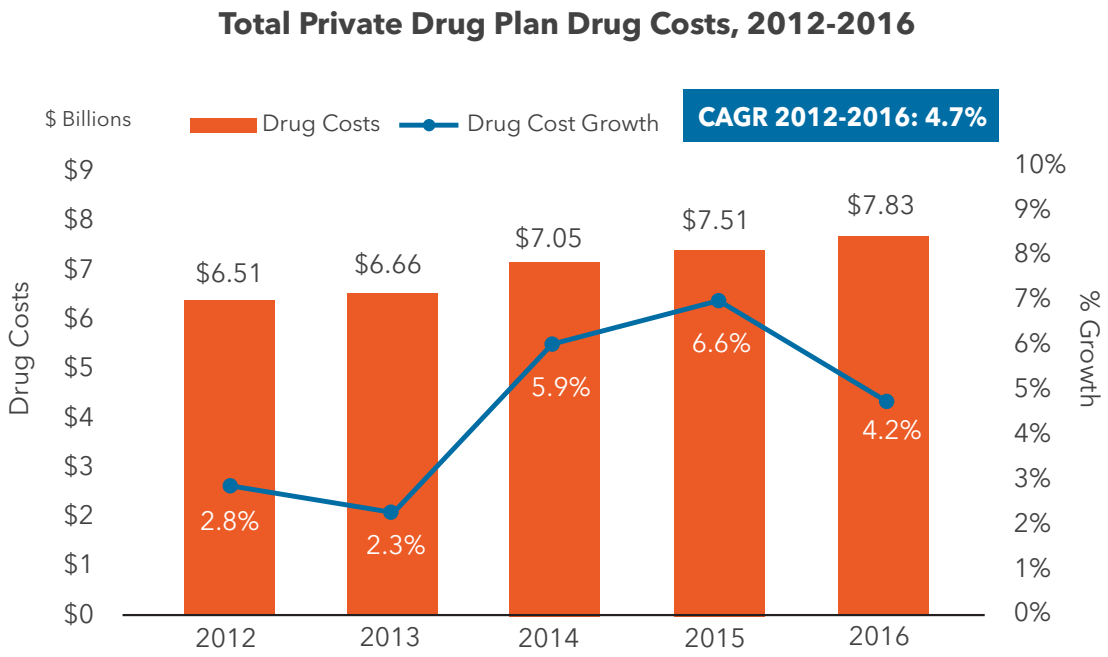


Figure 3. Total drug costs not extrapolated to represent the whole national beneficiary population. Source: IQVIA Private Plan Claims Database.

Cost Drivers 2012-2016

The three cost drivers had a different magnitude of impact on total growth, however the claimant effect contributed the most to total growth, followed by claims per claimant effect, and cost per claim effect.

FIGURE 4

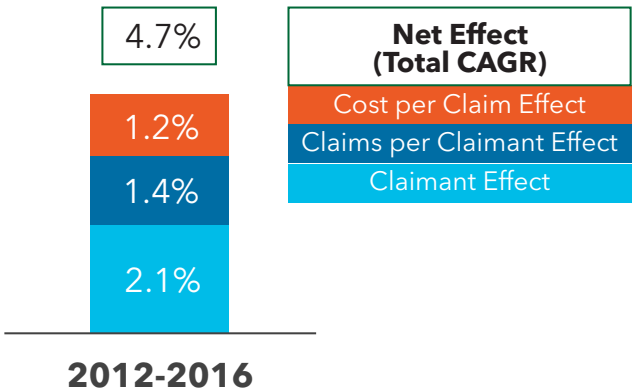


Figure 4. Source: IQVIA Private Plan Claims Database.

Claimants

The biggest driver of market growth (45% of growth) can be attributed to the increase in the number of private drug plan beneficiaries making claims (claimants) observed between 2012 and 2016, which represented a 2.1% CAGR (Figure 5). The number of claimants increased significantly in 2014 - 2016, following a small net drop in 2013 in the number of claimants.

FIGURE 5

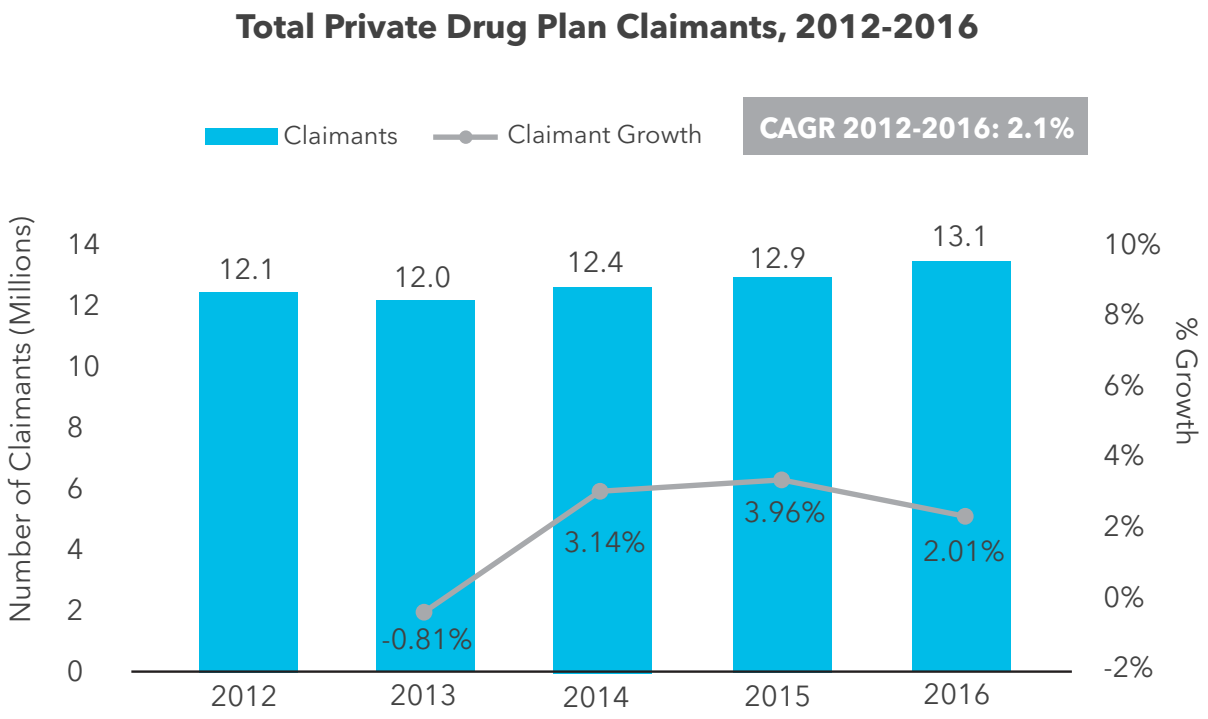


Figure 5. Number of claimants not extrapolated to represent the whole national beneficiary population. Souce: IQVIA Private Plan Claims Database.

Cost per Claimant

Cost per claimant is the other ingredient driving overall market growth. It is made up of two separate components: claims per claimant and cost per claim.

The number of claims per claimant grew by 1.4% CAGR and cost per claim grew by 1.2% CAGR, representing 30% and 25% of total cost growth, respectively (Figure 6). Adding up these two individual effects contributed to 2.6% CAGR growth in cost per claimant (out of 4.7% total CAGR growth). Average cost per claimant increased from $538 in 2012 to $596 in 2016 (Figure 7).

FIGURE 6

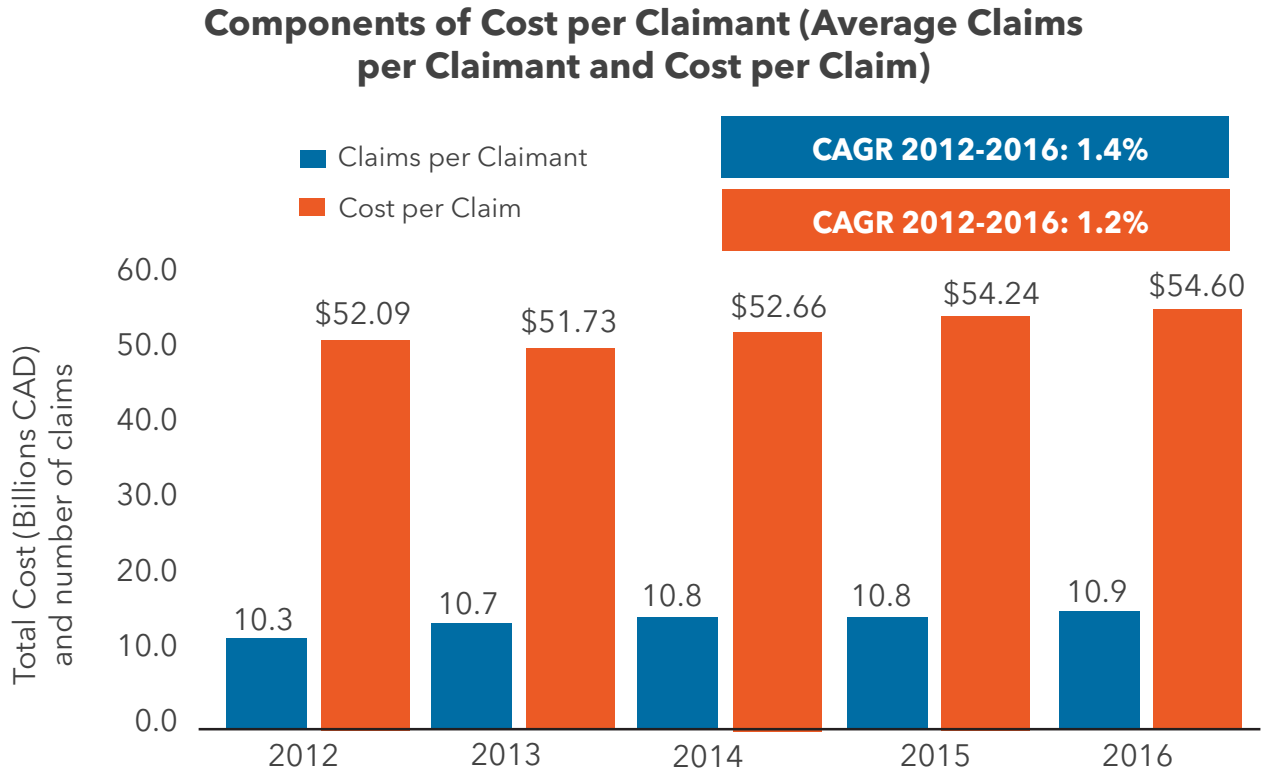


Figure 6. Source: IQVIA Private Plan Claims Database.

FIGURE 7

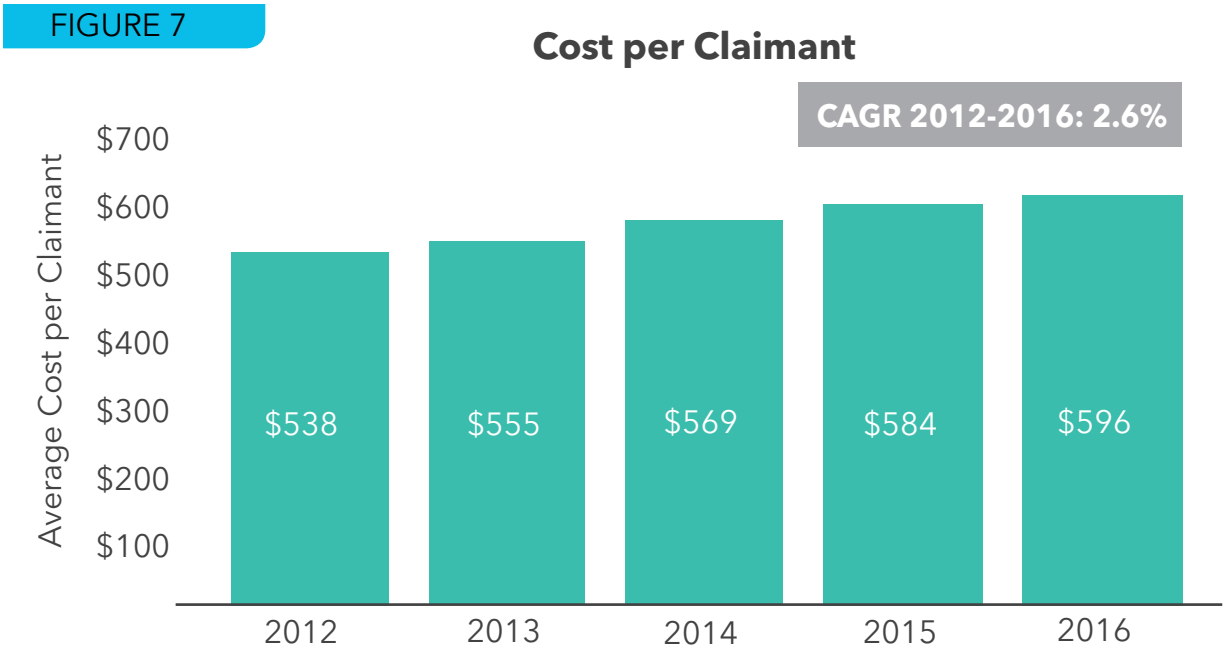
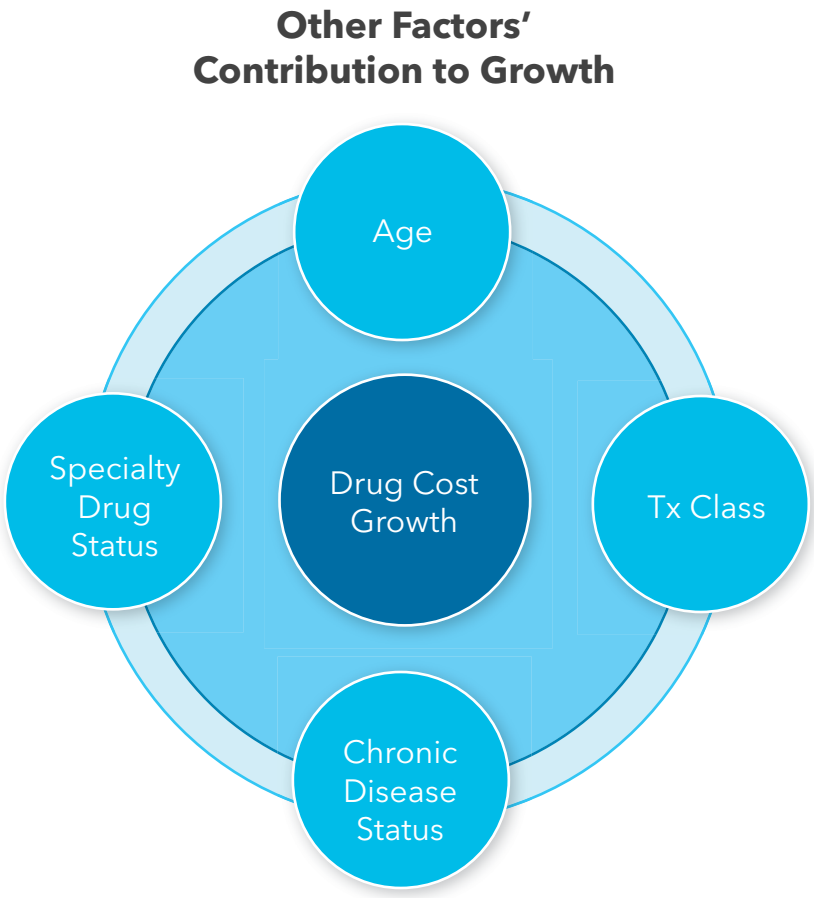


Figure 7. Source: IQVIA Private Plan Claims Database. (These numbers are rounded and may be different from multiplying the number of claims with cost per claim in Figure 6).

Growth Trends – Demographic and Therapeutic

Having gained an understanding that drug cost growth is mainly driven by utilization, most notably by claimant and claims per claimant growth, our analysis sought to identify the type of patient, disease profile and type of drugs that are experiencing greater growth. We examined several factors including age, therapeutic class, chronic disease drug status, and specialty drug status to understand where the greatest growth is occurring (Figure 8).

FIGURE 8



1. Age Effects

Of the 4.7% drug cost growth, the 25-54 age group accounted for 2.0% and the 55-64 age group 1.4% of the total growth (Figure 9).

Older age groups tend to have higher cost per claimant (Figure 10) and although they represent a smaller proportion of total claimants (55-64 represents less than 20% of the claimants in the private plan claimant population), they represent a larger proportional share of cost and thus contribute to more of the cost growth (Figure 10).

Although the 25-54 age group had the smallest CAGR growth (3.8%, Figure 9), they contributed the most to cost growth due to its larger share of the claimant population (~50%, Figure 10A). In contrast, the 0-24 and 65+ age groups had the biggest CAGR (6.5% and 8.3% respectively, Figure 9), but contributed the least to total cost growth because they represent a small share of the total population and/or have relatively lower average cost per claimant (Figure 10A & 10B)[1].

The 55-64 age group had greater growth than the 25-54 population (4.8%, Figure 9) and has the highest average cost per claim ($992, Figure 10B), therefore its contribution to cost growth was relatively high (1.4%, Figure 9).

FIGURE 9

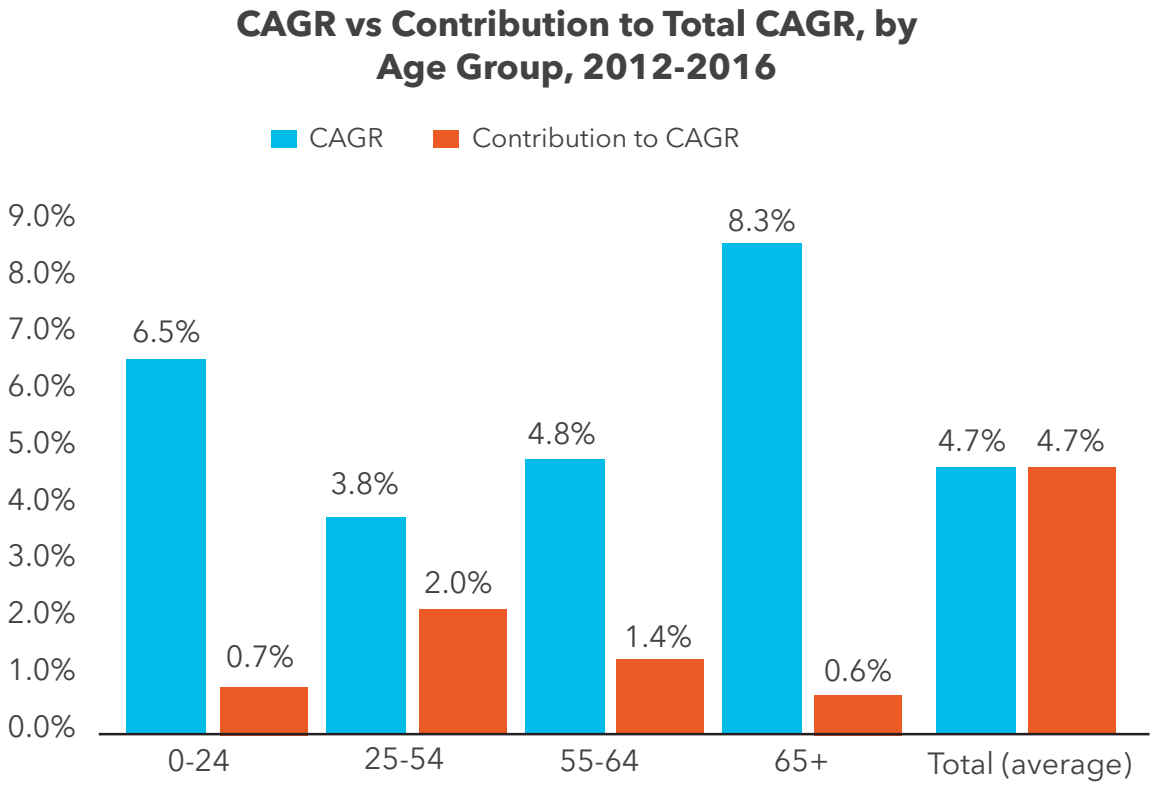


Figure 9. Source: IQVIA Private Plan Claims Database.

[1] The 65+ population in reality has the highest cost per claimant, however most of that cost is paid by the public drug plans due to private plan and public plan eligibility criteria and cost sharing design, leaving a relatively small proportion of cost in the private plans for that population.

FIGURE 10

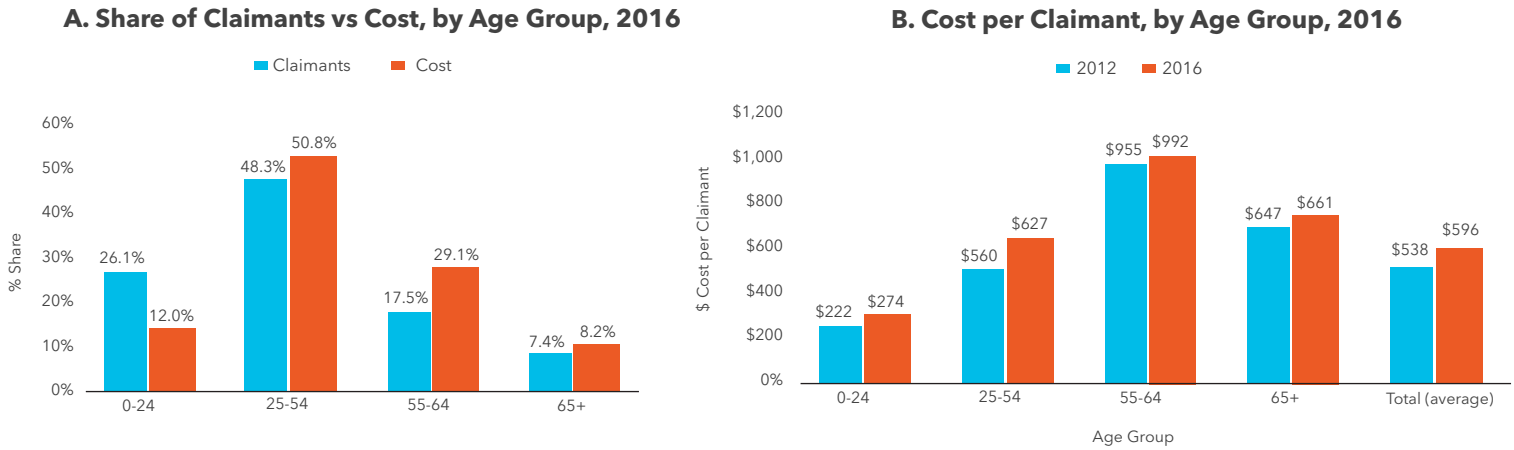


Figure 10. Source: IQVIA Private Plan Claims Database.

Growth drivers in each age group also differ (Figure 11). In the younger age group (0-24), claimant and claims utilization growth had less impact than cost per claim; whereas in the older age groups (55-64 and 65+), most of the growth is driven from claimant growth and claims utilization growth, whereas cost per claim has minimal or negative impact. The largest age group, 25-54, was equally impacted by all three factors.

FIGURE 11

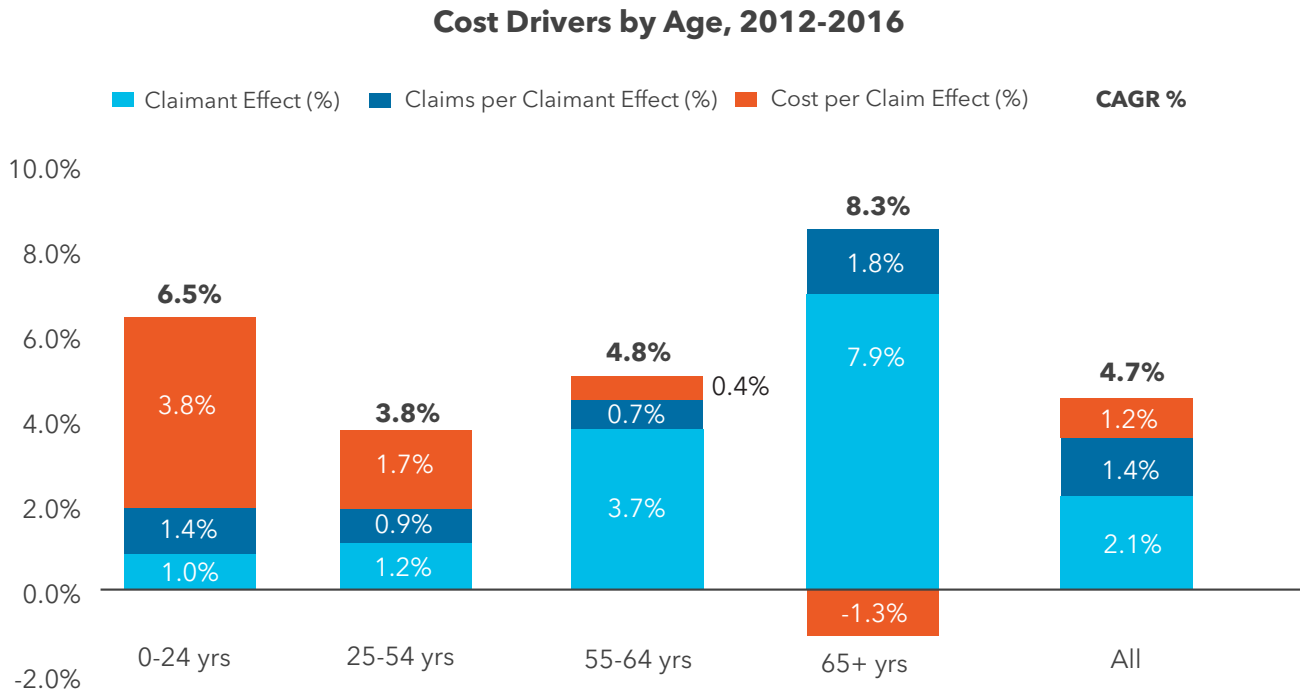


Figure 11. Source: IQVIA Private Plan Claims Database. Individual factors may not add up to the total net effect due to the impact of cross-effects, which is minimal, and not shown here.

2. Chronic Disease Drugs Effects

The analysis took a closer look at the impact on growth of drugs that treat chronic diseases versus non-chronic conditions. Drugs were grouped by therapeutic class as chronic or non-chronic by the characteristic of the disease they are treating (Appendix A). Oncology (antineoplastic) medications were kept as a separate category and not classified as either chronic or non-chronic.

Chronic Drugs:

- represented 63%-64% of total private plan drug costs (Figure 12)
- costs grew by 5% CAGR between 2012 and 2016 (Figure 13)
- contributed to most of the growth (3.1% out of 4.7%) (Figure 13)

In contrast, costs for drugs that treat acute, or non-chronic conditions, grew by 3.9% CAGR between 2012 and 2016 (Figure 13), and its share of total market costs represented 33- 34% (Figure 12). Of note, this covers the period with large sudden growth due to chronic Hepatitis C medicines, which are non-chronic therapies. Non-chronic drugs contributed to 1.3% of the 4.7% CAGR (Figure 13).

Oncology (antineoplastic) drug costs represented a small proportion of total drug costs (2.8% to 3.2%) (Figure 12), and although they grew by 8.8% CAGR between 2012 and 2016 (Figure 13), they contributed the least to total market growth (0.26% out of 4.7%) (Figure 13).

FIGURE 12

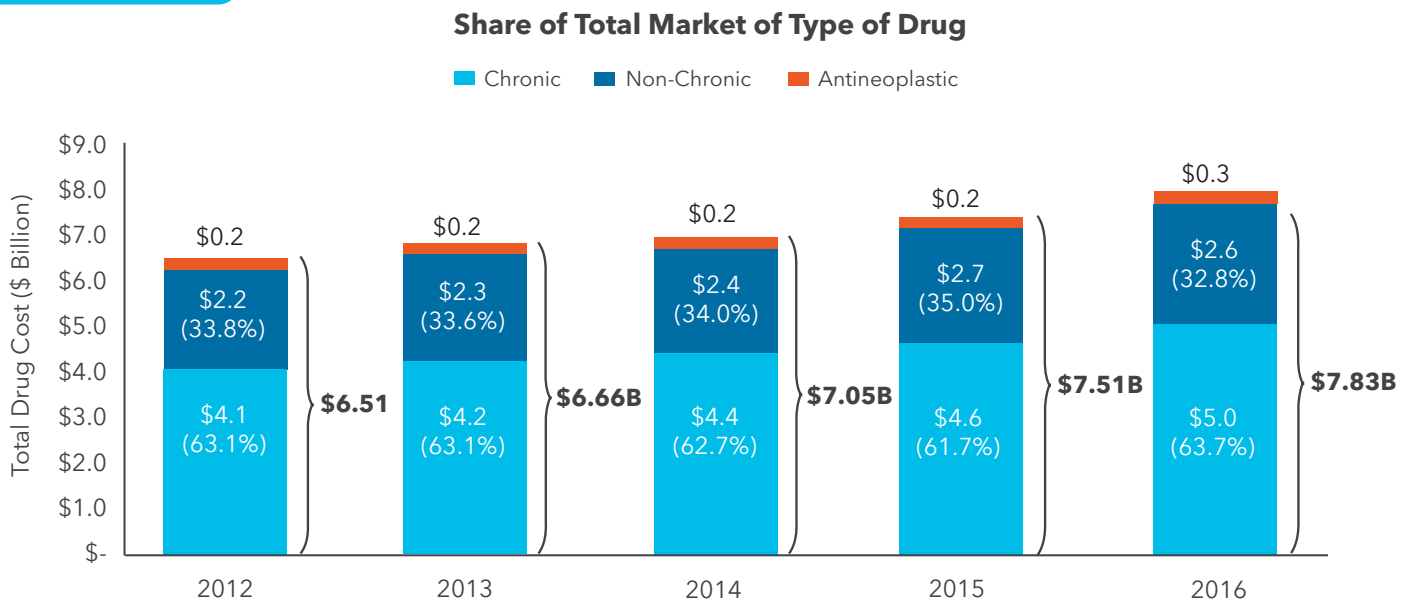


Figure 12. Source: IQVIA Private Plan Claims Database. Total drug costs not extrapolated to represent the whole national beneficiary population.

FIGURE 13

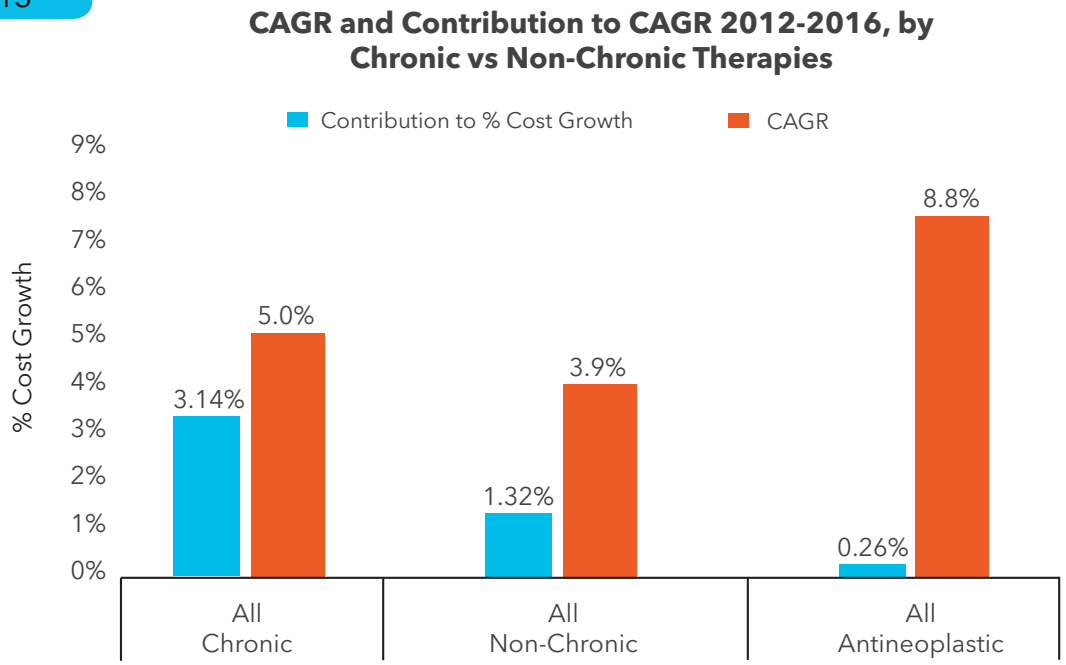


Figure 13. Source: IQVIA Private Plan Claims Database.

3. Therapeutic Class Effects

The top therapeutic classes in terms of cost in 2012 were compared to those in 2016. The top 10 classes in 2016 were the same as in 2012 and represented 82-83% of total private drug costs across the period (Figure 14).

Most of the Top therapeutic classes mainly represent **chronic drug therapies** (with some exceptions within the Anti-infective Agents, Other Therapy, and Gastrointestinal classes, which have been classified as "non-chronic" classes since their respective costs are principally non-chronic drugs, although they represent a mixture of non-chronic and chronic drugs).

The following classes moved DOWN in rank and/or had a negative contribution to drug cost growth, having seen major generic entrants and/or generic price reductions for top prescribed drugs between 2012-2016[2] : (Figure 14-15);

- **Cardiovascular drugs** declined by -5.2% and contributed -0.63% to growth of 4.7%, more than offsetting growth in the other immunomodulating/immunosuppressive class. They moved from the top ranking class in 2012 to 4th rank in 2016.
- **Gastrointestinal drugs** declined by -0.9% and contributed -0.06% to growth of 4.7%. They moved from 5th rank in 2012 to 10th rank in 2016.
- **Anti-depressants and Anti-psychotics** grew by 3.4% and contributed 0.37% to growth of 4.7%, but they moved down in rank from 2nd to 3rd position between 2012 and 2016.
- **Hormones and synthetic substitutes** grew by 3.5% and contributed 0.21% to growth of 4.7%, but they moved down in rank from 7th to 9th place between 2012 and 2016.

[2] pCPA generic value pricing initiative: http://www.canadaspremiers.ca/pan-canadian-pharmaceutical-alliance/

Despite the loss in rankings, **Cardiovascular drugs** and **Anti-depressants and antipsychotics** were still in the top 4 therapeutic classes in 2016.

The following four classes individually saw the most positive growth and contributed the most to drug cost growth. Combined, these four classes represented 37.5% of total private plan drug costs in 2016 and contributed 3.7% of the 4.7% CAGR growth (Figure 14-15).

- **Biologic disease modifiers** grew by 12.5% and contributed 1.36% of 4.7% growth. These are biologic drugs that treat rheumatoid arthritis, psoriasis, psoriatic arthritis, Chrohn's disease, ulcerative colitis, and other such auto-immune diseases. Biologic disease modifiers moved from 4th place in 2012 to 1st place in 2016.
- **Other Therapy Areas** grew by 7.5% and contributed 0.80% of 4.7% growth. This class combines drugs including allergy medicines, diabetic test trips, sexual dysfunction, and in 2016 included an age-related macular degeneration biologic drug. This class moved up from 3rd to 2nd rank between 2012 and 2016.
- **Antidiabetic agents** grew by 12.4% and contributed 0.71% of 4.7% growth. Antidiabetic drugs moved from 9th place to 6th place between 2012-2016.
- **Other Immunomodulating/Immunosuppressive agents** grew by 10.8% and contributed 0.60% of 4.7% growth. These include drugs that treat other auto-immune diseases including multiple sclerosis, and organ rejection. This class moved from 10th place to 7th place in 2016 compared to 2012.

FIGURE 14

	2012		2016			
Rank	**Top Classes 2012**	**PDP Cost, 2012**	**Top Classes 2016**	**PDP Cost, 2016**	**Change in rank from 2012**	**CAGR 2012-2016**
1	Cardiovascular	$915.3M	Biologic Disease Modifiers	$1.02B	▲	12.5%
2	Anti-depressants and anti-psychotics	$719.8M	Other Therapy Areas*	$884.2M	▲	7.5%
3	Other Therapy Areas*	$661.3M	Anti-depressants and anti-psychotics	$823.7M	▼	3.4%
4	Biologic Disease Modifiers	$638.5M	Cardiovascular	$740.0M	▼	-5.2%
5	Gastrointestinal Drugs	$482.0M	Anti-infective agents*	$565.8M	▲	6.2%
6	Anti-infective agents	$445.6M	Antidiabetic	$534.1M	▲	12.4%
7	Hormones and synthetic substitutes	$407.4M	Other Immunomodulating/immunosuppressive agents	$498.1M	▲	10.8%
8	Bronchopulmonary Therapy	$351.2M	Bronchopulmonary Therapy	$471.7M	↔	7.7%
9	Antidiabetic	$335.1M	Hormones and synthetic substitutes	$467.4M	▼	3.5%
10	Other Immunomodulating/immunosuppressive agents	$331.0M	Gastrointestinal Drugs	$465.7M	▼	-0.9%
	Total of Top 10 Classes (% of Total Market)	$5.3B (82%)	**Total of Top 10 Classes (% of Total Market)**	$6.5B (83%)		

▲ Increase in rank from 2012 ▼ Decrease in rank from 2012 ↔ No change in rank from 2012 Classes with >50% of costs from High Cost Drugs >$10,000 per patient per year

*Other Therapy Areas 2012: Nasonex, One Touch Ultra, Ascensia Microfill, Cialis; *Other Therapy Areas 2016: Contour Next, Lucentis, One Touch Ultra, Cialis.

Figure 14. Source: IQVIA Private Plan Claims Database.

FIGURE 15

CAGR vs Contribution to Growth by Top 10 Therapeutic Classes, 2012-2016
(Top 10 = 83% total drug cost)

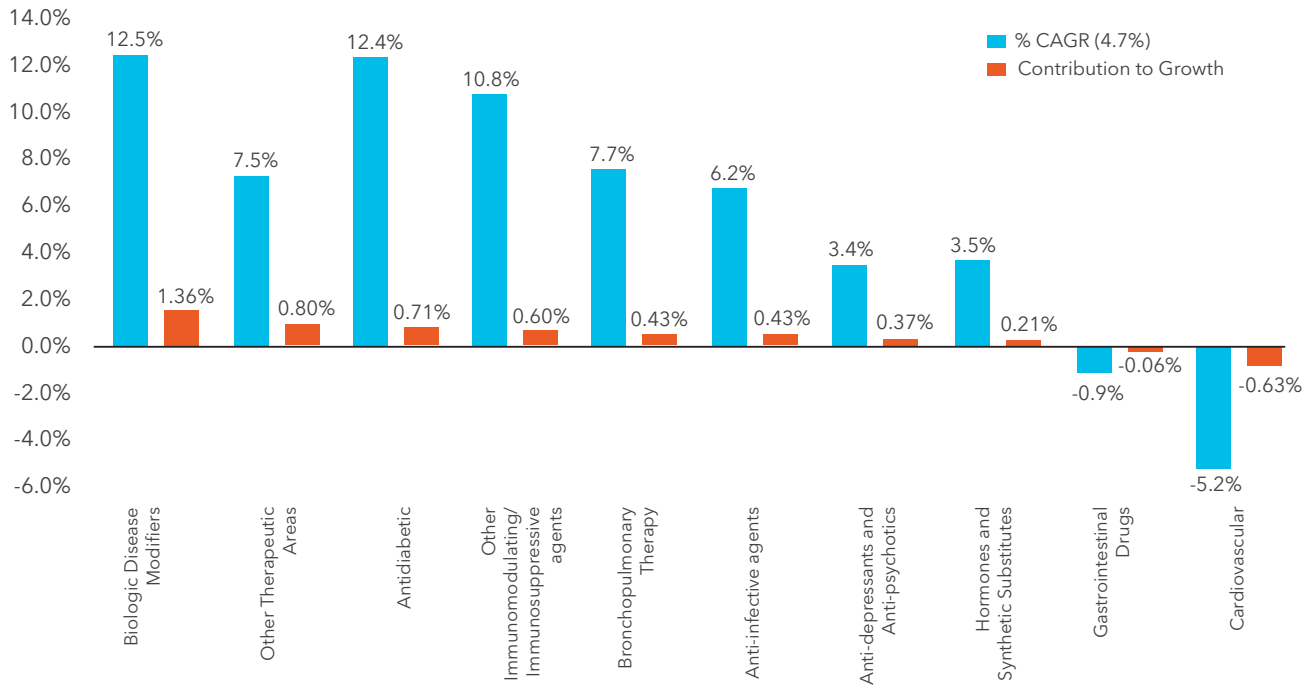


Figure 15. Source: IQVIA Private Plan Claims Database.

It is noteworthy that in spite of the growing volume and costs of specialty drugs[3], two of the top 4 classes and more than half of the top 10 classes still remain largely broadly-prescribed, genericized classes of drugs used chronically (Figure 14). Generally speaking, drugs whose cost are less than $10,000 per patient per year represented 75% of total private plan drug costs in 2016 (Figure 16), and they grew by 2.3% CAGR and contributed 1.8% of total CAGR of 4.7%. Once the impact of the patent cliff and pCPA generic price reductions wears off, growth is expected to resume in these classes of non-specialty drugs as these chronic diseases continue to affect a growing segment of the population.

FIGURE 16

Share of Non-specialty Drugs, 2016 vs 2012

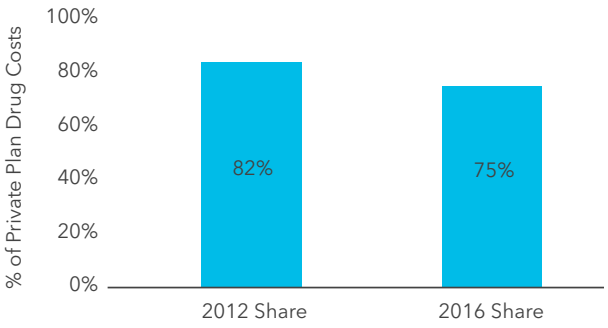


Figure 16. Source: IQVIA Private Plan Claims Database.

Specialty drug costs grew by 14% CAGR and their share of total private market drug costs increased from 18% to 25% of private plan drug costs, and contributed 2.9% of 4.7% CAGR growth. This is consistent with other data reported by insurers and pharmacy benefits managers. Growth in specialty drug costs was largely driven by growth in claimants, which increased by 8.2% CAGR. Two of the top 10 therapeutic classes and of the top 4 growing classes, Biologic disease modifiers and Other immunomodulating/immuno suppressive agents, are characterized by specialty drugs used for chronic, autoimmune disease. This is indicative of a growing working population affected by severely debilitating chronic diseases, and who require highly effective treatments to manage their symptoms and stay at work.

[3] In this report, specialty drugs are defined as drugs whose cost are over $10,000 per patient per year in the IQVIA private drug claims database.

Summary of Cost Drivers and Effects 2012-2016:

- The report identifies that 75% of the total growth was attributable to factors of increased utilization: of the total 4.7% CAGR between 2012-2016, 2.1% was attributed to claimant growth and 1.4% to claims per claimant growth.

FIGURE 17

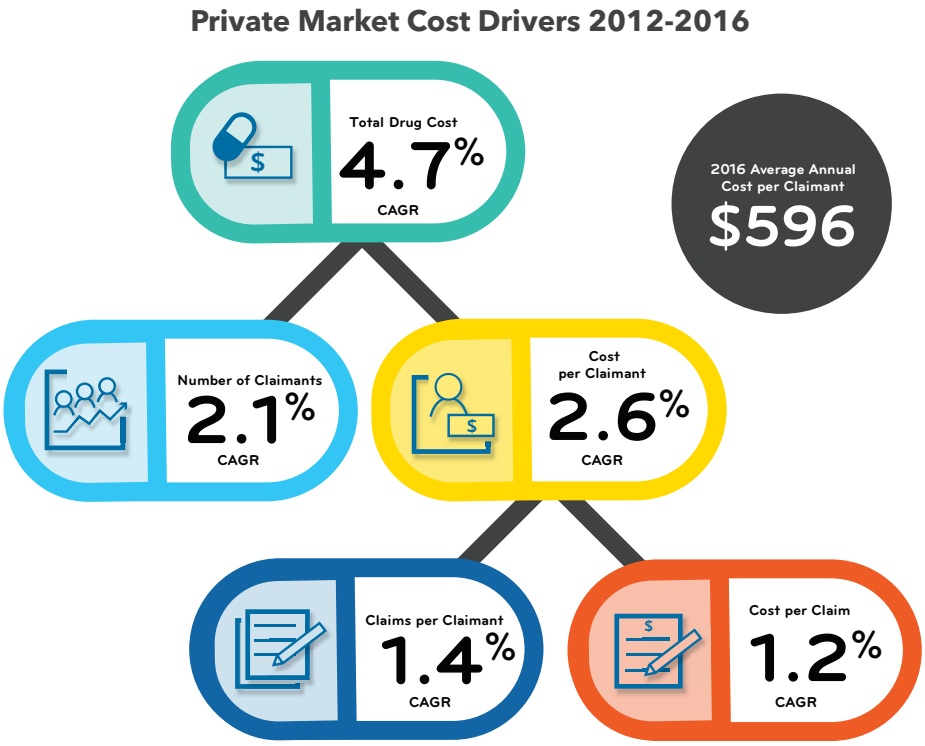


Figure 17. Source: IQVIA Private Drug Plan Database.

- The 25-54 and 55-64 age group were the largest contributors to the growth seen. The 55-64 age group in particular should be paid close attention due to its fast growth in number of claimants and higher utilization and average cost of drugs.
- Most of the growth occurred in the chronic disease category. The therapeutic categories which contributed the most to growth were diabetes and auto-immune diseases.

Even though growth is occurring mainly in and being driven by increased utilization of high-cost drugs due to increased incidence of chronic diseases in an aging workforce, payers need to pay attention to the fact that many of these are preventable and some even reversible diseases through lifestyle modifications. Employee health benefit plans should consider investing in wellness and prevention programs encouraging good habits in nutrition, sleep, exercise, and stress in the workplace as a cost-containment tool, to prevent the next wave of baby-boomers (those entering the 55-64 age group with the highest cost per claimant) from added costs to drug plan budgets.

FIGURE 18

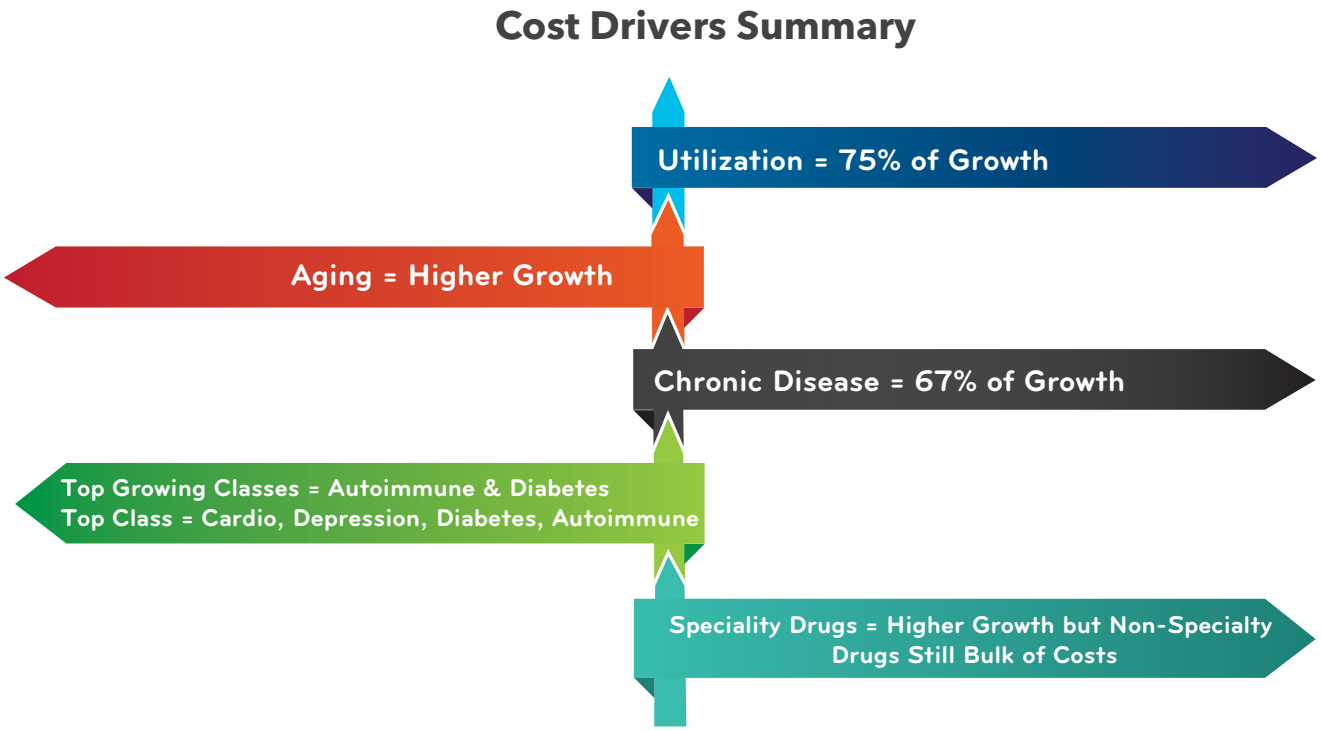


Figure 18. Source: IQVIA Private Drug Plan Database.

SECTION 2

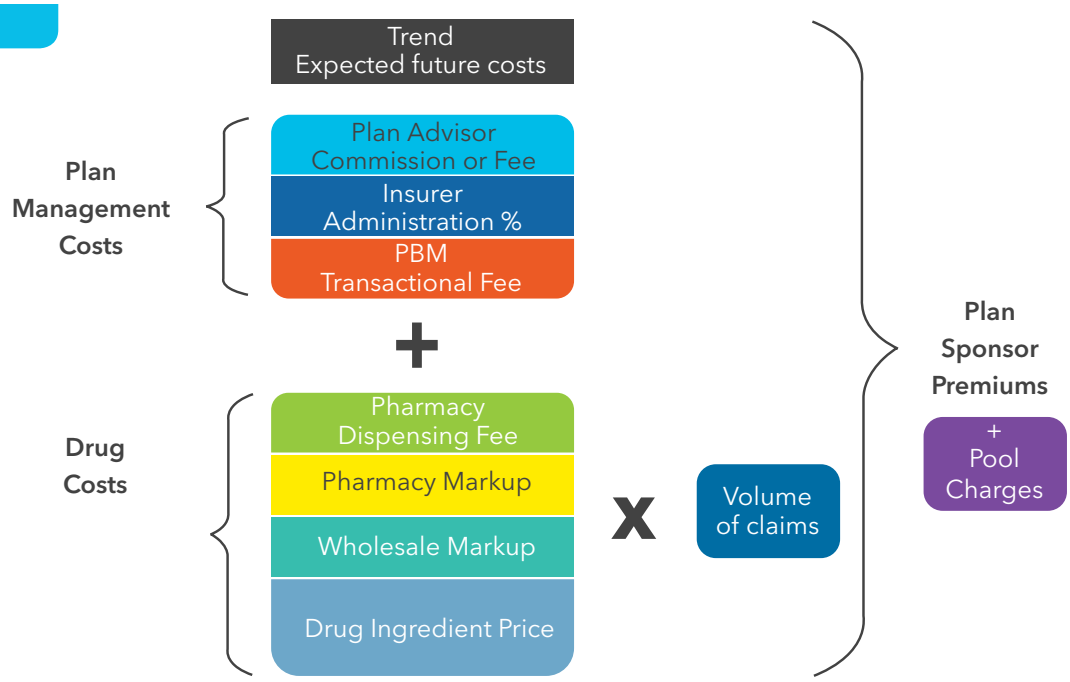
Other Factors Influencing Private Drug Plan Costs

Private Health Plan Premiums

When plan sponsors think about the "cost of drugs" they are really thinking about the cost of their plan – the premiums they pay for extended health benefits coverage, which includes the drug benefit.

Plan sponsors' premiums are dependent on their unique plan design and the makeup of the employee population. In addition to their drug plan utilization (claims experience), the premium calculation includes the following costs: insurer administrative charges, plan advisor commissions and trend factor – an actuarial prediction on what future claims might be. Although most of these are driven by claims experience, they should be recognized as an additional cost factor over and above drug claim costs.

FIGURE 19



For private plans, it is not enough to consider drug prices, drug cost and claims experience because they do not include factors to assess the potential risk of specific drug claims for any one private drug plan sponsor.

Many private drug plan analyses, like this one, look at historical claims costs, because the premiums charged for health benefit coverage are customized to the individual plan and a confidential negotiation between the insurer and the plan sponsor (employer). There are no publicly available records to track the changes in health premiums over time.

Individual plans need to take a holistic view of their plan costs and how they compare to the overall market level. An individual plan's claims experience or the risk of the plan having a high-cost recurring claim might have a significant impact on their premiums going forward.

Drug Costs

A drug ingredient price is how much an innovative pharmaceutical manufacturer sells their product to wholesalers or pharmacies in Canada. In Canada, an innovative drug's ceiling price is regulated by the Patented Medicine Prices Review Board (PMPRB), whose mandate ensures that the price that a pharmaceutical manufacturer sells their patented medicines in Canada is not excessive. In addition to regulating the Canadian launch price, PMPRB regulations also ensure that a drug's price cannot increase by more than the Consumer Price Index (CPI). Out of 2,014 DINs introduced between 1993 and 2016, there has been a 93% compliance rate with PMPRB regulations and price increases have been significantly below inflation since 1988[4].

Although the price of drugs may be regulated, the wholesaler and pharmacy retail mark-ups and dispensing are not generally regulated in private drug plans. These are negotiated and managed via pharmacy agreements with insurers or pharmacy benefit managers who process pay direct drug claims. The amount that pharmacies charge private plans for these costs are wide ranging due to the many different types of agreements that exist in the market. Some private plans have tried to curb the cost of specialty drugs, by implementing preferred pharmacy networks (PPN) that include a lower or capped markup for pharmacies in return for having claimants directed to them as part of the closed network.

Private Health Plan Trend Factor

To set a plan's health premiums, an insurer will consider a plan's prior year's claims experience, but will also apply a "trend factor", which is an annual inflation factor used in a health premium calculation to anticipate health claim costs for the upcoming year. The factor accounts for the insurer's expected increases in claims resulting from cost inflation, increased utilization, aging, new services and products, legislative changes, changes in the mix of products or services being used, or shifting costs from the public to the private sector.

The insurer trend factor is part of the confidential renewal calculation for an individual plan and is usually only seen by the plan sponsor and their benefit plan advisor. It may be questioned, or adjusted as part of the benefit plan renewal premium negotiation.

There are, however, some benefit plan advisors that survey insurance carriers and report on the annual trend factors being used. One such report that has been published for many years, is the Conduent Canadian Health Care Trend Survey[5].

Drug plans are included in health premium rates, therefore a trend factor for the health benefits will account for expected changes in drug claims. According to the Conduent 2016 survey[6], the insurers average health care tend factor for renewals was an expected growth of 11.81%. When the health trend factor is broken down to its individual components, the inflation factors for prescription drugs was 12.09% for 2016.

Comparing the insurer projected trend for prescription drugs to the actual increase in the cost of drug claims, it can be noted that there is a large gap between the projected and actual growth, and one can hope that this translated into reduced claims experience, refund accounting and/or a reduction in

[4] PMPRB Annual Report 2016, and New Patented Medicines Introduced to PMPRB

[5] Formerly known as the Buck, and then Xerox Canadian Health Care Trend Survey https://www.xerox.com/downloads/can/en/buck/reports/hrc_pub_hct_survey_CA.pdf?__hstc=205146511.f37150f7b7c21920c1adf-9d928c5669c.1436984704201.1438282188545.1438352484882.4&__hssc=205146511.3.1438352484882&__hsfp=533548306

[6] No report was published in 2017. A new report is expected sometime in 2018.

future premium calculations for individual plan sponsors (Figure 20). However, there is no obligation or guarantee that this is the case. Plan sponsors should be alert and question their premium increases at renewal time.

FIGURE 20

Prescription Drugs, Insurer Premium Trend Factors vs Actual Drug Cost Increases, 2012-2016

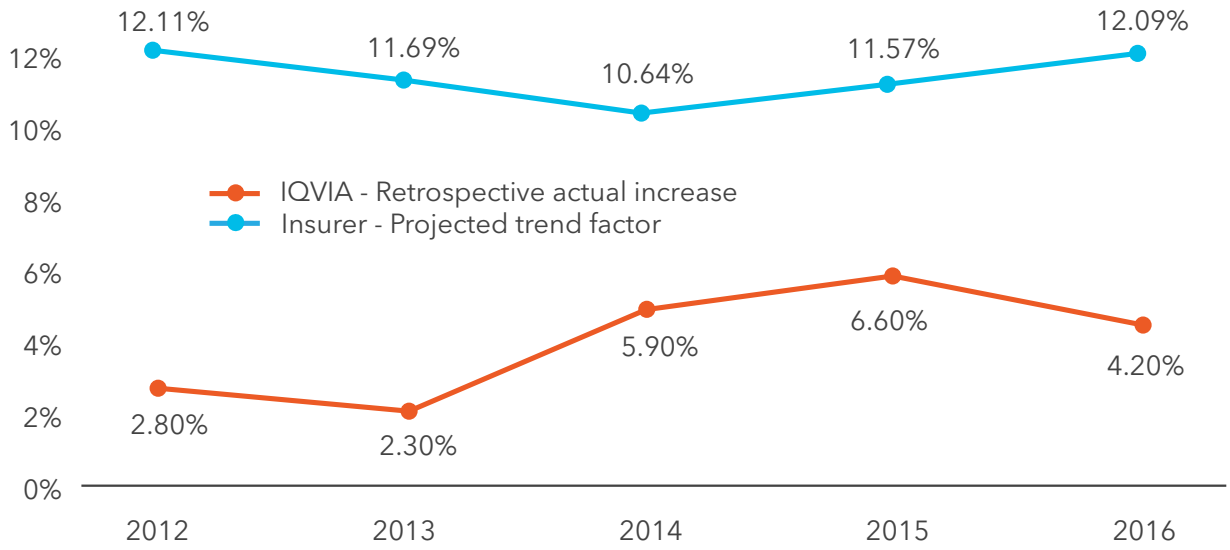


Figure 20. Source: Conduent Canadian Health Care Trend Survey (formerly known as the Buck, and then Xerox); IQVIA Private Plan Claims Database.

Plan Advisor Commissions

Plan advisors are compensated either by commission or fee for service. Traditionally fee-based advisors are consulting firms that deal with larger employers and charge an hourly fee for their services. The majority of advisors are commission-based, where they are paid a percentage of premiums by the insurer, and the commissions are built into a client's premium costs. Currently, some advisors disclose their commission rates to their clients, while others choose not to. According to industry sources plan advisors commission rates vary from 1% to 15% of premiums.

The CLHIA has recently proposed Guideline 19 to address the disclosure of compensation for the distribution of health benefit plans beginning in January 2020[7], which is being opposed, in its current form, by many benefit plan advisors[8].

[7] https://www.clhia.ca/web/CLHIA_LP4W_LND_Webstation.nsf/page/011F4F6ECC98F59F8525829D00642444!OpenDocument
[8] http://www.benefitscanada.com/news/new-group-formed-to-oppose-guideline-on-advisor-compensation-disclosure-111012

Private Health Plan Pool Charges

In addition to premiums, some plans pay pool charges, which are calculated differently and charged separately.

Within an insurer's group health plans, pooling protection is offered when an individual certificate's (an employee plus their family members) claims exceed a specific threshold. When this threshold (e.g. $10,000) is reached, the claim costs above that amount are removed from the plan's claims experience used to calculate future premiums and transferred to the insurance company's pool. The cost of the claims above this threshold are shared among all the plans in the pool, which, in turn, pay their insurer an additional "pool charge" for this extra protection.

Although drug pooling offers additional protection from the impact of high-cost drugs, plan advisors and plan sponsors have reported that the pool charges for this protection are growing at a much faster rate than their premiums.

The challenge is the lack of transparency by the insurers in their pooling charge calculations. When an insurer presents a plan sponsor with their benefit plan renewal, it provides supporting information such as claims experience to justify the proposed premiums. The sponsor's plan advisor will analyze the supporting materials and recommended premiums to determine if the figures are reasonable and competitive. Because pool charges are determined via an analysis of pooled claims from all the insurers' plans, insurers are bound by confidentiality restrictions and not able to provide much supporting information to justify their pool charges. As a result, plan advisors cannot determine if the increased charges are justified. The options that a plan sponsor is left with is to accept the increased pool charges to protect them from the impact of high cost claims, reduce or cap their health benefit coverage, or increase the pooling threshold and take on more risk. Another alternative is go back to the market and shop around for a better rate from another insurer.

COMMENTARY

The objective of the report is to quantify and identify the key cost drivers of the private drug market in Canada between 2012 and 2016.

Drug benefits are consistently one the most important benefits component of employee health benefits as shown in the 2016 Sanofi Canada Health Care Survey[9]. The total private drug plan market in Canada grew by 4.7% CAGR between 2012 and 2016. The report identifies that the majority of the drug cost growth is due to increased utilization attributed to increased number of claimants and growth in the number of claims per claimant. Although specialty drugs over $10,000/yr are growing at a faster rate, non-specialty drugs still represent 75% of the total drug spend. In most cases these are used to treat chronic diseases which are often preventable. In recent years there has been a shift from investing in feel-good wellness programs to a focus on chronic disease improvement programs with positive outcomes on health. This represents the best opportunity for employers to invest in programs that can improve employee health at work and reduce chronic disease load in the workplace leading to health benefit savings.

In addition, drug benefits are one single component of employee health benefits and can help patients stay at work and be more productive while reducing absenteeism. Premiums have been rising, and so have drug costs, but premiums appear to have increased more than drug costs.

Plan sponsors should request greater transparency from their insurers through their plan benefit advisers or brokers with regards to the rationale for premium and pooling increases in relation to their own plan cost increases.

[9] http://www.sanofi.ca/l/ca/en/download.jsp?file=3C0BE984-C001-4BC0-AC74-890CBFB3A3FC.pdf

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Disclaimer:

The views expressed in this report are those of the authors and not of IQVIA.

FIGURE 21

Appendix A: Chronic vs Non-Chronic Drug Classification Methodology Led by IQVIA

Therapeutic Classes by Chronic Status		
Analgesics **Non-Chronic**	Autonomic agents **Chronic**	Hormones and synthetic substitutes **Chronic**
Anticonvulsants **Chronic**	Biologic disease modifiers for RA/PsO/IBD **Chronic**	Other CNS* **Chronic**
Anti-depressants and anti-psychotics **Chronic**	Blood formation and coagulation **Non-Chronic**	Other immunomodulating/ immunosuppressive agents **Chronic**
Antidiabetic **Chronic**	Bronchopulmonary therapy **Chronic**	Other therapy areas** **Non-Chronic**
Anti-infective agents **Non-Chronic**	Cardiovascular **Chronic**	Skin and mucous membrane preparation **Non-Chronic**
Antineoplastic **Oncology**	Gastrointestinal drugs **Non-Chronic**	Nutritional Products **Non-Chronic**

Figure 21. Source: IQVIA.

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