2016-2019

Analysis of Private Drug Claim Cost Drivers

INNOVATIVE MEDICINES CANADA

MÉDICAMENTS NOVATEURS CANADA

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Suggested citation:

Innovative Medicines Canada (2020). *Analysis of Private Drug Claim Cost Drivers (2016–2019)*

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Key Findings

Private market drug plan claims costs grew at a compound annual rate of 5.3% between 2016 and 2019.

Over half of this growth (53%) was driven by increased utilization (more people claiming for more drugs), rather than increases in the cost of the drugs themselves.

Chronic disease is a major cost driver for private drug plans, accounting for 67% of drug plan claims costs and 79% of growth.

Non-specialty drugs (costing <$10,000 annually) account for more than two thirds (71%) of total private drug plan claims costs and close to half (41%) of the growth.

Over three-quarters (76%) of the growth was driven by older drugs launched more than 10 years ago.

A better understanding of the factors driving cost growth allows private plan sponsors to focus their efforts and resources more efficiently and effectively on managing benefit costs. This report examines the drivers of claims cost growth for private drug plan claims between 2016 and 2019, including the impact of OHIP+ changes in 2018 and 2019, based on IQVIA private drug plan claims data.

Overall, private drug plan claims costs grew at a 5.3% compound annual growth rate (CAGR) between 2016 to 2019. More than half of this growth was driven by increased utilization (more people making claims for more drugs), rather than increased costs per claim, which suggests that the price of drugs is not a major factor in overall cost growth.

> *The sky is not falling – contrary to popular belief, drug claim costs are increasing at 5% versus the 11% that the insurers would lead you to believe. These numbers fly in the face of insurers' drug trend factors and more closely resemble what we see in our own small to medium book of business."* ***~ Chris Pryce, CEBS, Founder and President, Human Capital Benefits***

Chronic disease remains the primary driver of drug plan costs, accounting for 68% of costs and 79% of the 2016–2019 cost growth. People with chronic diseases who take six or more drugs have the most disproportionate cost burden (9% of claimants but 32% of costs).

There has been a lot of focus on higher-cost drugs in recent years. However, this report finds that higher-cost specialty drugs are not the biggest cost concern. Non-specialty drugs (drugs costing less than $10,000 annually) are the biggest driver of private drug plan costs, representing 71% of private drug costs and 41% of growth between 2016 and 2019. In contrast, drugs with an annual cost over $100,000 contributed a 1% of drug plan costs and 4% of the total growth. Furthermore, data shows that drugs launched more than 10 years ago drove over two-thirds of the 2016–2019 growth.

Drug claims represent only one component of the overall cost of a private drug benefit plan (See Figure 23 on page 36), as insurers' risk management processes, premium setting processes, and pooling methodology all contribute to actual benefit plan costs paid by plan sponsors. These additional charges can be up to 20% of the total benefit plan cost.[1]

Recommendations

1. Given the significant impact of chronic disease on private drug plan claim costs and growth, there exists a real opportunity for employers to offer programs that improve plan member health and reduce the risk of their members developing chronic diseases. Even a small reduction in the prevalence of chronic disease in the plan member population can have a significant impact on future drug trends.

> *Plan sponsors should look critically at the area of chronic diseases and harness the opportunity to provide long-lasting solutions in the area of lifestyle interventions and well-being initiatives."* ***~ Rakiya Oseni, PharmD, Senior Associate, Drug Consulting Specialist, Mercer Marsh Benefits™, Mercer (Canada) Limited***

2. Plan sponsors and their benefit advisors should understand what is increasing private drug plan costs in general and review their individual plan data to understand the drivers of their specific plan's cost growth. Understanding the drivers will provide insight into what is needed to address their specific challenges, ensure their members have access to the health benefits they need, and plan for innovative products and programs in the future.

> *A good group specialist measures and monitors their client data to ensure they are on the right track.* ***~ Dave Patriarche, President, Mainstay Benefits***

3. Benefit plans should be measured not only by claims costs but also by the value of their benefit coverage and the outcomes the drugs deliver to the organization. Plan sponsors need to consider the primary objectives of their benefit plan and determine if their program delivers on these goals and offers a return on investment.

> *Remember the value of your plan to members in a health crisis, and recognize that while high-cost drugs are a concern, they are not the major driver of cost under most plans."* ***~ Lizann Reitmeier, Health Practice Leader, Buck Canada***

4. The advisors brought together to consider this report's findings emphasized the opportunities for collaboration to improve the insurance industry's risk management and pooling methodology, with the ultimate goal of better meeting the needs of Canadian plan sponsors and ensuring long-term benefit plan sustainability.

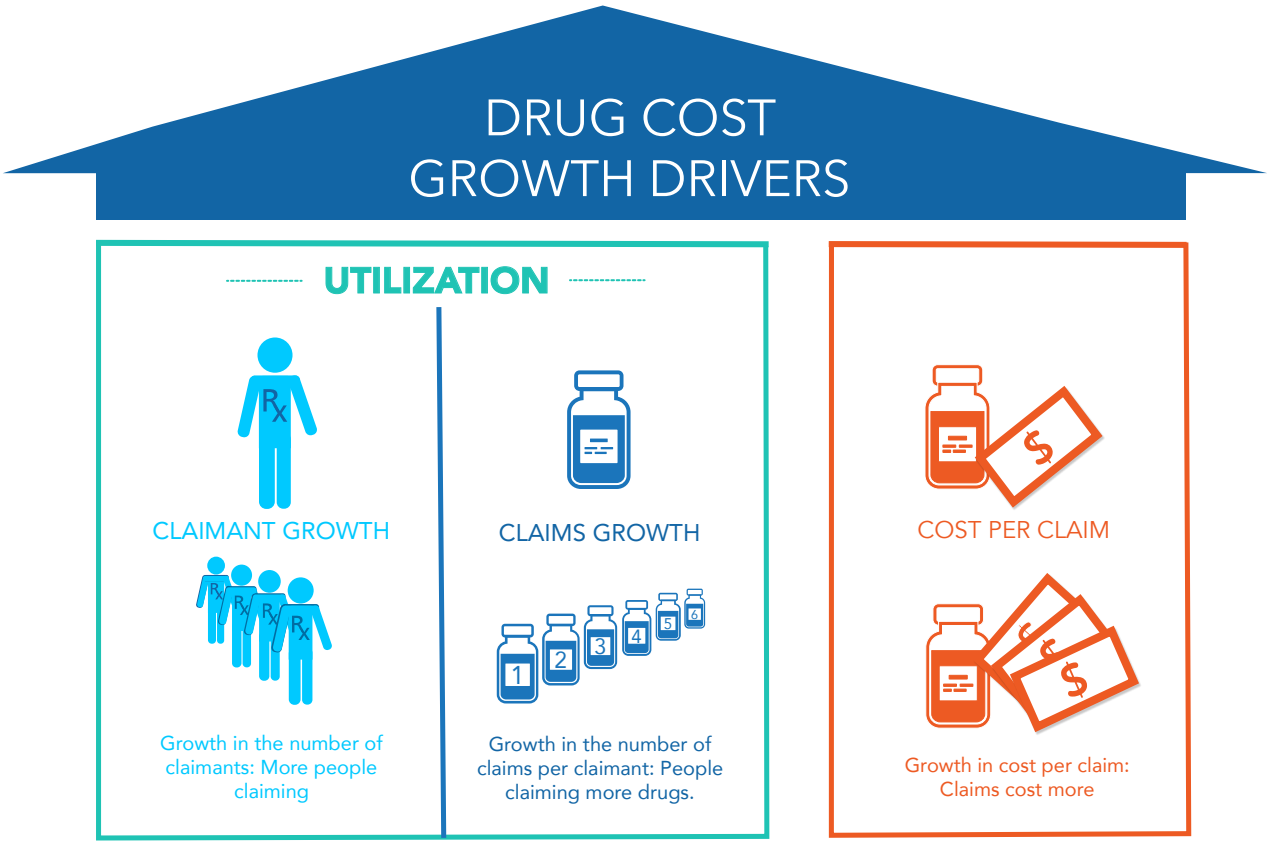
> *This analysis focused on drug claims costs; however, drug claims are just one piece of the puzzle of the total cost of a benefit plan."* ***~ Dave Patriarche, President, Mainstay Benefits***

1. Introduction

Private drug plan claims have three main cost drivers.

The cost growth of drug claims in private drug plans in Canada can be attributed to three primary drivers: increases in the number of claimants, increases in the number of claims that claimants make, and increases in costs per claim due to the adoption of new innovative medicines or to factors such as distribution fees and the frequency of dispensing. A combination of the first two – increases in the number of claimants and the increase in the number of claims – represent utilization.

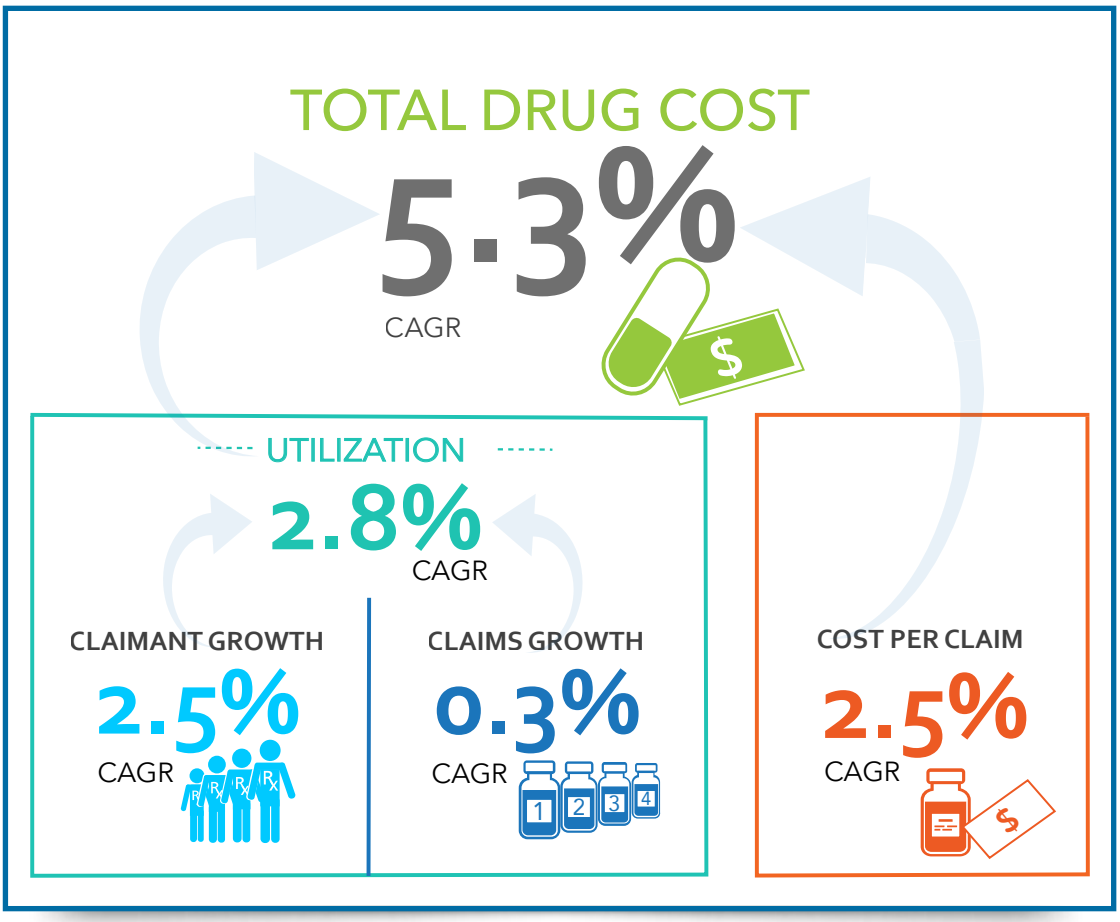
Figure 1: Drivers of Drug Cost Growth



2. Overall Private Drug Plan Claims Growth

Utilization had a significant net impact on growth.

Figure 2: Private Drug Plan Cost Drivers, 2016–2019



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

National private drug plan growth has been consistent for much of the past decade.

Private drug plan claims costs grew at a compound annual growth rate (CAGR) of 5.3% between 2016 and 2019, with more than half of total growth (53%) attributable to utilization – that is, growth in the number of claimants and number of claims per claimant. (See Figure 2.) This is consistent with the 4.7% overall growth recorded in 2012–2016. (See Figure 3.)

> *What we are really seeing here is the impact of more people taking more drugs."* ***~ Dave Patriarche, President, Mainstay Benefits***

Claimant growth on its own was also relatively steady over the two periods, at 2.1% for 2012–2016 and 2.5% for 2016–2019. (See Figure 4.)

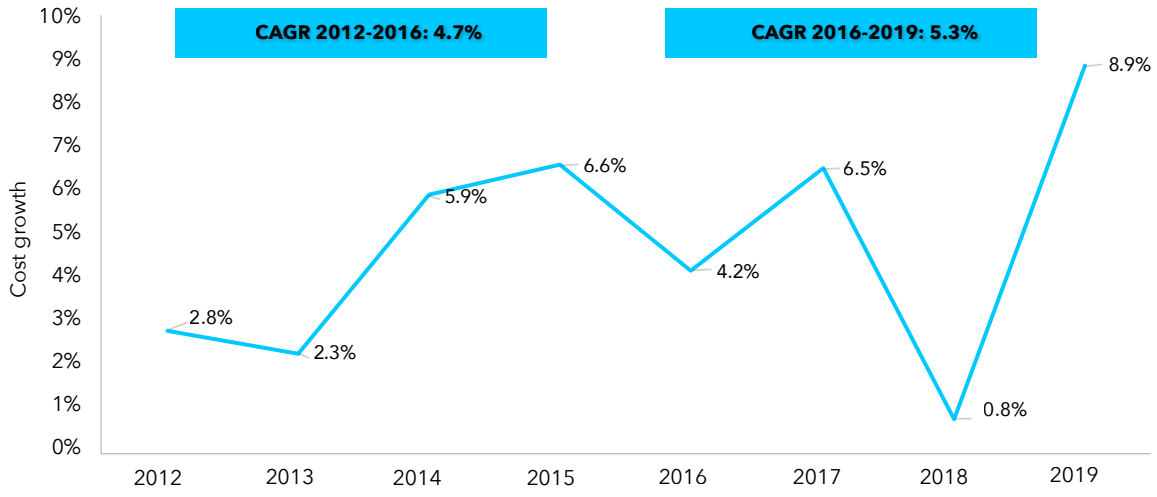
> *The sky is not falling – contrary to popular belief, drug claim costs are increasing at 5% versus the 11% that the insurers would you lead you to believe. These numbers fly in the face of insurers' drug trend factors and more closely resemble what we see in our own small to medium book of business."* ***~ Chris Pryce, CEBS, Founder and President, Human Capital Benefits***

As explained in Innovative Medicines Canada's Cost Drivers Analysis of Private Drug Plans in Canada 2016–2018 report (published in 2019), cost growth dipped in 2018 due to the introduction of OHIP+ for Ontarians under age 25 and the impact of the 2018 Canadian generic price reductions.

Part of the cost increase in 2019 was due to OHIP+ changes that required claimants eligible for coverage through a private plan to migrate back in 2019. (See Section 3.1 for more information.) To assess the impact of OHIP+ changes in 2018 and 2019, this report analyzes private drug claims data for the period between 2016 and 2019.

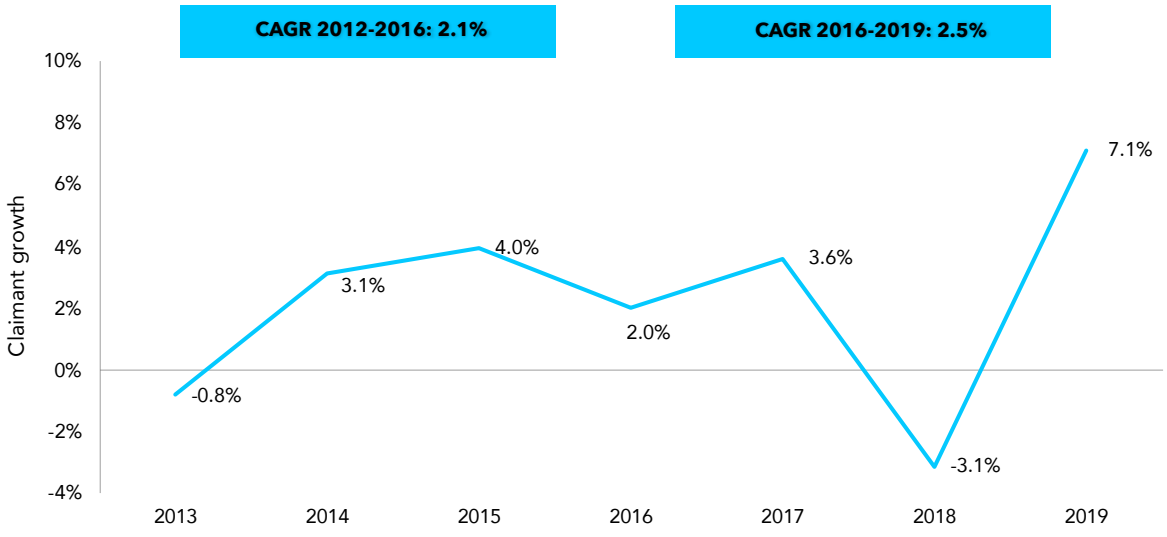
Growth in national private drug plan claim costs and claimants between 2016–2019 was consistent with historical rates.

Figure 3: Private Drug Plan Claim Cost Growth, 2012–2019



Sources: Innovative Medicines Canada Cost Drivers Analysis 2016–2019; Innovative Medicines Canada, Costs Drivers Analysis of Private Drug Plans 2012–2016.

Figure 4: Total Private Drug Plan Claimants, 2012–2019



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019; Innovative Medicines Canada, Costs Drivers Analysis of Private Drug Plans 2012–2016.

3. Regional Growth Analysis

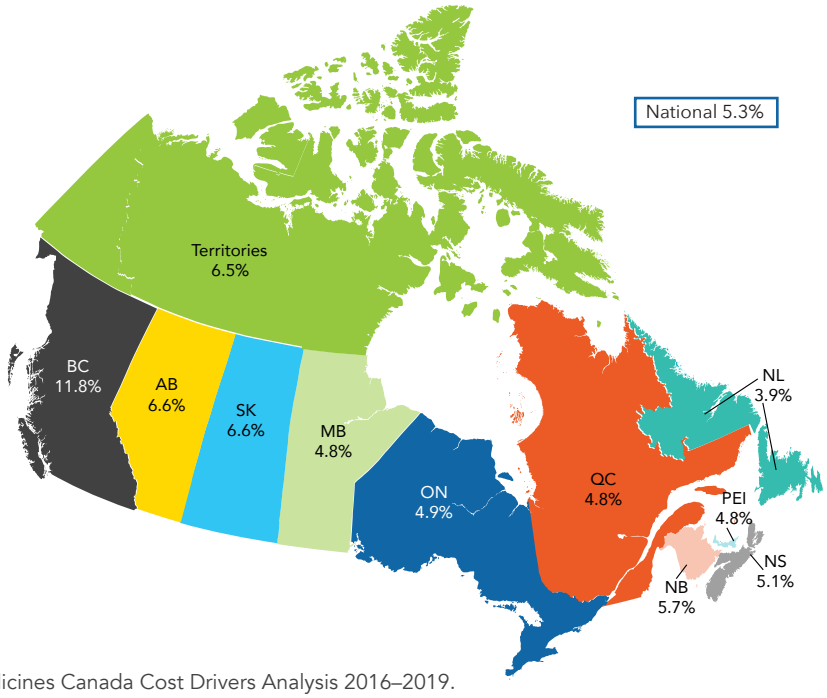
Ontario and Quebec drug plan growth was below the national rate.

Analyzing the cost growth for drug plan claims by region sheds light on differences across Canada that are likely due to variations in regional population, employment, and provincial drug plans.

Overall cost growth in Ontario and Quebec was below the national rate. Growth in Newfoundland and Labrador was the lowest, while growth in British Columbia was the highest. Increased utilization (more people taking more drugs) was the main driver of growth for Quebec, British Columbia, Saskatchewan, and Manitoba, whereas the cost per claim was highest in the Atlantic provinces and Ontario. (See Figure 5.)

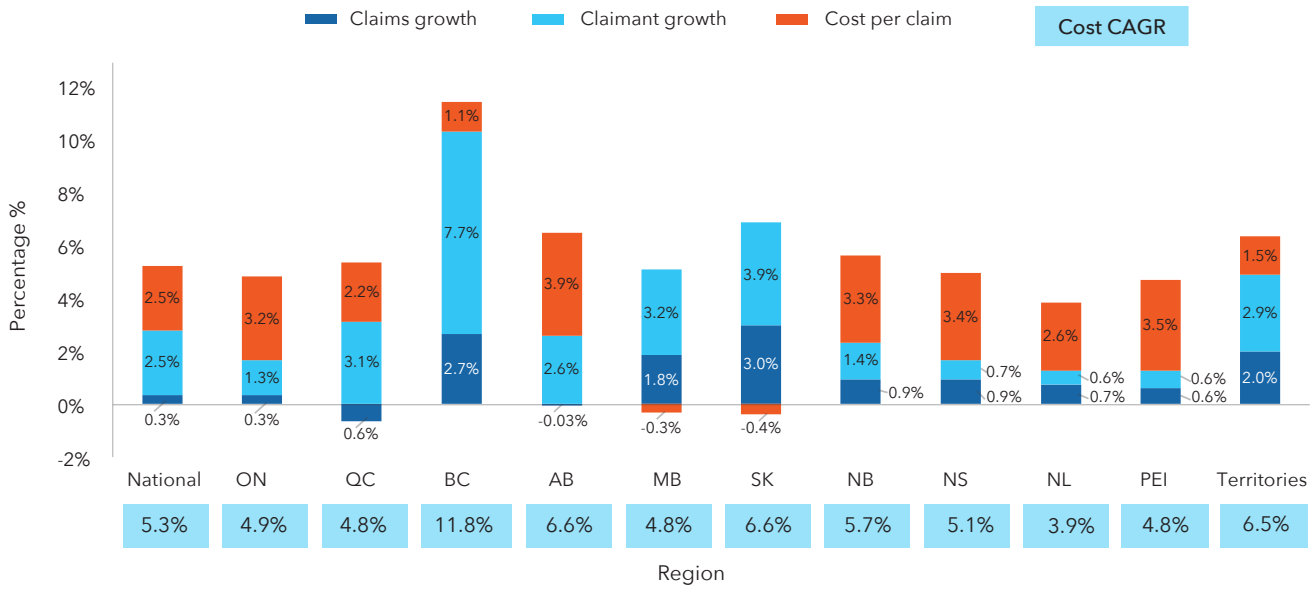
Utilization was the main driver of growth for Quebec, B.C., Saskatchewan, and Manitoba, whereas cost per claim had the highest impact in the Atlantic provinces and Ontario.

Figure 5: Overview of Cost Growth Across Canada



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

Figure 6: Cost Growth Drivers by Region, 2016–2019



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

3.1 Focus on Ontario: Impact of OHIP+

OHIP+ affected Ontario and national drug plan cost growth.

OHIP+ Background

The Ontario government introduced the OHIP+ drug program on January 1, 2018, offering free medication to all Ontarians under age 25 regardless of family income or access to private insurance benefits. Enrolment was automatic for eligible residents. As a result, drug claims for Ontario Drug Benefit (ODB) eligible drugs for Ontario plan members under age 25 were transferred from private drug plans to the Ontario provincial drug plan.

After the June 2018 provincial election, the new Ontario government implemented changes making children and youth with private drug coverage ineligible for OHIP+ effective April 1, 2019 (However, if they need provincial drug coverage in addition to their private drug plan, they may qualify for the Ontario Trillium Drug Program.[2])

As a result, claims for eligible plan members that had been transferred to the Ontario provincial drug plan from January 1, 2018, to March 31, 2019, transferred back to private drug plans starting April 1, 2019.

Although the Cost Drivers Analysis of Private Drug Plans in Canada 2016–2018 published in 2019 did not include the impact of the 2019 OHIP+ change in its analysis, the report did predict an increase in claimants for private drug plans in Ontario for the latter half of 2019.

OHIP+ Impact

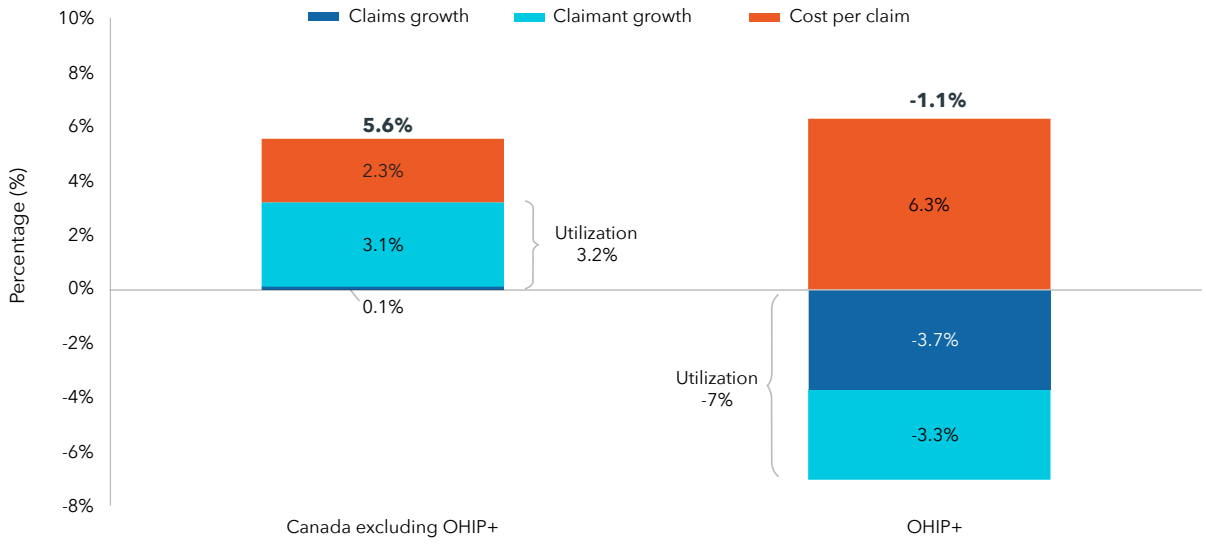
Between 2016 and 2019, private drug plan costs for claimants eligible for OHIP+ decreased by a CAGR of 1.1%. This compares with the increase of 5.6% for all other claimants in Canada – that is, Ontario claimants aged 25 years and older and all claimants in all other provinces. The decrease in costs for claimants eligible for OHIP+ was driven by a 7% reduction in utilization, based on a 3.7% decrease in the number of claims and a 3.3% reduction in the number of claimants. (See Figure 7.) This was likely due to the lingering effect of Ontario claimants under age 25 switching from private plans to the Ontario Drug Benefit for 15 months in 2018 and 2019.

An analysis of the contribution of OHIP+ claimants to overall costs by year shows that private drug plan costs decreased by 2.8% in 2018 when OHIP+ was implemented and then rebounded to increase by 2.3% in 2019 when the plan was subsequently changed. This may indicate that not all eligible private claimants migrated back to private plans in 2019. (See Figure 8.)

Because OHIP+ was in place for all of 2018 and for three-months in 2019, a full assessment of the impact of OHIP+ on private drug claims can only be made when the data is available for claims made in the 12 months after the program changed on April 1, 2019.

Claims for the OHIP+ population decreased 1.1% CAGR between 2016 and 2019.

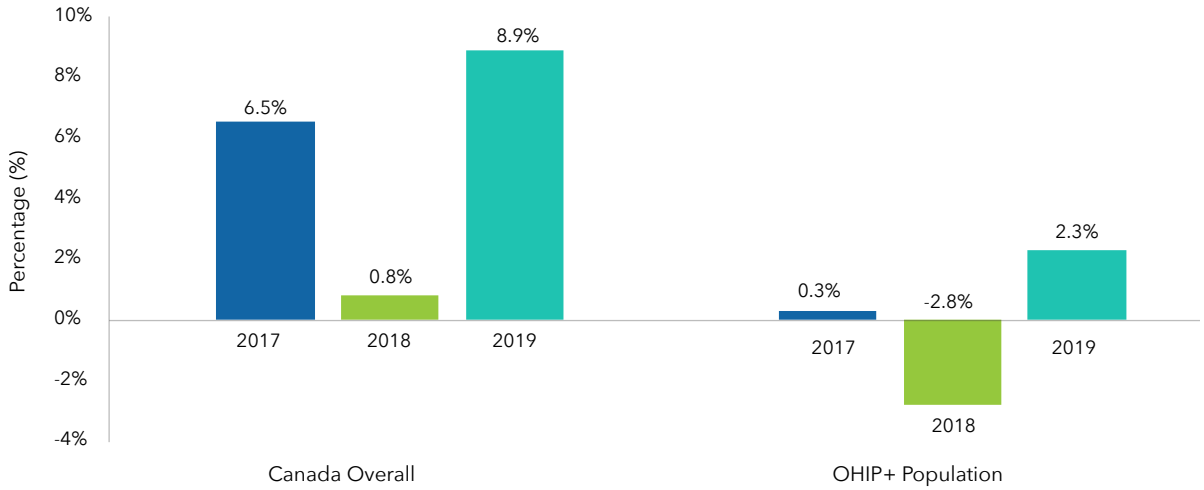
Figure 7: Impact of OHIP+ Claimants on Cost Growth Drivers 2016–2019



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

All private claimants may not have migrated back to private plans in 2019.

Figure 8: Contribution to Yearly Cost Growth — OHIP+ claimants vs. Canada Overall



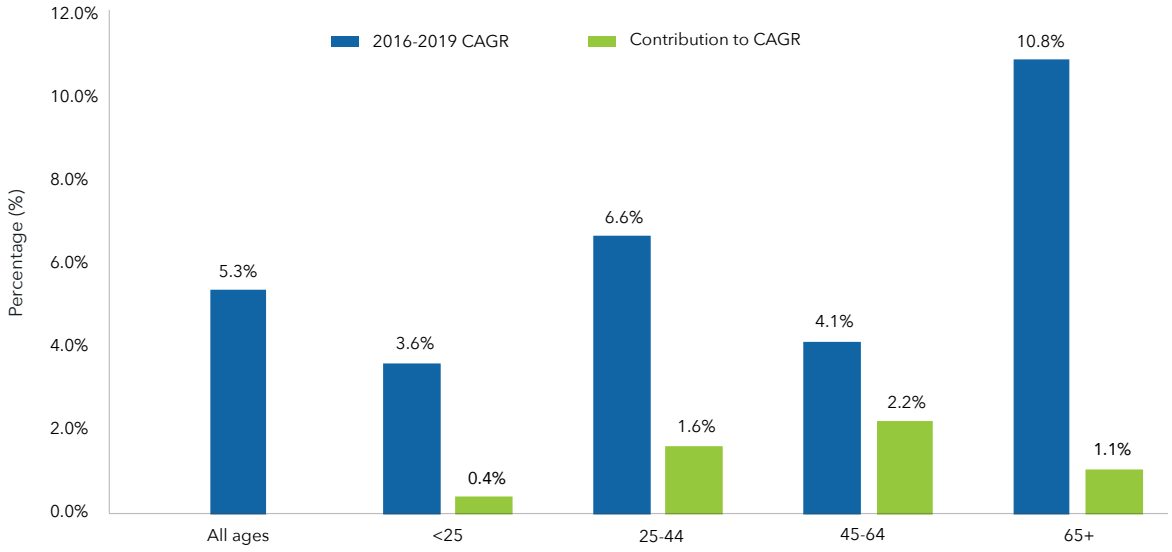
Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

4. Impact of Age

Claimants aged 25–65 contributed the most to cost growth.

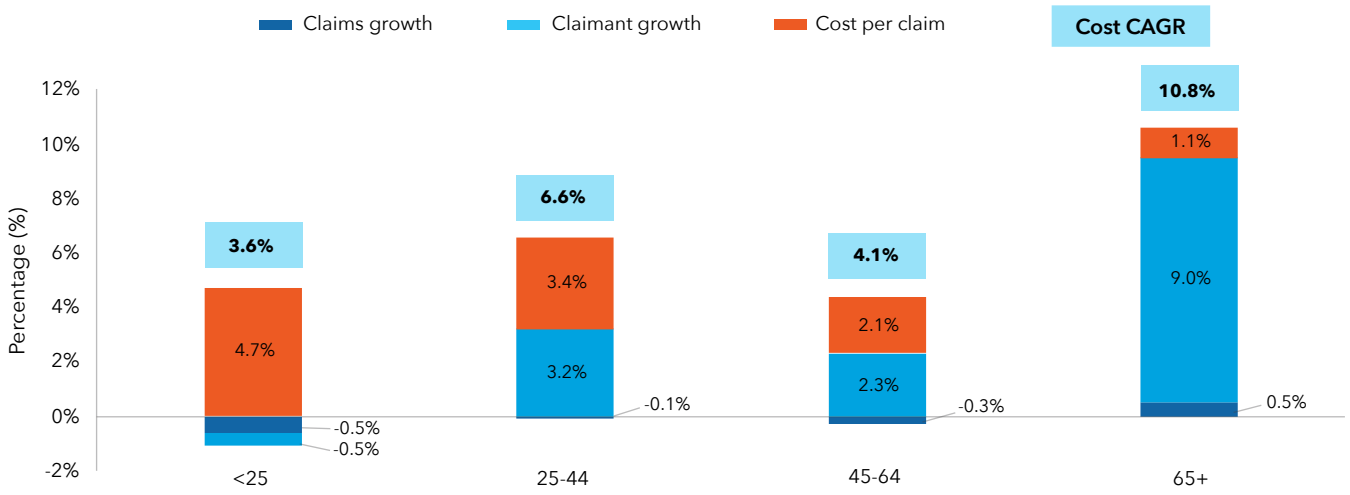
The 25–44 and 45–65 age groups were the greatest contributors to private drug plan cost growth between 2016 and 2019 (green bars), accounting for more than 70% of growth. However, the 65+ age group experienced the highest annual growth (blue bars) in the same period, followed by the 25–44 age group. (See Figure 9.) Analysis indicates that utilization (growth in number of claimants and number of claims per claimant) accounted for about half of the cost growth for those aged 25–65 years. (See Figure 10.)

Figure 9: Annual Growth and Contribution to Overall Annual Growth by Age Group, 2016–2019



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

Figure 10: Cost Growth Drivers by Age Group, 2016–2019



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

5. Impact of Treatment Costs

Non-specialty drugs accounted for 71% of total drug claim costs and 41% of growth.

Analyzing claims growth by total average annual cost per claimant reveals that non-specialty medications – i.e. those with an annual cost of less than $10,000 per year – accounted for the majority (71%) of private drug plan claims costs in 2019, whereas drugs with an annual cost of $10,000 to $25,000 ranked second, with 18.6% of the costs. Drugs in the $25,000 to $100,000 category accounted for 9.5% of 2019 private drug plan claims costs, while drugs over $100,000 accounted for 1.2% of 2019 costs. (See Figure 11.)

In terms of impact on claims growth for 2016–2019, non-specialty drugs (those costing <$10,000 annually) grew at a CAGR of 3% over 2016–2019 but represented the greatest portion (41%) of cost growth. Together, non-specialty drugs and drugs that cost $10,000 to $25,000 annually accounted for the bulk of the growth (80%).

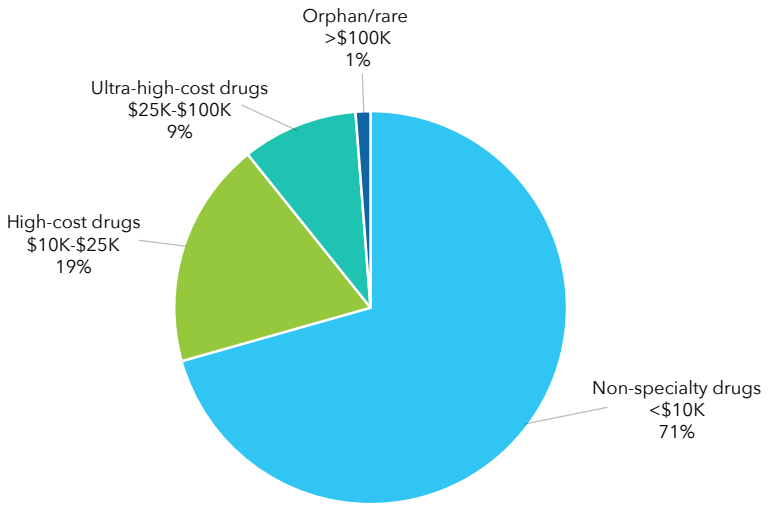
While drugs with an annual cost greater than $100,000 grew at a CAGR of 28.2% over 2016–2019, they contributed 0.2% of the overall 5.3% compound annual growth for that period. (See Figures 12 and 13.)

The main cost growth driver for drugs that cost more than $10,000 annually was utilization, with new claimants making up the bulk of the 2016–2019 growth. (See Figure 13.)

> *We keep hearing about the impact of specialty drugs; however, many advisors are trying to shift the focus to the lower-cost, chronic disease drugs that are really driving the drug plan growth."* ***~ Noel MacKay, Principal Consultant, National Benefits, Cowan Insurance Group***

Non-specialty drugs make up the bulk of drug plan costs.

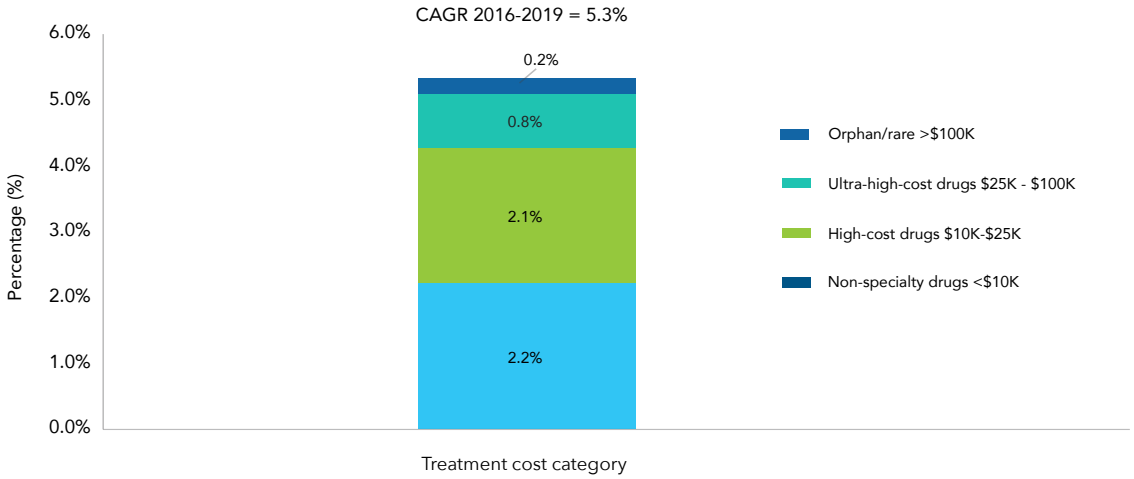
Figure 11: Share of 2019 Private Drug Plan Claim Costs by Treatment Cost Category



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

Non-specialty drugs had the greatest impact on overall growth.

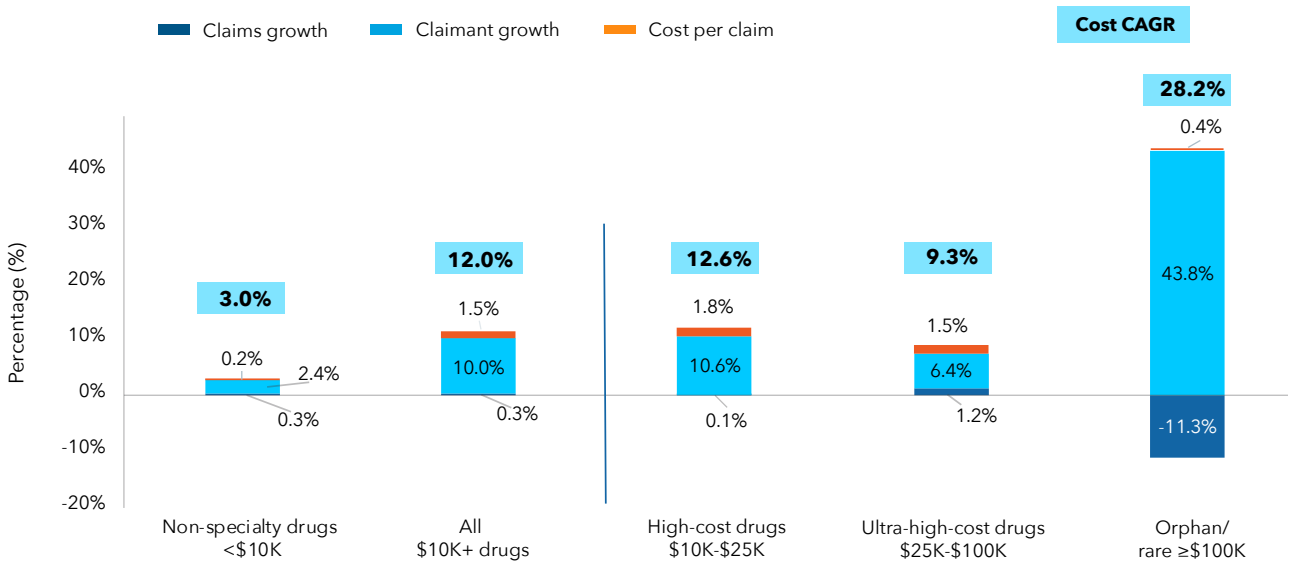
Figure 12: Contribution to 2016–2019 Growth by Treatment Cost Category



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

Growth for high-cost drugs driven by increase in claimants.

Figure 13: Cost Growth Drivers by Treatment Cost Category, 2016–2019



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.
Note that the sum of cost drivers might not add up to the total cost CAGR due to rounding and because the cross effects are not shown in the figure.

6. Impact of Chronic Disease

Most of the cost growth in private drug plan claims (80%) was due to chronic diseases.

To assess the impact of one-time versus ongoing claims, this analysis compared drugs that treat chronic diseases and drugs that treat non-chronic conditions. Chronic diseases are defined as non-communicable diseases that can be treated but not cured and that are persistent and generally slow in progression.[3] Chronic and non-chronic diseases may both be treated with specialty drugs (drugs that cost over $10,000 per patient per year). For this analysis, cancer medications were kept as a separate category and not classified as either chronic or non-chronic.

Some chronic diseases, such as rheumatoid arthritis and multiple sclerosis are unavoidable and may require treatment with specialty or biologic drugs. However, more than 70% of private drug spending is for lower-cost drugs, including treatments for many modifiable chronic diseases, such as type 2 diabetes, high cholesterol, and high blood pressure – chronic diseases that can be prevented or better managed through programs to improve plan member health.

> *"Modifiable chronic diseases continue to drive private drug plan costs and demonstrate the need for plan sponsors to consider well-being initiatives to support their plan members."* ***~ Rakiya Oseni, PharmD, Senior Associate, Drug Consulting Specialist, Mercer Marsh Benefits™, Mercer (Canada) Limited***

Drugs that treat chronic diseases represented 67% of private drug claim costs in 2019, whereas non-chronic disease treatments accounted for 27% of costs, and cancer therapies made up the rest, at 6% of costs. (See Figure 14.)

Chronic disease drugs contributed 79% of the 2016–2019 cost growth. (See Figure 15.) Data shows that 68% of claimants required chronic disease drugs, which made up 62% of claims in 2019.

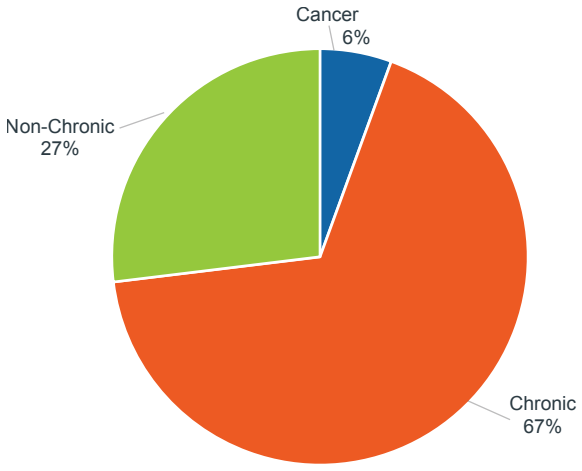
Costs for chronic disease treatments grew 6.4% annually between 2016 and 2019, whereas costs for non-chronic disease drugs grew 1% during the same period. Increased utilization (more people taking more drugs) was the primary driver for both chronic and non-chronic treatments.

The significant impact of chronic disease on private drug plan costs and growth highlights the opportunity to offer programs to improve plan member health and reduce the future risk of developing chronic diseases. Even a small reduction in the prevalence of chronic disease in the plan member population can have a significant impact on future drug trends.

> *We need to move from reacting to chronic disease to preventing it, or else nothing is going to change."* ***~ Noel MacKay, Principal Consultant, National Benefits, Cowan Insurance Group***

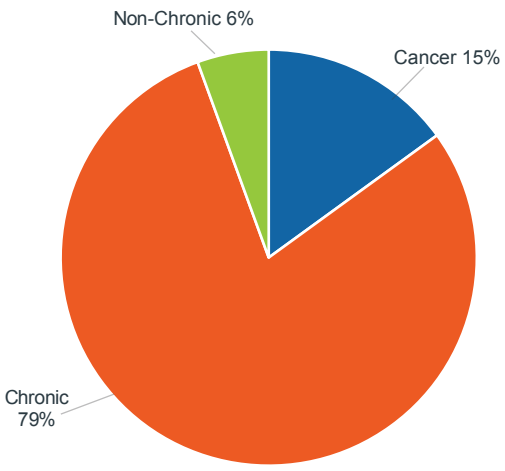
Chronic disease drugs account for the majority of plan costs.

Figure 14: Share of 2019 Private Drug Plan Claim Costs



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

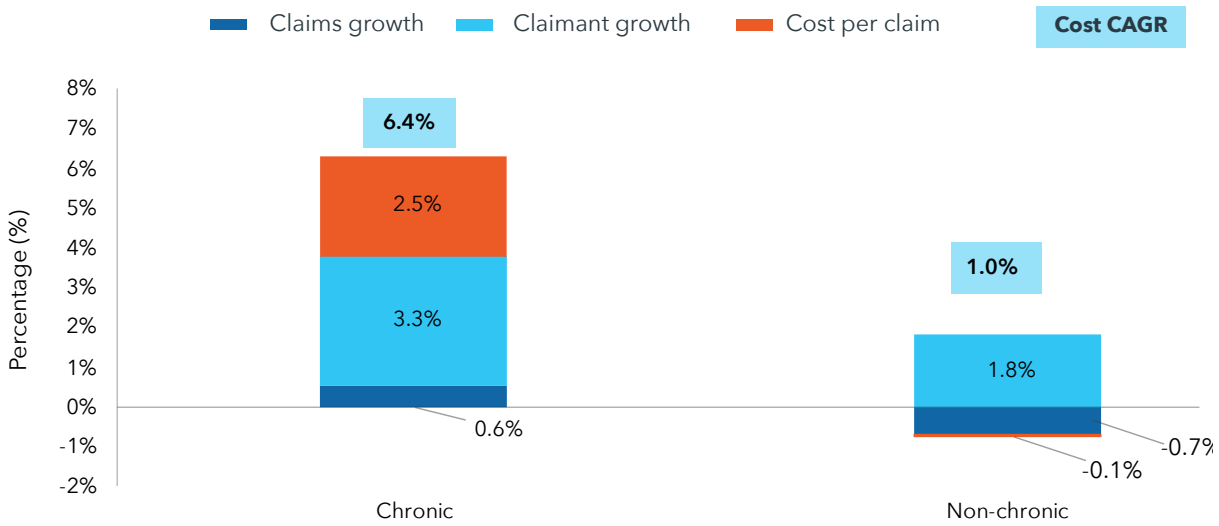
Figure 15: Contribution to 2016–2019 Growth of Private Drug Plan Claim Costs



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

Increased utilization accounted for most of the cost growth for chronic and non-chronic drugs.

Figure 16: Cost Drivers by Chronic and Non-Chronic Therapy, 2016–2019



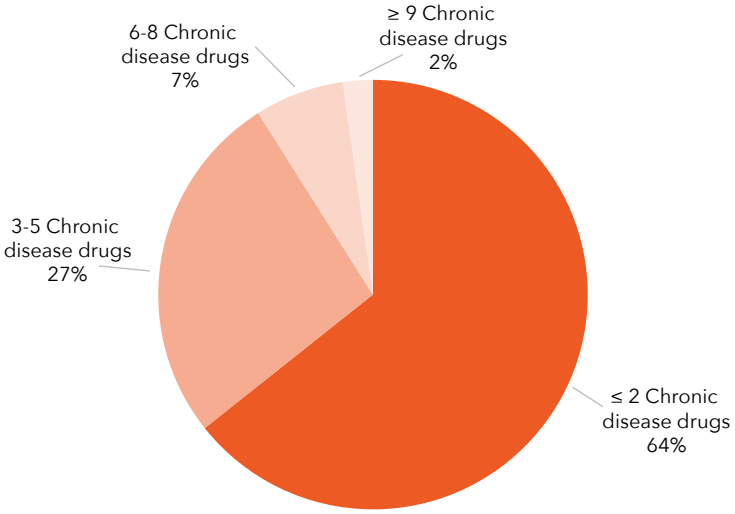
Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

Plan members with chronic diseases often deal with multiple comorbidities. Of all claimants who had at least one claim for a chronic disease drug, 36% took three or more drugs and accounted for the majority of the 2019 private drug plan claims costs (68%). Claimants who took six or more chronic disease drugs had the most disproportionate cost burden, representing 9% of claimants but 32% of costs. (See Figures 17 and 18.)

> *Unfortunately, by the time plan members are taking this many drugs, it's almost too late. We need to work with payers to develop proactive programs that can confidentially identify and support these members earlier."* ***~ Lizann Reitmeier, Health Practice Leader, Buck Canada***

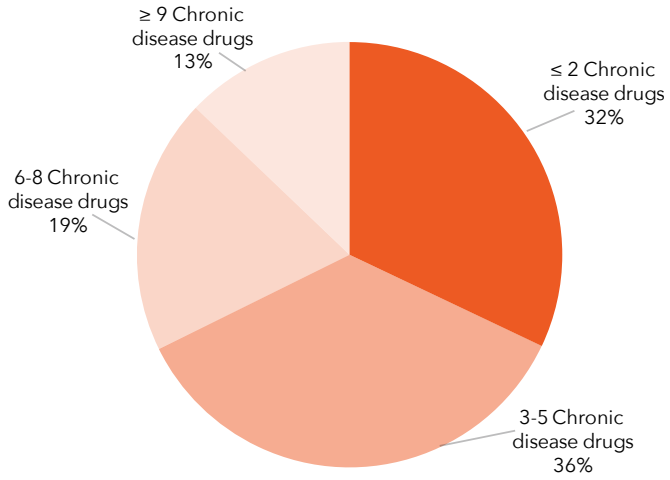
A large portion of private drug costs are for claimants who use 3 or more drugs. However, claimants with 6 or more drugs have the most disproportional cost burden.

Figure 17: Distribution of Chronic Disease Claimants by Number of Chronic Disease Drugs, 2019



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

Figure 18: Distribution of Chronic Disease Costs by Number of Chronic Disease Drugs, 2019



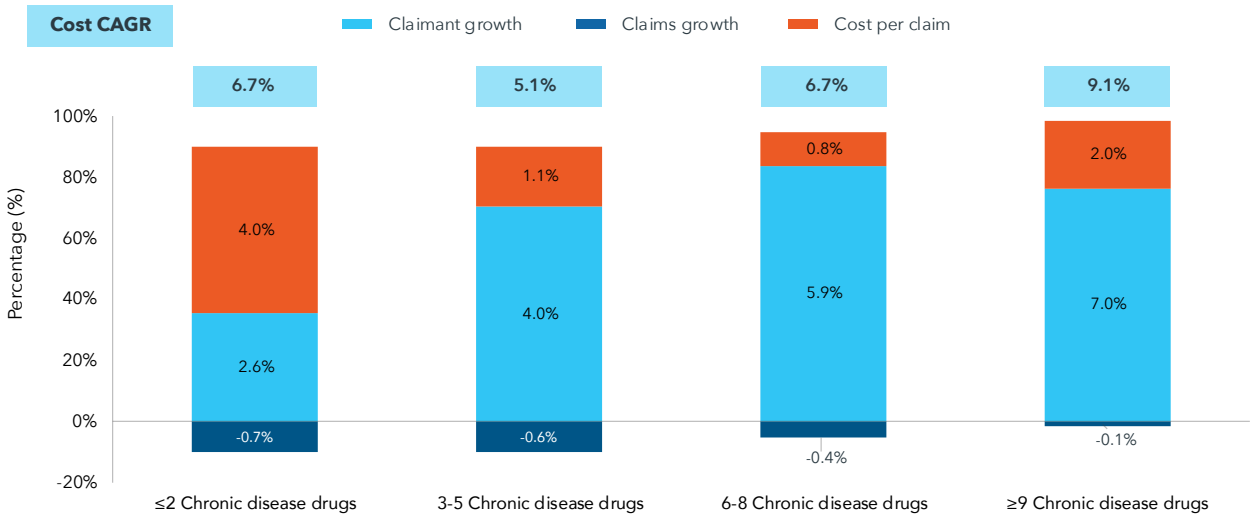
Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

Drug plan costs grew the most (CAGR of 9.1%) for claimants taking nine or more chronic disease drugs between 2016 and 2019, followed equally by claimants taking one or two drugs and those taking six to eight drugs (CAGR of 6.7% each). An increased number of claimants was the primary driver of cost growth for all segments with three or more chronic disease drugs, whereas cost per claim was a more significant driver of cost growth for claimants taking one or two chronic disease medications. (See Figure 19.)

Additional analysis shows that claimants taking nine or more chronic disease drugs were the highest-cost claimants, at nearly six times the average cost per claimant. In addition, as the number of chronic disease drugs used increased, so did the number of different conditions these claimants struggled with. Claimants with one or two drugs dealt with an average of 1.2 chronic conditions, whereas claimants with nine or more drugs were faced with an average of 4.2 chronic conditions.

Claimant growth drove all categories, and cost per claim was highest for those who take only one or two chronic disease drugs.

Figure 19: Cost Growth Drivers by Number of Chronic Disease Drugs, 2016–2019



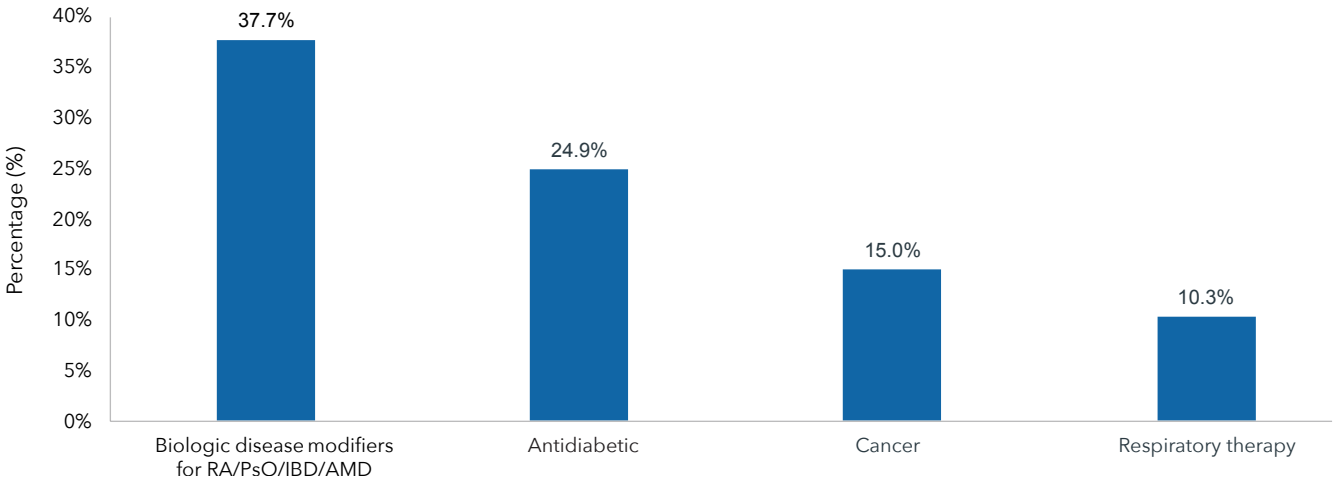
Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

7. Growth by Therapeutic Class

Drugs for auto-immune diseases, diabetes, and cancer led private plan cost growth.

The therapy classes which increased the most between 2016 and 2019 were biologics for auto-immune diseases (rheumatoid arthritis, psoriasis, inflammatory bowel disease, and age-related macular degeneration), diabetes drugs (including diabetes glucose meters and test strips), cancer drugs, and respiratory drugs (including drugs for allergies, asthma, chronic obstructive pulmonary disease and cystic fibrosis). (See Figure 20.) Interestingly, cancer drugs did not appear in the top four therapeutic classes in 2018 and 2019, but they were still in the top three in the three-year aggregate results, suggesting their importance as a driver of cost growth has decreased in the past two years.

Figure 20 - Top growing therapeutic classes, 2016–2019



Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

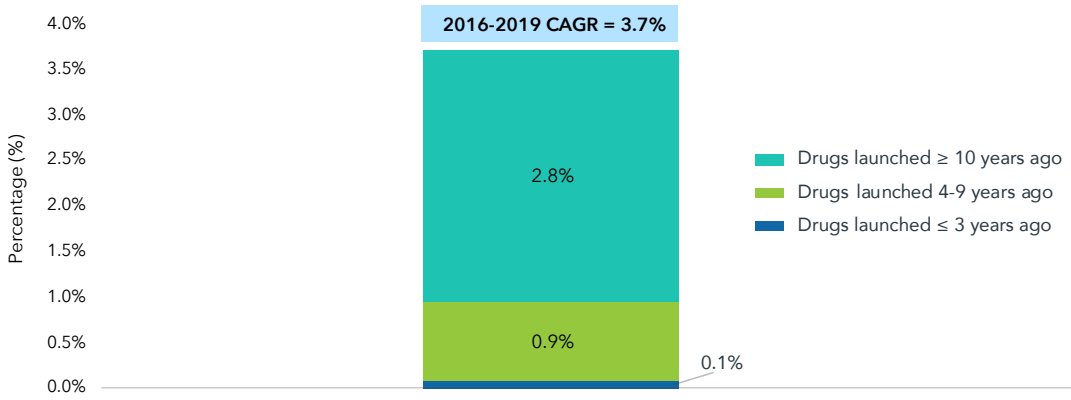
8. Growth by Launch Year

The impact of new drugs was limited, with the biggest cost driver being drugs launched more than 10 years ago.

To better understand the impact of new drugs on private drug plans, claim costs were analyzed for new active substances (NAS) as per the notice of compliance (NOC) by Health Canada and categorized by launch year based on the year of first private drug plan claim. New active substances are drugs that contain a medicinal ingredient not previously approved in a drug in Canada and not a variation of one. They exclude generic and biosimilar medications, new indications, and combination therapies for existing drugs.

Newer drugs are not the biggest cost drivers for private drug plan claims costs. By far the biggest driver of private drug plan claims costs between 2016 and 2019 were drugs launched 10 or more years prior, representing 74% of the growth. Drugs launched 10 or more years ago also had a significant impact in 2019 alone, accounting for 80% of the growth over 2018. Drugs launched less than three years ago had a limited impact on growth, making up 6% of 2019 growth and 2% of growth in 2016–2019. (See Figure 21.)

Figure 21: Contribution to 2016–2019 Growth of Private Drug Plan Claim Costs by Drug's Launch Year

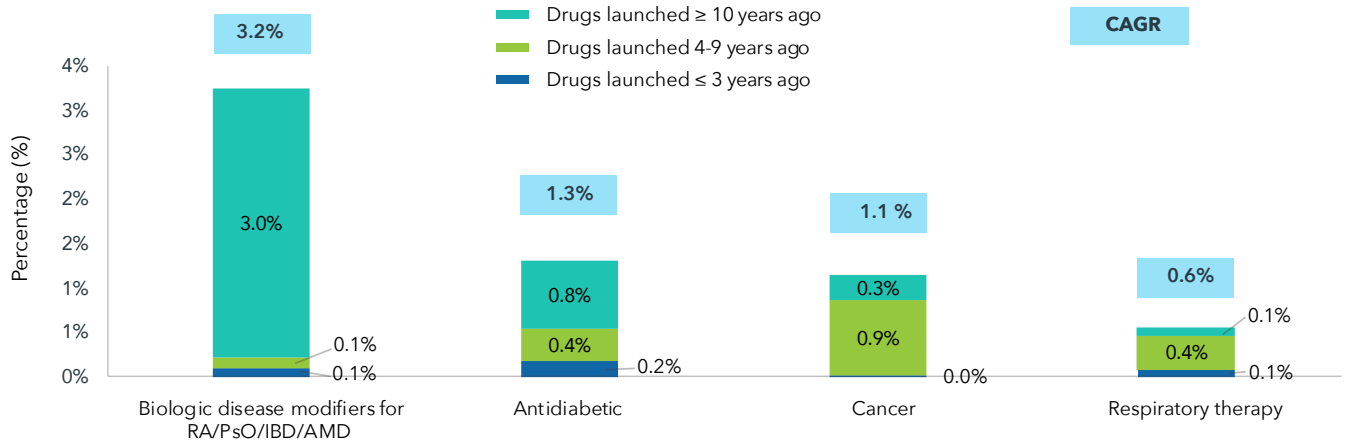


Note: In Figure 21, drugs refer to new active substances (NAS): drugs that contain a medicinal ingredient not previously approved in a drug in Canada and not a variation of a previously approved medicinal ingredient. Launch year refers to the year of first private drug plan claim.
Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

Analysis of the drugs that make up the top four fastest-growing therapeutic classes from 2016 to 2019 shows that claims cost growth for auto-immune diseases and diabetes was driven primarily by drugs launched more than 10 years ago, whereas claims cost growth for cancer and respiratory diseases was driven by drugs launched between four and nine years ago. (See Figure 22.)

Biologics and diabetes growth driven primarily by drugs launched more than 10 years ago.

Figure 22: Contribution of Launch Year for Top Growing Therapeutic Classes, 2016–2019



Note: Figure 22, launch year refers to the year of first private drug plan claim.
Source: Innovative Medicines Canada Cost Drivers Analysis 2016–2019.

9. Health Benefit Premiums

Claims are only one driver of health benefit premiums.

When plan sponsors think about the "cost of drugs," they are usually thinking about the cost of their plan, i.e., the premiums, pool charges, and administrative fees they pay for their drug plan coverage. Drug claims themselves represent only one component of the overall cost of a private drug benefit plan, as insurers' risk management processes, premium setting processes, and pooling methodology all contribute to actual benefit plan costs paid by plan sponsors. These charges can be up to 20% of the total benefit plan cost.

Each plan's unique premiums are dependent on the benefit plan design and the makeup of the employee population. In addition to the plan's claims experience (the actual claims that flowed through the drug plan), the premium calculation includes insurer administrative and risk charges, plan advisor commissions or fees, and a trend factor – an actuarial prediction of what future claims might be. The cost of a plan could include premiums and pool charges that are calculated differently and charged separately. For private drug plans, it is not enough to consider the cost of the drug claims alone because this cost does not include all the factors needed to assess the potential risk of specific drug claims for any one private drug plan sponsor.

> *"This analysis focused on drug claims costs; however, drug claims are just one piece of the puzzle of the total cost of a benefit plan"* ***~ Dave Patriarche, President, Mainstay Benefits***

9.1 Risk Management — Opportunity for Change?

A group of advisors was brought together to discuss the results of the cost drivers analysis and the insurance industry's current private drug plan model. This advisory board concluded that the insurance industry's current model, which assesses drug plan risk, sets premiums, and determines pool charges, does not meet the needs of many Canadian plan sponsors.

Plan sponsors turn to insurers to manage their benefit plans to protect them from the impact of future health claim costs, but the current methods to assess risk and determine premiums leave many wondering if there is true insurance protection for drug claims. "It seems that for smaller plans, there is no such thing as pooling," says Lizann Reitmeier, Health Practice Leader at Buck Canada. Dave Patriarche, President of Mainstay Benefits, concurs: "with experience rating and increased stop loss attachment points, small employers have really lost pooling protection, and in reality, there is no insurance."

Trend Factor

The factors that insurers use to determine health premiums require benefit plan advisors to carefully analyze the insurer's renewal package and calculations. "It appears the carriers' trend factors used in renewals to project future costs are dramatically higher to allow room for negotiation and can often be triple the actual growth our clients see," comments Patriarche. Indeed, according to Noel MacKay, Principal Consultant, National Benefits, at Cowan Insurance Group, "Most advisors don't accept the carrier's proposed trend factor, as it does not reflect our client's actual utilization. It's usually a starting point for negotiation."

It might be time for the industry to look at trend factors differently, says Chris Pryce, CEBS, Founder and President, Human Capital Benefits: "For years now, we have heard that the retrospective drug trend is much lower than the prospective trend factors insurers are proposing in their annual renewals. At what point have we looked in the rear-view mirror long enough to finally acknowledge that the 'retrospective trend' is a reasonable predictor of the true prospective trend; and as such, the industry should apply greater credibility to historical trends in their predictive modeling of future costs."

Pooling

The advisors agreed that the lack of transparency around pooling cost calculations makes it challenging to effectively assess pool charges that are levied on their clients' plans. "Insurers' pooling calculations are not transparent, and it often appears that pooling may be fully experienced-rated, or based on all the health claims, rather than just drug claims. Overall, there appears to be little justification for the pooling charges relative to the claims being paid," says Patriarche. With pooling, says MacKay, "we can explain to our clients how it protects them; however, it's very challenging to get a client to understand how it's priced."

There may be opportunities for collaboration to improve risk management and pooling methodology, however, as Rakiya Oseni, PharmD, Senior Associate, Drug Consulting Specialist, Mercer Marsh Benefits™, Mercer (Canada) Limited, notes,

"without increased transparency and collaboration amongst all industry stakeholders, we can't have a productive discussion on rising pooling charges." That said, insurers may not be motivated to change the current models, Patriarche says, because "pooling is the number one profit margin product for group insurers today."

The advisory board agreed that the Quebec drug pooling model could potentially work in the rest of Canada. Quebec has the only public-private universal drug coverage system in Canada. The Quebec Drug Insurance Pooling Corporation (QDIPC) was set up as part of the Prescription Drug Insurance Act (1997) to prevent a given group with a large drug claim from experiencing too great a cost increase that could put its plan's sustainability at risk. All insurers and administrators of employee benefit plans are required to pool the risks inherent in the cost of pharmaceutical services and medications of Quebec residents.[4]

"Advisors could support something like the Quebec pooling model, where everyone pays the same amount based on the size of their group, versus the way pooling is managed in the rest of Canada, which is inconsistent and varies all over the place from one insurer to another," Patriarche says.

The insurance industry's current model to assess drug plan risk, set premiums, and determine pool charges does not meet the needs of many Canadian drug plan sponsors. There is an opportunity for collaboration among industry stakeholders to improve Canadian group health plan risk management and pooling methodology.

Group Insurance Risk Management 101: Glossary

Trend factor: To set a plan's future health premiums, an insurer will not only consider a plan's prior years' claims experience (experience rating) but 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.

Experience rating: This insurance premium rating methodology predicts a group's future claim costs based on its past claims experience. The weight given to a group's actual claims experience is based on the insurer's assessment of the group's credibility.

Credibility: This refers to how likely a group's claims experience will be similar or predictive of future claims.

Pooling (or stop-loss pooling): In this arrangement, the insurer accepts the financial risk for a plan's claims that are more than a predetermined amount (threshold or attachment points), which limits or stops the policyholder's losses. Claims that exceed the stop-loss threshold are removed from a group's experience used to calculate its future premium. When the claims are removed from the plan's claims experience, they are transferred to the insurance company's pool. All plans in the pool pay their insurer an additional "pool charge" for this extra protection.

10. Discussion and Implications

Chronic disease offers an opportunity to manage drug plan costs.

Plan sponsors and plan advisors need to understand their plan's prescription drug usage and the key drivers of drug plan claims costs to effectively manage their plan and negotiate realistic health benefit premium renewals.

This analysis demonstrates that:

- Private drug plan claims costs grew at a CAGR of 5.3% – significantly less than the double-digit annual trend factor being proposed by insurers in annual rate renewals for health benefit premiums. To more accurately predict future benefit costs, insurers should refer to actual drug costs in the recent past.
- Private drug claims costs were primarily driven by increased utilization (more people claiming more drugs) rather than increased cost per claim. In other words, private drug plan growth is being predominantly driven by the increasing number of claims and claimants, rather than the cost of drugs.
- Older, lower-cost drugs were the primary cost drivers, rather than newer, high-cost specialty drugs. Most of the cost growth being experienced by plan sponsors is due to older drugs being prescribed more often.

> *We often hear that new high-cost specialty drugs are driving private drug plan costs, yet this data shows that older, lower-cost drugs are the primary cost drivers."* ***~ Chris Pryce, CEBS, Founder and President, Human Capital Benefits***

- Private drug plan costs are being driven primarily by lower-cost chronic disease drugs and not high-cost specialty drugs and drugs for rare diseases. The bulk of drug costs are for plan members with modifiable chronic diseases who could benefit from programs that prevent or manage these conditions.

Recommendations

1. Given the significant impact of chronic disease on private drug plan claim costs and growth, there exists a real opportunity for employers to offer programs to improve plan member health and reduce the risk of their members developing chronic diseases. Even a small reduction in the prevalence of chronic disease in the plan member population can have a significant impact on future drug trends.

> *Plan sponsors should look critically at the area of chronic diseases and harness the opportunity to provide long-lasting solutions in the area of lifestyle interventions and well-being initiatives."* ***~ Rakiya Oseni, PharmD, Senior Associate, Drug Consulting Specialist, Mercer Marsh Benefits™, Mercer (Canada) Limited***

2. Plan sponsors and their benefit advisors should seek to understand what is pushing up private drug plan costs in general and review their individual plan data to understand the drivers of their specific plan's cost growth. Understanding the drivers will provide insight into what is needed to address their specific challenges, ensure their members have access to the health benefits they need, and plan for innovative products and programs in the future.

> *A good group specialist measures and monitors their client data to ensure they are on the right track."* ***~ Dave Patriarche, President, Mainstay Benefits***

3. Benefit plans should be measured not only by claims costs but also by the value of their benefit coverage and the outcomes the drugs deliver to the organization. Plan sponsors need to consider the primary objectives of their benefit plan and determine if their program delivers on these goals and offers a return on investment.

> *Remember the value of your plan to members in a health crisis, and recognize that while high-cost drugs are a concern, they are not the major driver of cost under most plans."* ***~ Lizann Reitmeier, Health Practice Leader, Buck Canada***

4. This report analyzes drug claims, which are only one of the components used to determine health benefit premiums paid by plan sponsors. The advisors brought together to discuss the results of the analysis in this report believe there are opportunities for collaboration to improve the insurance industry's risk management and pooling methodology to better meet the needs of many Canadian plan sponsors and ensure long-term benefit plan sustainability.

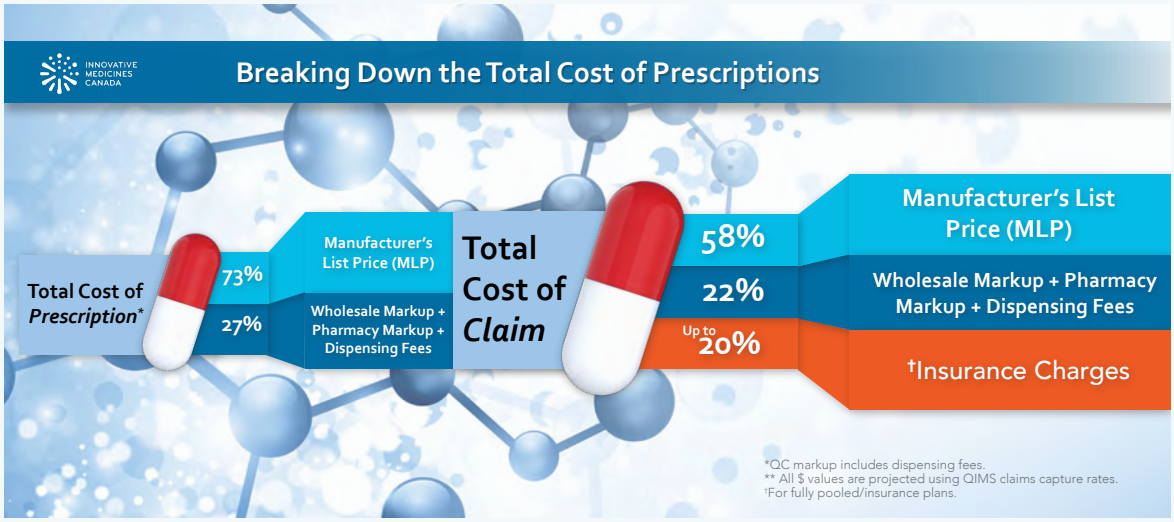
> *"This analysis focused on drug claims costs; however, drug claims are just one piece of the puzzle of the total cost of a benefit plan."*
> ***~ Dave Patriarche, President, Mainstay Benefits***

Data Sources, Methodology, and Definitions

1. The analysis in this report is based on the IQVIA Private Drug Plan Claims database, the largest national private drug plan claims database in Canada, which represents 82% of pay direct private drug claims nationally. (Figures in this report have not been adjusted to represent 100% of the market.)

2. Drug claims represent only one component of the overall cost of a private drug benefit plan. (See Figure 23.) An insurer's risk management process, premium setting processes, and pooling methodology all contribute to the actual benefit plan cost paid by plan sponsors. (See Section 9, Health Benefit Premiums, for more information.)

Figure 23: Breaking Down the Total Cost of Prescriptions



Note: This analysis applies to fully insured plans.
Sources: Innovative Medicines Canada, Better Access Better Health; Innovative Medicines Canada, "Private Drug Plan Distribution Fees Analysis," conducted by IQVIA (formerly Quintiles IMS), 2016, based on IQVIA Private & Public Drug Claims Database

3. Claims costs are based on eligible amount, including both the plan-paid and the patient-paid portions, and include drug ingredient costs and pharmacy and wholesaler markups (dispensing fees are not included, except in Quebec).

4. Although private spending on drugs includes group benefit plans, individual health insurance, and cash-paying customers, this report includes only drug pay direct claims processed through group and individual private drug plans, and not uninsured cash-paying customers.

5. Costs do not include private-payer product listing agreements, other rebate programs, and manufacturer financial assistance, all of which can lower drug claim costs.
6. This report includes the period between 2016 and 2019 to reflect and analyze the impact of OHIP+ changes in 2018 and 2019.
7. This report analyzes the compound annual growth rate in private drug plan claims for the period between 2016 and 2019, which, in effect, considers the following three-year period of aggregate growth.
    a. 2017 growth over 2016
    b. 2018 growth over 2017
    c. 2019 growth over 2018
8. Growth is measured using the compound annual growth rate (CAGR). Given that actual growth may vary from year to year, CAGR defines the average annual growth rate for the entire period and adjusts for volatility.

Advisory Board

Thank you to the advisory board:

1. **Rakiya Oseni**, PharmD, Senior Associate, Drug Consulting Specialist, Mercer Marsh Benefits™, Mercer (Canada) Limited
2. **Lizann Reitmeie**r, Health Practice Leader, Buck
3. **Chris Pryce**, CEBS, Founder and President, Human Capital Benefits
4. **Noel MacKa**y, Principal Consultant, National Benefits, Cowan Insurance Group
5. **Dave Patriarche**, President, Mainstay Benefits

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[1] Innovative Medicines Canada, "Private Drug Plan Distribution Fees Analysis," conducted by IQVIA (formerly QuintilesIMS), 2016, based on IQVIA Private & Public Drug Claims Databases.

[2] Government of Ontario, Get help with high prescription drug costs.

[3] Public Health Agency of Canada, Chronic Diseases.

[4] Quebec Drug Insurance Pooling Corporation website.

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