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THE **INCREASE IN DRUG COSTS** FOR PRIVATE PLANS IS ABOUT 5.2 PERCENT PER YEAR, WHILE THE ANNUAL GROWTH FOR GOVERNMENT-SPONSORED DRUG PLANS IS 2.2 PERCENT.

REFORMS AND INITIATIVES AROUND LOWER-PRICED GENERIC DRUGS HAVE ALSO BEEN A KEY FOCUS.

AMONG OECD COUNTRIES, CANADA'S PER CAPITA **SPENDING ON DRUG COSTS** IS NOW SECOND ONLY TO THE UNITED STATES.

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MANY EMPLOYERS HAVE INCLUDED **MANAGED FORMULARIES IN THEIR PLANS** AND ARE PLACING LIMITATIONS ON COVERAGE PROVIDED FOR DRUG MARKUPS.

"BIOLOGIC" OR "SPECIALTY" DRUGS ARE A GROWING AREA OF FOCUS FOR INSURANCE COMPANIES.

PROVINCIAL GOVERNMENTS ARE RECOGNIZING THAT A **KEY WAY TO CONTROL THEIR DRUG COSTS** IS THROUGH CLOSER EXAMINATION OF WHICH DRUGS THEY WILL LIST ON THEIR FORMULARIES.

CANADIAN HEALTH CARE

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AS A PERIOD OF LOWER HEALTH CARE INFLATION COMES TO AN END, CANADIAN GOVERNMENTS AND PRIVATE PAYERS MUST FIND WAYS TO KEEP COVERAGE SUSTAINABLE. BY TAMAR PILAVDJIAN

CANADIANS HAVE WATCHED WITH INTEREST as health care reform unfolds in the United States. In a country that has enjoyed publicly funded health care for all, and employer-sponsored health and drug coverage for many, the pitched congressional and legal battles that have taken place around the Affordable Care Act have fascinated us all.

But as the winds of change sweep through the United States, Canada is facing a different health care cost crisis. Rising drug—and, to a lesser extent, health care—costs are creating long-term challenges for not only governments and employers across Canada but for individuals as well, with no easy answers.

THE CANADIAN LANDSCAPE

Before we begin to examine the current situation in Canada, it's important to consider the background.

Canada's federal and provincial/territorial governments as well as social security initiatives (including workers' compensation) currently fund approximately 70 percent of Canadians' health care costs. The remaining 30 percent is funded by employer-sponsored plans or out of pocket by individuals.

Public health coverage by governments is primarily focused around physician care and hospital-originated services such as surgery. Senior citizens and those on social assistance are also eligible for government-sponsored drug coverage. Although just over half of Canada's population is entitled to this coverage, increases in overall claims and the cost of drugs covered continue to escalate. As a result, the annual outlay by Canada's governments for drug coverage was expected to have reached $12.3 billion by 2012, compared to $10.8 billion five years before. The country's total drug spending for 2012—from both public and private sources—was forecast to hit $32.9 billion. By comparison, in 2008 Canada's total drug spending was $27.9 billion.

The table below illustrates the total 2010 health expenditures in Canada for both public and private sectors combined.

SPENDING BY CATEGORY	COMBINED SPENDING (%)	PUBLIC SECTOR SHARE (%)	PRIVATE SECTOR SHARE (%)
HOSPITAL	29.1	90.9	9.1
DRUGS	15.9	38.3	61.7
PHYSICIANS	14.2	98.9	1.1
OTHER PROFESSIONALS[1]	10.6	8.1	91.9
OTHER INSTITUTIONS[2]	10.4	71.8	28.2
ALL OTHER HEALTH SPENDING[3]	19.8	78.8	21.2

[1] Dental, vision care, chiropractor, massage, etc.
[2] Nursing homes and residential care facilities.
[3] Includes administration, public health, research, capital investment, etc.
Source: National Health Expenditure Trend 1975–2012, CIHI.

The private payers—in the form of individual and employer-sponsored coverage—supplement government-sponsored programs in Canada. A majority of Canadians (60 percent) are covered through an employer-sponsored health plan, and these, too, are feeling increasing cost strains. This has been a consistent trend for many years. Private payer drug costs were expected to reach $20.6 billion ($17.1 billion five years ago) in 2012 and represent 62 percent of the country's total drug spending.

A recent report from the Canadian Institute of Health Information shows that, among OECD countries, Canada's per capita spending on drug costs is now second only to the United States. From 1985 to 2012, the report indicates, the country's total drug spending grew an average of 8.9 percent per year (it was in the double digits in the late 1990s and lower in more recent years). Currently the rate of increase in drug costs for private plans is about 5.2 percent per year, while the annual growth for government-sponsored drug plans is 2.2 percent.

Due in part to changing generic drug pricing—more on that later—the situation around escalating drug costs has shown

signs of improvement recently. Overall drug spending increased by 4 percent in 2011 and by more than 3 percent in 2012, well below the annual cost increases seen previously. But evidence suggests that the drivers behind this slowdown are fading, paving the way for further rapid cost increases.

WHAT'S BEING DONE?

As drug costs have increased in recent years, employers offering coverage have struggled to deal with the cost of these benefits, particularly as the population ages and people stay in the workforce longer.

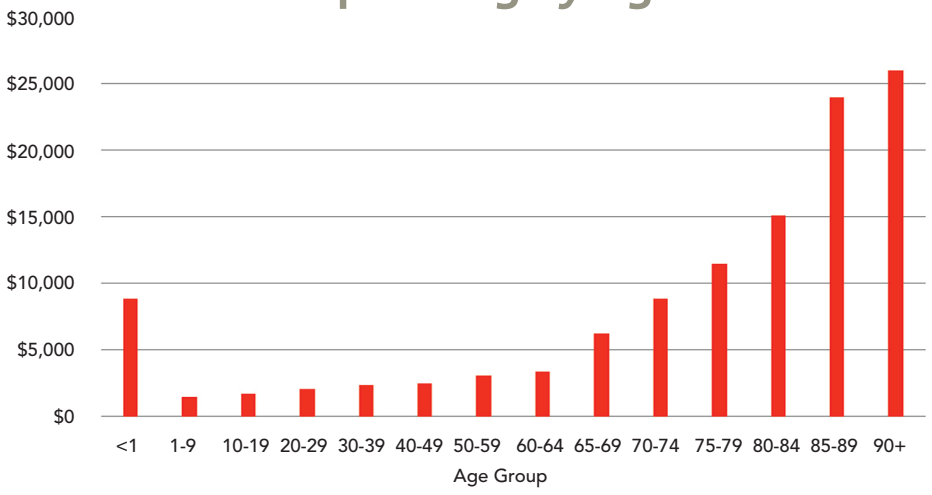
The chart to the right illustrates the cost of health care by age band.

Although Canadians aged 65 and older account for 14 percent of the country's population today, they consume 45 percent of total public health care dollars. Current demographic trends suggest that by 2041, 25 percent of the population in Canada will be 65 or older. It is clear this shift will continue to place pressure on government- and employer-sponsored coverage if something is not done soon.

So, what are employers doing to curb rising plan costs? Recent data from the Conference Board of Canada suggest that more than half of Canadian employer-sponsored plans (primarily those that cover public-sector employees or are sponsored by large private corporations) include drug coverage and other benefits for retirees. However, only about half of these plans continue to be open to new retirees.

Reforms and initiatives around lower-priced generic drugs has also been a key focus. In the public realm, provincial governments have moved in recent years to reduce what they pay for generic drugs; Alberta currently has the lowest cap, restricting generic prices to no more than 18 percent of brand equivalents, with other provinces shifting gradually into that

Total per Capita Health Care Spending by Age



Source: National Health Expenditure Trend 1975–2012, CIHI.

PROVINCE	GENERIC PRICES 2013 (CURRENT AT JUNE 2013)
BRITISH COLUMBIA	25% (20% EFFECTIVE APRIL 2014)
ALBERTA	18%
SASKATCHEWAN	35%
ONTARIO	25%
QUEBEC	25%
NOVA SCOTIA	35%
NEW BRUNSWICK	25%
PRINCE EDWARD ISLAND	35%

range, as illustrated in the table above (shown West to East).

In addition, a majority of Canada's provinces joined forces in 2011, leveraging their combined buying power to conduct joint pricing negotiations for seven brand-name drugs. Pricing for an additional 13 products is currently being negotiated. The initiative was expanded in January 2013 to include generic drugs. Since then, participating provinces and territories have successfully negotiated a common reimbursement level for six of the most commonly used generics (atorvastatin, ramipril, venlafaxine, amlodipine, omeprazole and rabeprazole), which together represent approximately 20 percent of the publicly funded spending on generic drugs in Canada; pricing for these treatments has been set at no more than 18 percent of the equivalent branded drug.

Employers are recognizing the value generics can have in controlling plan costs too. A growing number of plan sponsors are implementing mandatory generic substitution clauses into their coverage and/or capping the amount covered for brand-name drugs at the generic cost. Taking these techniques a step further would be to include provisions for "enhanced generic substitution." This method applies evidence-based adjudication controls: if plan members want to use a brand-name drug, they must submit evidence through a physician's statement that they cannot take the generic drug for medical reasons. Otherwise, the member pays the cost difference between the brand-name drug and the generic out of pocket.

Many employers have also included managed formularies in their plans and are placing limitations on coverage provided for drug markups and pharmacy dispensing fees. Some workplace plans have even introduced tiered reimbursement levels for different drug therapies. These so-called "step therapies" have been introduced in a few plans for certain types of conditions like rheumatoid arthritis.

The large number of popular drugs coming off patent protection in the last few years—and thereafter generic equivalents being produced—has also helped to significantly slow the cost increases seen by both private and public plans. However, this slowdown may be short lived, because more expensive biologics are coming onto the market versus drugs coming off patent.

"Biologic" or "specialty" drugs are a growing area of focus for insurance companies. These medications, used to treat complex and chronic medical conditions, are often administered by injection, infusion, inhalation or orally; they are providing patients with options that weren't available in the past. But these options come at a price, with average costs for these treatments ranging between $20,000 and $600,000 or more per patient per year. Although these medications are currently used by fewer than 1 percent of plan members, it is estimated that they account for 10 to 15 percent of total drug claims for private plan sponsors.

With Canadian insurers expecting the costs for these drugs to eventually increase to more than 25 percent of total drug expenditures, management is key. As a result, insurers have put a "special authorization process" in place for biologic drugs. The provider, patient, and his or her medical specialist work together to ensure adherence, which is important given the high cost of these medications.

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But with the cost relief seen from generics leveling off as the end of the provinces' gradual generic price drops nears, and with the number of major drugs coming off patent slowing, private insurers, employers and governments are justifiably worried that health care inflation will creep back up to the high double-digit rates of the late 1990s. With the increasing prevalence of biologic drugs and the impact their high price tags may have on plan costs, employers are looking for more ways to shield themselves. They may have no choice but to shift more costs to individuals.

READY FOR REFORM?

Passing the cost of drug coverage on to individual Canadians seems much easier said than done. It would require a major shift in both plan design and thinking around health coverage in Canada. In the meantime, increasingly, employers are recognizing the link between plan costs and the health of their employers. As a result, there has been a big push in recent years toward ensuring that covered employees remain as healthy as possible.

Employer-led wellness initiatives focused on weight loss, diabetes management and mental health are designed to stem the growth in chronic conditions that often lead to frequent drug claims. Although this is a positive step forward, there is further room for growth around wellness. Currently most employer wellness initiatives are aimed at employees currently in the work force. But those that offer drug coverage to retired members would be wise to consider such initiatives aimed at retirees.

Looking at public coverage, provincial governments are recognizing that a key way to control their drug costs is through closer examination of which drugs they will list on their formularies. A recent report from the Canadian Health Policy Institute indicates that from 2004 to 2011, Health Canada certified 373 new drugs. On average, Canada's provincial plans offered coverage for just 20.5 percent of these drugs by adding them to their formularies, and it took an average of 659 days, or 1.8 years, to add each drug.

In contrast, more than 80 percent of these drugs were covered by at least one private insurer, usually with coverage coming much faster than in the public sphere. Perhaps cost-conscious employers who sponsor drug plans should look to mimic the scrutiny and pace by which provincial plans offer coverage. By covering only those drugs listed under the provincial formularies, employers could realize cost savings on their drug costs upward of 20 percent, depending on the plan design.

There is no magic bullet. While they protect costs around their own public plans, the provinces have begun shifting costs down to the private payers. For example, when arrangements are implemented to administer drugs outside of a hospital setting, the costs may fall to the employer plan rather than the provincial plan. Although this is a cost-effective strategy to reduce provincial costs, the burden falls on the employer plans as they end up paying for the drugs administered in outpatient clinics. Also, when provinces make their plans income tested, the income-based deductibles are generally covered under the employer plan.

If these offloaded provincial costs are not paid by the employer, either because the employer plan won't cover the costs or because the individual isn't covered by a work plan, the cost burden will fall on the individual.

Historically, Canadians haven't had to pay much out of pocket for health care services. Most Canadians, therefore, are not aware of what these costs are, or how health care expenses may increase as people age. Without a solid understanding of what drugs and health care services cost, most people in this country are not prepared to help their employer keep plan costs down by being better consumers. And most people are

Research Report on Canadian Health Care System Released

The Society of Actuaries and the Canadian Institute of Actuaries sponsored research on the Canadian health care system. Performed by Stéphane Levert, FSA, FCIA, the study estimated the future costs of the Canadian health care system, assessed the sustainability of the system over a 25-year horizon, and analyzed the implications of the changes to the Canada Health Transfer proposed on Dec. 19, 2011 by the federal government. The report summarizing the findings is now available and indicates that, without significant government intervention, the Canadian health care system in its current form is not sustainable.

Visit *www.soa.org/Canadian-Health-Care-Sustainability/* to access the full report titled, "Sustainability of the Canadian Health Care System and Impact of the 2014 Revision to the Canada Health Transfer."

certainly not aware of what they might need to save to cover the growing cost of health care needs throughout their retirement years.

In a broader context, it seems policymakers and politicians aren't ready for rising drug costs, biologics and an aging demographic either. Previous generations of governments set in place legislation that allowed individuals to set aside money on a tax-preferred basis for their retirement, but they did not anticipate the need for significantly more dollars to be available to help fund Canadians' health care needs over their lengthening retirement lifetimes.

A key question being asked now is whether governments will introduce changes that will allow individuals to start saving extra money for their future health care on a tax-preferred basis. Even if this were to happen, do Canadians have the extra money to put aside? Will they have to choose between retirement income and retirement health care?

Canada may be in a period of relative calm as far as drug costs are concerned, but the coming years could be a rude awakening. Governments, employers, insurers and all Canadians need to be willing to have serious discussions around how to pay for these increasing costs in a sustainable manner.

As seen from our southern neighbors, the move forward will not be easy, nor will it happen overnight. The time to start thinking about the future is now. A

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