

HEALTH CARE BENEFITS IN CANADA

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We Take a Closer Look

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Agenda

- State of health care in Canada
- Issues affecting benefit utilization and costs
- Impact on benefit plan design



STATE OF HEALTH CARE IN CANADA

Benchmarking of Canada's Health Care System

- Canada and 23 other countries benchmarked on 24 health status indicators Conference Board of Canada

- Canada's results:
 - Middle of pack -13th overall out of the 24 countries
 - 3rd highest in total health spending
 - 6th highest public spender
 - Spending as a % of Gross Domestic Product - 7.4%, one of the highest in world

Health of Canadians

- Benchmarking results:
 - Good on health status indicators i.e.. life expectancy, low birth weight etc.
 - 20th out of 23 on health outcomes i.e.. lung cancer rates, myocardial infarcts, stroke rates, breast cancer, suicide etc.
 - 6th in obesity
 - 2nd highest sulphur dioxide emission

* CIHI (Canadian Institute for Health Information)

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Healthy Provinces

- In Feb 2006 Conference Board of Canada issued a report benchmarking the health of Canadians by province – health status, healthcare outcomes, utilization and performance
 - No province does well in all areas
 - British Columbia and Alberta have top performance but B.C. lowest satisfaction level
 - Higher spending not associated with better health care indicators
 - Ontario – second lowest female life expectancy, second highest low birth weights, very low satisfaction levels but shortest wait times

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Issues – Health Care

- Canadians have high expectations versus other countries and do not use health care resources effectively – i.e.. high incidence of emergency room use.
- 2004 estimated health spending – \$130.1 billion*
 - Public spending more than \$91.1 billion
- Canada performing okay – male life expectancy, mortality rates on strokes, incidence of AIDS
- Canada performing poorly and needs attention to:
 - obesity, prostate cancer, infant mortality, female lung cancer, breast cancer and colorectal cancer

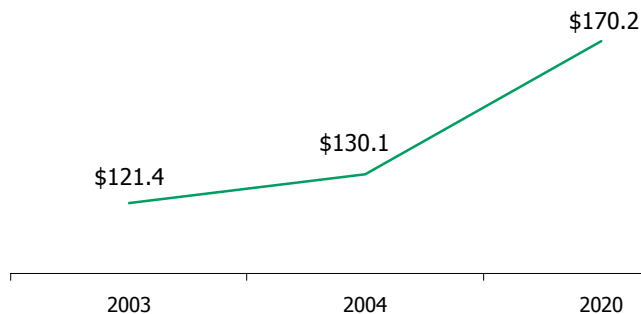
*Conference board of Canada

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Costs of Health Care

Total Health Care Spending

Billions



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Costs - Health Benefits

Benefit plan costs (Conference Board):



1990 – **3.7%** of payroll



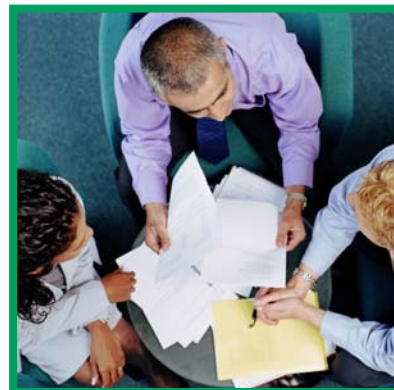
2003 – **6%** of payroll



2007 – expected to reach **8%** of payroll

Cost Drivers

- Aging population
- Diminishing demographics
- Increasing consumer and provider expectations
- Cost of chronic disease management



Cost Escalators

- Health human resources:
 - Access
 - Patient safety
 - Environmental issues
- Pharmaceuticals
- Home care



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Patient Expectations

- Expectations for quick access to sophisticated and high quality services will continue to grow
- Failure to match the expectations of the providers and consumers will lead to the erosion of universality for services not deemed medically necessary (hip /knee replacements, etc)
- First wave of boomers – age 65 in 2012, but they will attempt to hold onto their youth – watch grandma windsurf - new drugs to do so.
- Accountability and access on every Government agenda
- Chaoulli ruling opened door to two tier Health Care

Health Council of Canada

2005 Health Care Summit's Goals for New Health Funding: their solution and how we fix the problem

- Reduce waiting times
- Add health professionals
- Home care – expand services
- Health innovation – HER (electronic health records), prescribing, science, research
- Primary care reform
- National RX (catastrophic) strategy
- Prevention promotion and public health

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National Pharmaceutical Strategy

By June 2006 a Report on Progress Including Options for:

- Catastrophic coverage (national)
- National Drug Formulary
- Strengthening evaluation of drug safety and effectiveness
- Pursuing purchasing strategies
- Influencing prescribing patterns – drugs only used when needed
- Expanding access to non-patented drugs, pricing information
- Better analysis of cost drivers, best practices etc.
- Increasing e-prescribing and deployment of EHR (electronic health records)

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Ontario Drug Secretariat

- Appointed mid 2005 by Minister Smitherman
- Ontario Drug Benefit Plan unsustainable and not achieving results needed to increase health of Ontarians
- Report was tabled January 2006 – consulted with all external stakeholders including benefit plan sponsors
- Report not yet released. changes will be forthcoming and implemented over next year +
- Will form basis of Ontario's response to National Catastrophic Drug plan

National Pharmaceutical Strategy

Issues

- Income based eligibility:
 - With up front out of pocket expense required
 - 5% to 10% of taxable income estimated as out of pocket financial impact
 - No Canadian to be financially disadvantaged because of drug cost



National Pharmaceutical Strategy

Issues

- Formularies will be limited and drugs will be reviewed before added (time delays) and will consider cost/value equation. some drugs now covered by province may not be . i.e. basic meds like PPI's may be affected
- Out of Pocket to qualify will increase (Ontario - now one of lowest)
- May introduce other things like Maximum Allowable Costs in therapeutic classes . (drug plans pick up slack if not dealt with in plan language)
- Few employer plans currently have annual or life time maximums nor do they restrict medications i.e.. limited or managed formularies
- Without changes the concern is most plans will automatically pick up shortfall – plan wording will be significant go forward issue

Changes to Drug Costs as a Result

- Bulk purchasing by provinces
- National catastrophic drugs could force up prices to private sector
- Drug pricing strategies:
 - Manufacturers listed prices not what drug sells for
 - Possibly change/influence current rebating



Primary Health Care Reform

- Fundamental to improving our health care system and making it sustainable and accessible
- Built on four pillars
 - Teams
 - Information (E.H.R)
 - Access
 - Health Living

Primary Health Care Reform

- Interdisciplinary teams working cooperatively – doctors, nurses , pharmacists, physiotherapists, nutritionists etc.
- Shared information across all health professionals (E.H.R.- electronic health record and diagnosing tools)
- Access beyond office hours -goal 50% of Canadians have access to 24/7 by 2011
- Health living, chronic disease prevention ,management and self care

ISSUES AFFECTING BENEFIT UTILIZATION AND COSTS

Chronic Disease

- 16 million Canadians live with a chronic disease: cardiovascular, cancer, mental illness, diabetes, chronic obstructive lung disease
- Chronic disease accounts for 87% of disability
- Chronic disease accounts for 67% of all direct health care costs and 60% of indirect costs



Chronic Disease

The Most Important Common Risk Factors*:

- Smoking including exposure to second-hand smoke
- Obesity – 48% of Canadians are overweight; 15% are obese
- Physical inactivity – 56% of Canadians are inactive; only 18% of teenagers active enough to meet international guidelines

* Conference Board

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Mental Health & Work Life Conflict

- \$16 billion or 15% of payroll is the economic impact of work related health and mental health issues
- Work life conflict adds \$6 billion
- 60% of Canadians indicate they can't balance work and family life

Job stress
Depression
Anxiety
Substance abuse
Addiction
Back pain
On the job injuries

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Depression

- By 2020, depressive disorders will become one of the leading cause of disease burden in Canada; represents anywhere from 4% to 12% of payroll costs in Canada.
- Depression & stress disorders at work account for more than 30% of disability claims
- Mental health claims are the fastest growing category of disability costs in Canada (overtaking cardiovascular disease)

Source: Canadian Mental Health Association



Depression

- 3 million Canadians depressed (~10% of population)
- 1.4 million working Canadians depressed (~10% of labour force)
- Over 33% of teenagers likely to experience depression
- 8% of Total Drug Expenditure in 2004

Source: Global Business And Economic Roundtable on Addiction And Mental Health



Home Care

- Home Care is considered an Extended Health Care Service under the Canada Health Act and is deemed a non-insured service
- Currently no strategy in Canada to address home care issues
- Throughout the 1990's the cost of home care increased at an annual rate 4X greater than other health care spending (not pharmaceuticals)
- Significant cost off loaded to drug plans and growing

Escalating Drug Costs

- CIHI reports drug spending at \$22 billion in 2004 (5x > than in 1995)
- Public sector finances only 37.6% of cost of prescription drugs

Escalating Drug Costs

- 1980's; \$1.00/day was considered expensive (e.g. Tagamet, Zantac)
- Today's barrier has been estimated at \$100,000/year
- Biologics (DNA technology) – next wave of pharmaceuticals – over 800 in development - 350 in late stages of development



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Escalating Drug Costs

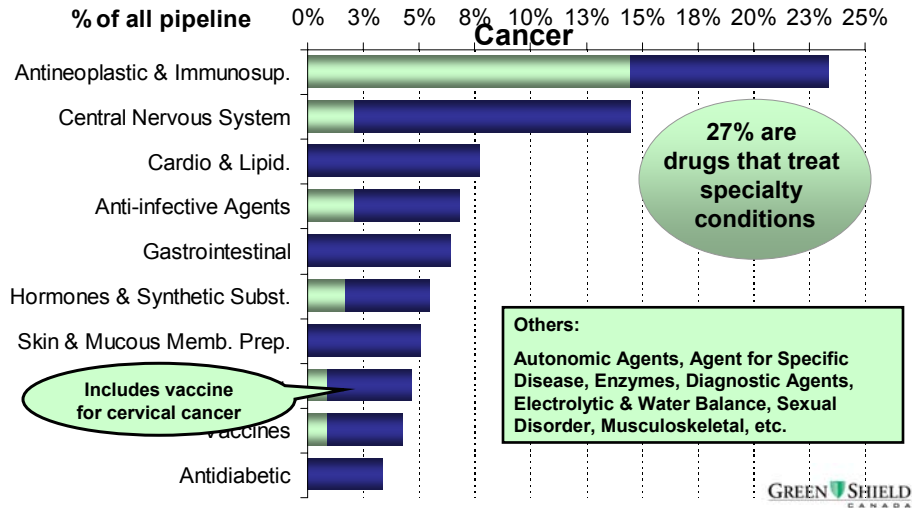
Average Prescription Price*

1980	\$8
1985	\$14
1990	\$20
1995	\$27
2000	\$39
2005	\$50-100
2010	\$250-500

* HKS & Company, Warren, NJ, Academy of Managed Care Pharmacists, 2003

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Pipeline Drugs Therapeutic Distribution



New Drugs

Drug Name	Use	Estimated Cost
*Humira®	Rheumatoid Arthritis	\$20,000/year
*Strattera™	ADHD	\$1000-\$1300/year
*Xolair®	Severe Asthma	\$12,000/year
*Amevive®	Psoriasis	\$10,000 - \$34,000
*Forteo™	Osteoporosis	\$10,000/year
* Replax®	Migraine	\$20. per tab
Eloxatin™	Colorectal Cancer	\$17,000

Increasing Utilization

- Growing scope of pharmacotherapy:
 - New treatments for diseases
 - Maintenance medication
 - Preventative medication
 - Multiple medications – same condition
- More consumer driven demand
- Direct marketing to physicians by drug companies

DRUG UTILIZATION

- 5% of claimants have highest drug costs - more than 40% of all costs
- Average utilization of high costs claimants - heavily weighted to 55-64 year old age group
- Selected therapy users average costs - \$11,500 +
 - Cancer, Rheumatoid Arthritis, Multiple sclerosis, HIV, Hepatitis C
- Multiple chronic diseases - average annual use \$17,251

Pharmacogenomics

"Study of how an individual's genetics affects the body's response to drugs"

- 1/3 of drugs in testing are genetic/biologic .
- Estimate is that about 50 of the top 100 drugs (anti depressants, pain meds etc.) are affected by "one metabolizing enzyme" – 5-8% of Caucasians, , 70% of Asians have some defect in this gene strand.
- Statin study Iceland – 10,000 users – 2,000 no effect at all 20% ineffective
- Development of predictive genetic tests – prevention, planning
- Will ensure the right drug for the right patient - better, safer. more powerful drugs- which could decrease overall costs

Pharmacogenomics

- Extremely high cost entities
- More drugs coming to market for previously untreated/under treated diseases
- Patents are being awarded on genetic markers/testing (no cost controls)
- 2003 in U.S. > 1 million genetic tests performed
- Market growing by 30% per year

Pharmacogenomics

- In use at University of Montreal and Genome Quebec:
 - Childhood leukemia
 - Antidepressants
 - Pain medication
 - Herceptin (breast cancer)



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Pharmacogenomics Issues

- Test costs – who pays? (U.S. – some drug plans pay)
- Complexity in deciphering gene variations and interpretation of testing on drug response – who can do it
- How do you ensure information is used by physician and not just another alternative.
- How does physician/pharmacist apply to prescription/dosing
- Disincentives for drug companies - limits their markets
- Limited drug alternatives – if does not work
 - Education – public and health care providers

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Electronic Health Record

Objectives:

- Improve health outcomes
- E-prescribing – reduce error rates, improve patient safety
- Improve decision making
- More efficient use of resources and services
- Permit remote access – improve access



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Electronic Health Record - Model

The Old World

Provider focused
Illness
Site of care
Episode management
Supply management
Lone Ranger decisions
Efficiency
Decentralized care

The New World

Patient and family focus
Wellness
Continuum of care
Disease management
Demand management
Collaborative, evidence-based
Effectiveness
Centralized, specialized

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Electronic Health Record Issues

- Costs of implementation – *technology, cognitive fees, transaction fees, consent etc.*
- Compliance with standards by all providers – adds costs
- Privacy- knowledgeable patients
- Plan Adjudication increased sophistication new information, new standards, new plan types
- Emergence of e-prescribing will affect :
 - formulary design, utilization of pharmaceuticals
 - the current supply chain

Impact on Benefit Plan Design

Impact on Benefit Plan Design Plan Sponsors

- Existing publicly funded benefits will be significantly changed:
 - More off-loading, home care, drugs for home use - cancer therapy oral not IV
 - Income based –provincial coverage
 - Limited use drugs and drugs not on formularies - increasing
- Current benefit plans can not meet all expectations – high cost drugs may be available only to a few people, need to consider maximums
- Shift from “paternal view” of taking care of employees to “shared responsibility”
- Plan sponsors will have to make choices – focus on sustainable costs

Impact on Benefit Plan Design Plan Sponsors

- If issues with access not addressed:
 - 2 - tier pricing
 - Private clinics/Private referrals
- EHR will add costs to the delivery model - cognitive fees, transaction fees, password maintenance, consent maintenance etc.
- National Catastrophic Drug Plan - how does plan language ensure plan members are protected?
- National Pharmaceutical Strategy

Impact on Benefit Plan Design Plan Members

- Plan members will demand expansion of covered services i.e.. value of semi private in relation to other “at home” services
- High costs for new tests/diagnostics will have to be evaluated and costed –when they bring value, who pays?
- MRI in private clinic for active employee only – get employee back to work
- All benefits and services will have to be reviewed to ensure they meet medically necessary criteria of improved health outcomes . Vision care every two years- cosmetic or a health requirement

Impact on Benefit Plan Design

Plan Language	Considerations
<ul style="list-style-type: none"> ■ Benefit plan language needs to address changes to: <ul style="list-style-type: none"> - delivery chain and primary health care model (Canada Health Act) - reimbursement model 	<ul style="list-style-type: none"> ■ traditional drug language probably not appropriate, consider if language covers drug ingredient costs alone, cognitive fees, amount covered if physician dispenses etc. ■ Consider costs transactions, private health etc. ■ The requirement to use any government coverage as first payer.
<ul style="list-style-type: none"> ■ Introduction of new costs from implementation of emerging initiatives: <ul style="list-style-type: none"> - picked up by existing language - significant pressure to add 	<ul style="list-style-type: none"> ■ Give employer alternatives with cost containment – right person, right drug etc. ■ Overall plan maximums , so as additional costs are added exposure does not increase..

Impact on Benefit Plan Design

Chronic Disease and Mental Health	Considerations
<ul style="list-style-type: none"> Costs of diagnoses and treatments increasing Prevention and healthy lifestyle need to be encouraged and rewarded 	<ul style="list-style-type: none"> Provide education and prevention programs Have a healthy life focus Put attention to employees versus dependents and spouses – i.e., physio for active only not dependents Reward good consumerism and healthy choices through plan design

Impact on Benefit Plan Design

Escalating Costs	Considerations
<ul style="list-style-type: none"> If expectations are not dealt with - costs unsustainable Generic vs. Brand drugs, Maximum allowed costs, EGS Off-loading from Government 	<ul style="list-style-type: none"> Offer co-pays, deductibles, maximums, increased off-loading to public plans Flexible technology and ongoing due diligence to ensure maximum coordination with all government Move to formularies that same or similar restrictions that government will or picking up costs - Conditional Drug Formulary™-prescribing guidelines Coverage for preventive services enhanced , chronic decreased, Flex Benefits®

Impact on Benefit Plan Design

Education and Interventions	Considerations
<ul style="list-style-type: none"> ▪ Plan members have high expectations – but not everything covered all the time ▪ Coverage personalized to health condition, level of compliance (diabetic - benefit of dietician), target “at risk” individuals 	<ul style="list-style-type: none"> ▪ Communicate cost/value of current plan and benefits plan, ▪ Education to make better decisions ▪ Ensure patients understand impact of treatment options – plan design must force choices ▪ Begin philosophy of not everything covered – lag fee guides eliminate things cosmetic alone. ▪ Reward good lifestyle choices e.g. (nicotine patches covered) ▪ Reward good consumerism - (generic drugs – lower copayment) ▪ Health care spending account to deal with diverse needs and offer protection from delisting, new costs and services

Health Promotion Frivolous Cost or Sound Investment?

- Conference Board of Canada– Dec. 2005
 - Very difficult in turbulent times (survive today is focus)
 - Absenteeism and disability rates for “personal” reasons are increasing
 - Rising drug and dental costs, cost shifting from public sector is significant concern
 - Still uncertainty of results and the link to productivity and competitiveness is tenuous.
 - Research has evidence of the relationship between employee satisfaction and profitability, higher employee engagement
 - ROI on workplace health promotion wrong debate – focus has to be strategic and long term.

Green Shield Canada

Right Benefit, Right Person, Right Time:

- Green Shield Canada Conditional Drug Formulary™
- Initial Days Supply
- Enhanced Generic substitution and Maximum Allowed Costs
- Claims Management – Green Shield *Advantage*®
- Green Shield Canada Passport to Health™
- Reporting and Analysis – Web ShieldStats®

