A crowded crossing on Ste. Catherine Street in Montreal. Non-government payers cover more than $15 billion in prescription drug costs. But is universal pharmacare the answer? Tax credits might be another one. *Montreal Gazette* photo

Can an Innovative Tax Credit System Sustain Drug Plan Coverage in Canada?

Mike Sullivan

The fight for sustainable prescription drug plan benefits for all Canadians has to move far beyond a national pharmacare conversation. Until government and non-government payers find common ground with respect to how to leverage their current spending on prescription drugs and build meaningful partnerships focused on efficient investment and improved health outcomes, meaningful long-term solutions will not be achieved. Well-designed policy is a critical initial step in the process.

In an election year, and with a flurry of headlines in recent months around the introduction of expensive blockbuster innovations in prescription medications, it is not a surprise to see discussions of a "national pharmacare" strategy gaining momentum. There is no question that the current system for drug coverage in Canada is broken and unsustainable, but the idea that a government-led national pharmacare strategy will solve the challenges the system faces is unrealistic.

> *There is no question that the current system for drug coverage in Canada is broken and unsustainable, but the idea that a government-led national pharmacare strategy will solve the challenges the system faces is unrealistic.*

Non-government payers in Canada spend in excess of $15 billion per year in prescription drug costs in Canada. Non-government payers hold the key to sustainable solutions in this area, and the first step in that direction is looking at appropriate tax credits and other financial incentives to keep employers and other non-government payers in the business of underwriting prescription drug costs in years and decades ahead.

The challenge in looking at sustainable solutions to funding prescription medications is that the immediate past is misleading. The period between 2010 to 2014 is affectionately known to those in the drug plan management space as the "Golden Era." Thanks to generic drug prices that are now one-third what they were five years ago and the number of blockbuster drug products that lost their exclusive patent in recent years, both government and non-government payers (often referred to as third-party payers) saw significant savings in recent years that kept overall drug plan spending at bay and hid the growing impact of expensive specialty drugs on plan sustainability.

These savings seen in recent years were all passive—they were not the result of better member health or better plan design/management in a majority of cases, it was simply a perfect storm of substantially lower costs, a greater selection of lower-cost generic equivalents and a relatively quiet drug pipeline. The savings seen were essentially the by-product of public policy and legislative changes that transformed generic drug prices at precisely the time more blockbuster generics were entering the market.

The Golden Era has come to a sudden end in 2015, and the years ahead will prove to be a significant challenge for both government and non-government payers. Generic drug utilization rates have begun to plateau under the ineffectiveness of current plan designs, generic prices won't materially decline in the years ahead, and the number of new and emerging blockbuster therapies is remarkable. While innovative and game-changing Hepatitis C medications have stolen most of the headlines in 2015, there is great innovation happening in other key disease areas like diabetes, hypercholesterolemia, cancer, multiple sclerosis, Alzheimer's disease, and the list goes on. That will continue to impact plan spending in the years ahead.

> *Generic drug utilization rates have begun to plateau under the ineffectiveness of current plan designs, generic prices won't materially decline in the years ahead, and the number of new and emerging blockbuster therapies is remarkable.*

The provincial and territorial governments need to find innovative ways to partner with employers, healthcare trusts, and other third-party payers to develop a long-term strategy for ensuring access to drug therapies for Canadians. It's remarkable that two parties that collectively spend in the range of $30 billion annually on medications have not sought each other out sooner to look for ways to combine their resources and information more effectively.

One Ontario-based plan sponsor has seen its drug plan expenditure increase by 12.7 per cent in 2015. The plan now spends $8.5 million annually to support drug plan spending for just under 13,000 plan members. The plan's increase in spending is being driven by expensive specialty drugs for serious conditions. Spending on the one per cent of all claims made in the past year that are categorized as *specialty drugs* cost the plan 36 per cent of its plan spending.

In other words, one per cent of all claims made represented over one-third of the total plan spending. This is what is driving the sustainability question. This is why we need to rethink government and non-government payer collaboration.

This employer saw a $1 million dollar increase in plan spending year-over-year on specialty drugs alone for conditions that included: hepatitis C, Crohn's disease, rheumatoid arthritis, multiple sclerosis, HIV, cancer and psoriasis. This plan is an Administrative Services Only (ASO) plan. This means that the insurance company processes the claims and administers the plan on behalf of the employer, but the company is self-insured—meaning they take on the vast majority of the financial risk (which is the case with most medium- and large-size employers). The result is that cost increases directly impact the plan sponsor and their members, with whom they share costs.

The latest challenge to ASO plans is that many will insure against high-cost claims (often called catastrophic claims) by buying protection that says above a certain level—such as $25,000 per member per year (or $50,000)—the insurance company will pick up the balance of the cost. This results in insurance carriers selling stop-loss insurance to protect plans from high-cost claims. What insurance carriers are finding is that they had no idea how much expo-

sure they faced from the growth of these specialty claims, so the cost of stop-loss is increasing dramatically. This means that plans are having to move their limits from levels such as $10,000 or $15,000 or $25,000 per member per year to levels of $50,000 or more, and/or are facing substantial premium increases to offset the risk of high-cost drug claims.

One employer plan we recently analyzed is facing a 117 per cent increase in stop-loss premiums. So, not only are plans taking on more risk, they are paying more to ensure the portion of their experience covered by catastrophic insurance. Let's look at our plan sponsor example above: if specialty spending increased by over $1 million in one year, what are the odds that the premium paid to insure high-cost claims will stay anywhere near the same in 2016?

What happens if either of the employers highlighted above significantly reduces or limits their spending on prescription drugs in response to rising plan costs? What happens to the Canadians impacted and to their health? Who picks up the slack? We need to find ways to protect all payers to ensure the long-term ability of plans in Canada to provide access to needed drug therapy.

The numbers above look bleak. It will be tough for any payer—government or non-government—to handle double-digit drug cost inflation annually (or anywhere near that level) moving forward. These two groups need to find some common ground. The major disconnect that needs to be addressed is around cost offsets. Public plans base drug coverage decisions around prices they can negotiate (that non-government plans cannot access to date) and economic modeling that looks at the offset to the healthcare system such as fewer surgeries, hospitalizations, physician visits, and so on, by paying for a given drug for a given member today.

> ***"It's remarkable that two parties that collectively spend in the range of $30 billion annually on medications have not sought each other out sooner to look for ways to combine their resources and information more effectively."***

The challenge for third-party payers like employers is that these cost offsets have no relevance to a non-government payer. An employer offers a drug benefit to its employees in order to keep them healthy, productive and on the job, while at the same time offering a form of tax efficient compensation. The only offsets that matter to an employer for an investment in a drug therapy are: does the investment keep an employee healthy and productive, and does the investment reduce disability and short-term absences.

Employers will not necessarily see the benefits of investing $75,000 in a hepatitis C cure that may offset the need for surgery or transplant or liver disease decades down the road when the member is no longer an employee. It doesn't matter to an employer that a large upfront investment will benefit the healthcare system years later. The same thing goes for wellness programs that aim to ensure the optimal care and treatment of members with diseases like diabetes. Most of the long-term complications of poorly controlled diabetes manifest themselves later in life when individuals become the concern of the healthcare system, not the employer.

Governments should be working with non-government payers to look at appropriately designed tax credits or related financial incentives that keep these plans involved in the provision and funding of drug plan benefits and optimizing the health of plan members. It is not enough that these benefits are afforded tax efficient status, it needs to go further. Non-government plans do not have access to the same cost-containment tools that governments have, such as pricing agreements and risk-sharing agreements with pharmaceutical manufacturers. Some of those resources need to be reallocated to other payers by providing appropriate incentives, such as tax credits or wellness innovation funds that keep non-government payers in the game. P

Mike Sullivan is a Co-Founder and President of Cubic Health, a healthcare analytics and drug plan management company based in Toronto. He began his career as a pharmacist in Saskatoon. Cubic is focused on ensuring the sustainability of investments made in health benefits. msullivan@cubic.ca