

WHAT'S GOING ON IN SMALL AND MID-SIZED DRUG PLANS

A BROKER/CLIENT PERSPECTIVE

Dave Patriarche
November 23rd, 2021
ISCEBS - Alberta



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BACKGROUND

- Group insurance broker (Mainstay Insurance Brokerage Inc.) for 25 years specializing in providing group benefits to small and mid-sized businesses (mainly Ontario focused)
- Clients represent \$3-3.5 million in annual premiums
 - Average annual benefit plan increase of 3.1% over 15 years
- Founded Canadian Group Insurance Brokers (CGIB) in 2008 to share knowledge and educate benefit brokers
 - seminars, webinars, slack exchanges, sample documents, unique products & HR resources to assist advisors.

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AGENDA

- Discuss how small and mid-sized group benefit drug plans have changed from the past, to the present and what I think the future may look like
- Discuss the trends and the challenges they create
- Provide examples of clients and their situations
- Discuss what the market needs, what we are getting, and the one change that could make things more sustainable.

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BENEFITS PAST



- Historically, drug plans have been administered on an insured basis, with insurers pooling their client's premiums and claims
- In an effort to reduce risk, insurers introduced stop loss coverage to protect their pools and move costs to employers
- There were no options for small firms to implement drug plan maximums or exclusionary formularies (except lifestyle drugs)
- There were no “defined contribution” plan options (Health Spending Accounts) as an alternative for smaller employers
- Overall small firms had fairly “packaged” off the shelf plans.

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BENEFITS PRESENT



- Insurers are administering plans on a more “experience based” model where employers with high claims pay more
- Insurers have raised stop-loss attachment points from zero (insured/pooled) to \$5,000 to \$7,500 to \$10,000 with some now at \$12,500 annually per insured (previously by certificate)
- Brokers can now choose from drug caps of \$1,000 to \$50,000 (annual or lifetime) and are being offered formularies that exclude specific (speciality) drugs or drug classes
- We now have defined contribution plans (Health Spending Accounts) as an alternative to control costs (& hybrid options).

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2-24 LIFE OPTIONS

Drugs		
Drug Plan Type	• Reimbursement Drugs	• Pay-direct drugs (drug card) or Deferred Payment
Drug Plan Basis	• Brand drugs or provincial formulary • option to include vaccines	• Brand or generic drugs or provincial formulary • option to include vaccines few choices
Deductible	• \$0, \$25/\$25, \$25/\$50, \$50/\$50, \$50/\$100, \$100/\$100, \$150/\$300, \$200/\$300 (single/family) – applies to prescription drugs and professional services NO high deductible options	• Per prescription deductible: Flat - \$0, \$1-\$10 • Percentage – 10%, 20%, 25%, 30%, 32%, 40%, 50% • Dispensing fee – total dispensing fee; \$5 or \$7 fee cap • Combination - % combined with dispensing fee
Reimbursement	• 50%, 60%, 68%, 70%, 75%, 80%, 90%, 100%	• See above
Drug Maximum	• Unlimited, \$1,000, \$5,000, \$10,000 per calendar year	Note few options

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BENEFITS FUTURE



- Employers who experience high drug claims will face higher drug plan costs, forcing employers to make radical design changes
- Drug costs are being downloaded to employees who must seek relief from spousal plans (if available), from Provincial Plans (ON - Trillium) or Patient Assistance/Support Programs if available
- Insurers will continue to avoid the risk associated with high cost claims (e.g. increased credibility, higher stop-loss attachment points, declining to list drugs) and become more transactionally focused, at the expense of both employers and their employees
- Extremely restrictive formularies, low annual drug maximums, and a shift to HSA & hybrid plans will become the norm.

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WHY IS ALL THIS AN ISSUE?

- Experience shows that once employers implement a drug plan maximum they will never remove it - Why reassume the risk?
 - Insurers will likely not allow the removal of drug caps once instituted - They ask about high cost drugs when accepting cases
- Are you aware of any employees or dependents with in Canada Extended Health claims exceeding \$10,000 per year?
Yes ☐ No ☐ If yes, please provide details below.
- Some providers are even using benefit plan communication to provide indirect political pressure when drug caps are used
 - ...if your drug costs are higher than the cap on your plan, make application to the Trillium Drug Plan for assistance, should your drug not be covered, please contact your M.P.P and the Ministry of Health and Long Term Care.

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SO WHAT?

- Each year employers are faced with benefit plan challenges and increasing costs.
- Fraudulent claims increase paramed and dental rates
 - All Canadians pay for healthcare fraud. In North America alone, it is estimated that 2 to 10% of all healthcare dollars are lost to fraud. This means higher costs for everyone. CLHIA member companies provide important supplementary health coverage to 28 million Canadians and pay over \$32.5 billion annually for healthcare services delivered to Canadians.
- **SO... \$650 million to \$3.25 Billion?** <https://www.clhia.ca/antifraud>

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SO WHAT?

- Aging workforce drives life, LTD and health costs up
- Changes from single to family coverage
- Plan members are using more drugs & medical services
- Demand for more robust, inclusive plans
- Employees want more flexibility to cover health, but also wellness programs (HSW & WSA)

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WHY ME?

- Employers often ask themselves...
 - Why am I responsible for my employee's and their dependants health care costs?
 - Why are we seeing such high drug costs?
 - Why isn't the province picking up drug costs?
 - When costs rise, what benefits can I eliminate?
 - How will my employees be impacted? And who will be hurt?
 - Why are the insurers not being more supportive?.

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A TYPICAL STORY

- 10-12 person plan established plan with Sun Life in 1995
 - 1995 - Sun Advantage product was mostly pooled
 - 2000 - Shifts to higher level of claims experience credibility
 - 2005 - Stop-loss at \$5,000 (25% credible)
 - 2011 - Stop-loss increased to \$7,500 (55% credible)
 - 2014 - Stop-loss increased to \$10,000
 - 2015 - Increased to 60% credible claims experience

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HEALTH RATE HISTORY

- 2002 to 2007 rates flat
- 2007 Biologic claim (RA) (approx. \$20,000/year)
- 2008 • 31% rate increase
- 2009 • 10% rate increase
- 2010 • 2% rate decrease
- 2011 • Stop-loss to \$7,500 -
• 9% health rate increase
- 2011/12 - 2nd RA claim -
introduced a \$5k drug cap,
resulted in 13% rate decrease
- 2012 • assuming no cap +18%
- 2013 • assuming no cap +25%
- 2014 • Stop-loss to \$10,000
• 21% health rate increase
- 160% rate increase over 7
years (~23% per year).

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40 LIFE COMPANY



- Health/Drug rates dropped 10% over the past 5 years
- 2014 TWO Hep C claims added \$20,000 to their claims experience
 - 2015 renewal resulted in a 46% health/drug and pooling rate increase
- Claims will continue, cross the renewal reporting line, and end in late 2015
- At 2016 renewal, the insurer may not remove the \$20,000 claims

EXTENDED HEALTH CARE - NON-POOLED COMBINED

	Billed Premium	Paid Claims	Incurred Claims	Incurred Loss Ratio
Feb 1, 2012 to Jan 31, 2013	\$ 81,224.00	\$ 49,379.00	\$ 50,421.00	62.08%
Feb 1, 2013 to Jan 31, 2014	\$ 82,308.00	\$ 46,024.00	\$ 45,814.00	55.66%
Feb 1, 2014 to Jan 31, 2015	\$ 68,812.00	\$ 72,584.00	\$ 71,248.00	103.54%

EXTENDED HEALTH CARE - POOLED (\$10,000 STOP-LOSS)

	Billed Premium	Paid Claims	Incurred Claims	Incurred Loss Ratio
Feb 1, 2012 to Jan 31, 2013	\$ 9,744.00	\$ -	\$ 349.00	3.58%
Feb 1, 2013 to Jan 31, 2014	\$ 11,210.00	\$ -	\$ 195.00	1.74%
Feb 1, 2014 to Jan 31, 2015	\$ 11,206.00	\$ 104,874.00	\$ 104,723.00	934.53%

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WHAT IS GOING TO CHANGE?

- Aging population is more expensive to treat
- Continued higher usage of more services
- More insurers will be avoiding risk
- Employees want more benefits
 - New drugs will be higher in cost and more patient specific
- So are we sailing off into the sunset? or off the world's end?



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WHAT DO BROKERS RECOMMEND TO CLIENTS?

• **Protect Employees**

- Maintain the plan as-is, educate, pay the increasing price & hope (pray?) for pharmacare or provincial coordination

• **Protecting Yourself and Your Employees**

- Modify the plan (cap or exclude) and try to ensure there is coverage through provincial plan coordination (Trillium), or patient assistance programs to protect the employee(s)

• **Protect Yourself**

- Implement a drug cap, exclusionary formulary or move to a HSA, as a way to effectively control costs - It is the employees issue to deal with.

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WHAT DOES THE MARKET NEED?

- Stop-loss rates that are charged at a dollar and cent rate and that are not claims experience rated
 - Insurers use a percentage of claims to set the SL rate
 - Misrepresentative as it assumes higher total drug claims equal high risk of catastrophic claims (often not the case)
 - Some insurers set pooling rates as a percentage of health care - in these cases, high paramed claims can dramatically increase stop-loss premium cost (not reflective of risk)
- Stable stop-loss attachment points.



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WHAT ELSE DO WE NEED?

- Fully Pooled plans (no experience credibility, no stop-loss)
 - Protects employers by sharing risk and balancing rates
 - Average increase < 5% over the past 10-15 years
- Some insurers are starting to offer this and some have been doing so successfully for years (with pools in pools)
- Coordination with provincial drug plans
 - BC, MB, SK and Quebec all have programs in place to support not just employees, but the employers as well.

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Ontario **TRILLIUM DRUG PROGRAM**

- For 20 years insurers have failed to coordinate claims
- Trillium becomes first payor when the “out of pocket deductible” has been paid for by the employee
 - Most plans (58% according to Telus) have high enough co-insurance levels that would suggest employees may already be applying for and receiving provincial support for themselves
- Just as the employee portion is being paid by the province, the employer portion of the claim can also be paid
 - Insurers currently nullify this process by paying for the claim rather than declining it (and charging our clients experience).

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TRILLIUM (OR PHARMACARE)

- Insurer will not coordinate claims as there is no simple electronic solution to auto adjudicate with Trillium
 - Telus says “it is impossible for them to coordinate”
- Many insurers coordinate in other provinces by paying initial claims, having the employee apply to the provincial drug/support program, providing proof of coverage to the insurer and then having the province take over the claim
- This can happen, now, failing to do so will mean most plans may have low drug caps (\$5k or less) within 5-10 years.

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WHAT ELSE ARE WE GETTING?

- Industry pooling (EP3)
 - Protects the insurance industry overall (mainly the insurers) and shares the largest risk over a greater pool
 - Provides a better method to track and report claims
 - Almost impossible to remove caps, as well as change carriers when a case has high claims - only resolved with drug caps
- Newer drugs may not be covered
 - prior authorization programs, Drugwatch...



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WHAT'S NEXT ?

- For insured clients it is not as bright as before demutualization as the provider focus changes, but some forward thinking insurers and TPA's are beginning to respond with innovative (or old style) pooled plans (an example is the CGIB CHIP)
- Incidence of capped drug plans will continue to rise and push more of the risk (and cost) for treatment on to employees
- CLHIA is talking to the Ontario Min. of Health on coordination but it may be too little too late or they may decide to wait for a Pan-Canadian Pharmacare solutions
- Brokers/Employers need to speak up and share their concerns and experiences in order to be heard before it is too late.

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QUESTIONS?

Dave Patriarche



www.mainstayinsurance.ca
dave@mainstayinsurance.ca

