Christy Insurance Agencies Ltd.

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Rising Health Care Costs an Issue for US Employers too

INSIDE THIS ISSUE:

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The rising cost of healthcare isn't just a Canadian-employer concern. Our American counterparts are struggling with the same issues, new report finds.

Annual premiums for employer-sponsored family health coverage in the U.S. are up 4% from last year, according to the Kaiser Family Foundation/Health Research & Educational Trust (HRET) 2012 Employer Health Benefits Survey released on September 11.

Although this increase is moderate by historical standards, it has outpaced the growth in workers' wages and general inflation, which was 1.7% and 2.3% respectively.

Since 2002, premiums have increased 97%—three times as fast as wages (33 %) and inflation (28%).

Employer expectations for 2013:
Employers were asked in August whether they had information about possible changes in premiums (or total cost for self-funded plans) for their current health plan. The average increase reported by employers who had received information for their current plan is 7%. However, the initial numbers given to employers were just estimates and costs could go up or down from there next year.

As plan costs continue to increase, insurers should be wary that plan sponsors may start looking to different providers and options. This year 54% of employers who offer health benefits reported that they had shopped around for new coverage. Of that group 18% switched carriers and 27% changed the type of plans they offer.

- April Scott Clarke

Friends With Health Benefits

Drug benefits are the most significant cost component in most employer-sponsored health benefits plans. Drug costs range between 40% and 70% of an organization's total health benefits costs, and they are set to rise. Clearly, employers have to get a handle on drug plan management—for economic reasons and for the overall wellness of the organization.

Drug cost increases are being driven by several factors. First is the increased prevalence of health issues in the workplace population. A January 2010 Heart & Stroke Foundation study, *A Perfect Storm of Heart Disease Looming on Our Horizon,* found that the rates for many key health risks in Canada increased significantly between 1994 and 2005: for high blood pressure, it was 77%; for diabetes, 45%; and for obesity, 18%. Rate increases for the 35 to 49 age group—the prime of people's working careers—were even higher than for the population at large. In this group, the incidence for high blood pressure was up 127%; for diabetes, 64%; and for obesity, 20%.

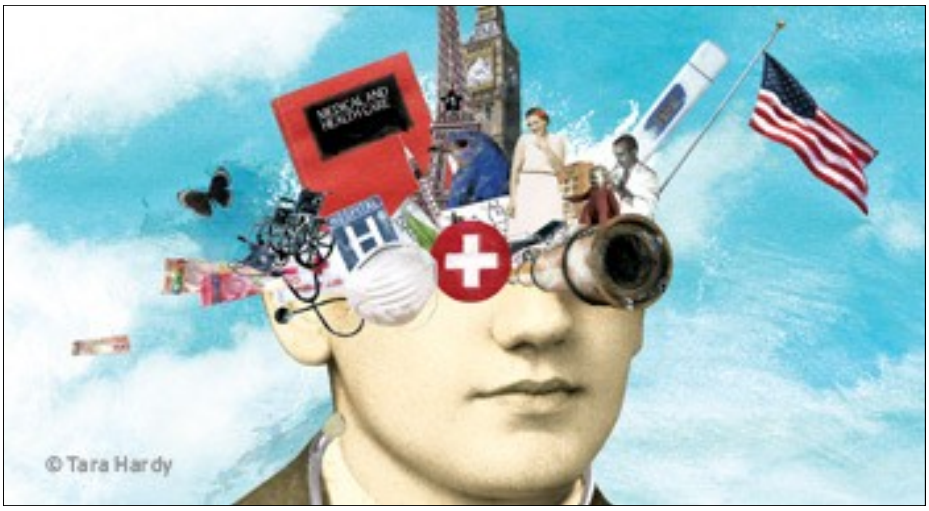
The second factor involves the types of drugs on the market. There is a significant increase in the number of new specialty medications, many of which are biologic. Biologic drugs are more expensive to manufacture and, as a result, more expensive to purchase; certain specialty biologics can cost more than $30,000 per year. For some individuals, these medications have a high value in managing certain chronic conditions and, therefore, are hard to simply exclude from benefits plan coverage.

In the next year, we expect to see an end to the brief reprieve in ever-increasing costs due to the expiry of several patented medications (e.g., Lipitor), and over the next 10 years we expect annual drug plan costs to increase at double-digit rates. This problem is not unique to Canadian employers, which would be well advised to manage their drug benefits plans effectively. What employers can and cannot do depends, to a degree, on the type of healthcare system in the countries where they operate. This is where Canadian employers can learn valuable lessons from other jurisdictions.

The United States

Consider the plight of an employer in the U.S., where drug costs are significantly more expensive than in Canada. When Health Canada approves a drug, typically that drug will be covered by the employer, unless a managed formulary is in place. Given the cost of medication and other health expenses, American employers almost always have a managed formulary.

In a managed approach, the insurance company or administrator of an organization's benefits program appoints a committee of pharmacists who are knowledgeable about drugs and drug costs.



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Friends with Health Benefits Cont...

This committee looks at the cost of a drug and performs an analysis based on QALY (quality-adjusted life year). QALY is a statistical measure of the burden of disease where both the *quality* and *quantity* of life are vital considerations. A good example is an employee who suffers from rheumatoid arthritis and the treatment costs $30,000 per year. Is it worthwhile for the employer to foot the bill?

If the drug in question can significantly reduce the number of days the employee is away from work, it may be worthwhile for the employer to pay for it. If the employee does not have access to that drug, she probably can't work at all, so the organization is minus one valuable worker.

In the U.S., there are also challenges involving coverage for drugs and, of course, the lack of universal healthcare. To this end, *The Patient Protection and Affordable Care Act*—also known as "Obamacare"—has been proposed as a major healthcare reform. This reform will require uninsured Americans to maintain at least minimal private health insurance coverage.

While the U.S. does have programs for military service families, the disabled and children, and also Medicare for the elderly and Medicaid for those in financial need, there are still scores of Americans with no health coverage, or who are underinsured. It's not surprising then that the U.S. ranked only No. 37 on the World Health Organization's (WHO) *World Health Report 2000.* Canada was ranked No. 30. The U.K., with its universal tax-funded system, came in at No. 18. In first place was France; in second, Italy.

In the WHO ranking, most European countries were ahead of Canada, as were the likes of Japan, Australia, Colombia and Saudi Arabia. While this WHO report has been criticized in some circles for the criteria—effectiveness, fairness and responsiveness—used in its ranking, it certainly inspires discussion about healthcare in Canada and around the globe.

Still, from an employer's point of view, the U.S. has paid more attention to cost management than Canada. With the threat of increased cost, it's important for Canadian employers to manage their drug benefits plans from a total health perspective. This has been the trend in the U.S. Total health approaches typically involve having a health coach and/or disease management program to help employees manage the lifestyle factors that are important in getting the most of any medication or, ideally, to reduce, remove or prevent the need for medication.

The United Kingdom

Canada can learn a few things from our friends in the U.K., too. In the U.K.'s National Health Service (NHS), virtually everyone is covered in a health plan, but, according to the WHO, 11% of the population also has private health insurance. Funded by the taxpayer and run by the government, the NHS provides access to most citizens, and almost all treatment is free. The system favours a total health approach as well. Consider the case of a working mother who has just had her first child. In the U.K., she is covered for visits from a nurse or other healthcare professional every day for six weeks. Canadian mothers don't have this, unless—at least, in some prov-

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"In the WHO ranking, most European countries were ahead of Canada, as were the likes of Japan, Australia, Colombia and Saudi Arabia. …"

Friends with health Benefits Cont...

provinces—the mother had twins or triplets.

France

France's social insurance system extends to all legal residents. Health insurance is funded by compulsory social health insurance contributions from both employers and employees, and you can't opt out. In France, 92% of the population also has extra private insurance to cover areas not eligible for reimbursement by the public health insurance system, according to the 2008 report *Le secteur privé dans un systemè de santé public: France et Pays Nordique.*

The private-public French system is a model of efficacy as it pertains to wait times and average cost per capita. In fact, according to a July 11, 2008, National Public Radio broadcast called "Health Care Lessons Learned From France," the average per-capita cost of healthcare in that country was estimated at $3,300 in 2005, compared with $6,400 in the U.S., which was the most costly in the world. The French system is so efficient that in a 2008 study comparing 19 industrialized countries, France was shown to have the lowest number of deaths deemed preventable with timely access to healthcare. This is not surprising when most of the population can have access to a medical appointment in less than a day.

The philosophy in France is a total health approach with 100% coverage. This level of coverage supports both preventative and comprehensive care.

No doubt, there are valuable lessons to learn from a total health approach about cost and health management for both public sector and private sector employers, but the key is having a proactive system of total health management. The big takeaway from around the globe is that it's best to take the holistic approach. This involves prevention and case management, and helping people get the tools they need so they can support their own health without waiting until they are ill.

- Paula Allen

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CANADIANS WAIT LONGER FOR NEW CANCER DRUGS

The process for reviewing and approving new cancer drugs in Canada takes almost twice as long as that in the United States and is longer than the approval times in Europe, concludes a new report from the public policy think tank Fraser Institute.

The result has Canadians waiting significantly longer for new, potentially life-saving cancer drugs.

"Unfortunately, the review and approval process for new cancer-fighting medications is unnecessarily longer in Canada than other industrialized countries," says Dr. Nigel Rawson, Fraser Institute senior fellow and author of Access to New Oncology Drugs in Canada Compared with the United States and Europe.

"This raises serious questions as to whether the drug evaluation system in this country is beneficial or detrimental to Canadians with cancer."

The report compares the time it took to approve each of the 33 new cancer medications receiving market approval in Canada, the United States, and the European Community between 2003 and 2011.

In addition, the report notes whether these new oncology drugs were approved for public reimbursement under provincial government insurance programs.

Of the 33 oncology drugs slated for market approval between 2003 and 2011, 30 were approved in the United States, 26 in the European Community, and just 24 in Canada.

With the exception of one medication, Health Canada took longer to approve every new cancer drug than the U.S. FDA, where the median review time was 182 days compared to 356 days in Canada.

Furthermore, 25 of the 30 drugs approved by the American FDA between 2003 and 2011 received an expedited review, compared with only eight of the 24 drugs approved by Health Canada that received a priority review. "Even then, expedited products in the United States had a median review time of six months, whereas Canadian priority review took close to a year," Rawson notes.

"Making matters worse is that once a drug has finally been approved by Health Canada, patients more often than not discover that the medication is not covered under their public drug plan."

By the end of March 2012, only three of the 24 drugs approved in Canada since 2003 were covered to some degree by government insurance in all 10 provinces, while seven others had government-subsidized access in some provinces.

Almost 60% were not covered under public drug plans in any province. To ensure Canadians have timely access to new oncology drugs already approved in the United States and Europe, the report suggests Health Canada be required to monitor approvals in those countries. If a drug is not approved in Canada within a certain period (e.g., 90 days) of the American or European approval dates then Health Canada should be required to report to Parliament on the reasons for the delay.

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CanadianHealthcareNetwork.ca

Christy Insurance Agencies Ltd.

#19 –636 Clyde Avenue
West Vancouver, B.C.
V7T 1E1

Phone: 604-913-2474
Fax: 604-922-9534
Email: info@christyinsurance.com

We're on the Web!
www.christyinsurance.com

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