When Tea and Sympathy are not Enough:
The Catastrophic Gap in Prescription Drug Coverage in Atlantic Canada

16 May 2006
Halifax

On 16 May 2006, the Atlantic Institute for Market Studies (AIMS) convened a conference on the catastrophic gap in prescription drug coverage in Atlantic Canada. Titled "When Tea and Sympathy are not enough", the conference attracted people from health care associations, pharmaceutical companies, the insurance industry, patients' rights groups and government. This is a summary of the proceedings, with links to individual presentations. The visual presentations and full text of all the remarks are available on the AIMS website at www.aims.ca under Event Proceedings.

Keynote: The Challenges of Catastrophic Drug Coverage

Ken Fraser, who advised the Kirby Senate Committee on health care reform, set the stage for the day's discussions by laying out the dimensions of the challenge of catastrophic drug coverage nationally and regionally. Ken Fraser is president of Fraser Group, a market research firm specializing in insurance markets.

The good news when it comes to drug costs is that all but two per cent of Canadians have coverage. The bad news is that those without any coverage are all here in Atlantic Canada. That was the clear and dire message delivered to the conference by Ken Fraser.

He explained the findings are part of a study conducted by the Fraser Group and Tristat Resources on drug coverage in Canada, an issue they have been studying for the past decade. The study revealed that, while not coherent or publicly mandated, Canada does have a system that works well for the majority of Canadians, but less so for Atlantic Canadians.

"Here in Atlantic Canada, we are talking roughly 25 per cent of the population, minor variations among the four provinces, but basically one in four individuals in Atlantic Canada do not have coverage," he said.

Fraser said many public drug plans across Canada use income as the criteria for coverage, and most plans have a threshold of approximately three to four per cent of income. With the exception of Atlantic Canada and Alberta, all provinces provide full protection for their population, meaning that out-of-pocket costs are capped. In Atlantic Canada, less than half of the population enjoys full protection, while roughly a quarter have only partial protection.

"There is a significant difference in how much of the drug bill is picked up by public plans in Atlantic Canada, versus the rest of Canada," he said.

"There's a fairly major gap of about 20 percent, about half of that is made up by increased expenditures by private plans and the other 10 percent is picked up by increased out-of-pocket expenditure here in Atlantic Canada."

Fraser suggested there are solutions within reach and indicated that if the goal was that no one pays more than three percent out of pocket for prescription drugs the gap in Atlantic Canada could be closed with additional public or private sector spending of about $150-million (in 2004 dollars).

He concluded, "It equates to $65 per capita for the people in Atlantic Canada, or about $245 for each uninsured individual in Atlantic Canada."

The full text of these remarks is available at
www.aims.ca/library/KenFraser.pdf
To view the presentation, **click here**.

9:30 Panel — What Canada has Learned So Far about Catastrophic Drug Coverage

Karen Philp, National Director, Public Policy and Government Relations with the Canadian Diabetes Association.

"The issue is not whether Canadians can afford a national program, but that we can't afford not to make the investment." – Karen Philp

Philp told the conference she is convinced that, through a national program, Canadians with chronic diseases such as diabetes, cancer and arthritis can lead healthier, more productive lives, and that would considerably relieve the current burden on our already beleaguered health care system.

"One in 10 hospital admissions list diabetes as an underlying cause for that admission," explained Philp. "People who have diabetes enter hospital more frequently and they stay there longer. They are clogging up emergency wards; they are clogging up the wait list for heart surgeries. They are one of the challenges for health care renewal."

Continued Philp: "So if we are going to do anything about health care renewal and ensuring wait times are being reduced, we have to address it at the source, which is ensuring that people with diabetes don't develop those complications."
To prove her point, Philp cited changes that Pitney-Bowes made to their drug coverage plan in the U.S., expanding it to include all diabetes medications and strips. While diabetes medication costs did increase by 7 per cent, the company saw a 25 per cent drop in overall medication coverage and costs.

There are 17 Health Canada-approved diabetes medications, but there are wide variations between provinces of which ones are covered by provincial plans.

"When we ask people with diabetes what's the biggest problem they face they say it is the affordability and access to diabetes medications, devices and supplies," said Philps. They need some help in order to manage the disease and reduce their risk of the complications."

More than 50 experts participated in AIMS' *When Tea and Sympathy are not enough* conference.

Research conducted by the association shows the problems are particularly pronounced in Atlantic Canada. For example, people with Type 1 diabetes earning $15,000 pre-tax are facing costs that average well over 20 per cent of their earnings annually, while in BC, only 2.7 per cent of earnings are required for managing diabetes.

The association is advocating a plan based on prescribed drugs where all Canadians are eligible and the threshold for out-of-pocket costs is set at 3% of adjusted family income.
"We are growing increasingly concerned that those with money can afford to purchase the medications that the doctor prescribes, and therefore have better health outcomes. And those who can't afford it and rely on the public plans, primarily seniors, don't have access to the best medications and,

therefore, don't have the best health outcomes," said Philp.

She estimated the cost of a national programme would be minimal, roughly $500 million, and could be covered by the federal government surplus. She suggested that, based on Atlantic Canada's population and tax base, the federal government should provide support so the region can fully participate in such a plan.

Click here for full text of these remarks.
To view the presentation, **click here**.

Brian Ferguson, Associate Professor - Department of Economics, University of Guelph & AIMS Fellow in Health Care Economics

"If we want a financially sustainable programme, it must be structured like an insurance pool and not a government program." – Brian Ferguson

"One of the advantages of this approach is that it gets away from the notion that our health coverage is something that the government does for us," explained Ferguson. "By running it strictly as government-based entitlements, we are creating a distinct impression that, somehow or other, there is an endless pool of funds out there that can be drawn on to do this kind of thing."

He said there is another advantage in that a guaranteed renewable insurance pool would take control of such a programme out of the hands of politicians, removing the temptation for them to add to or expand programs without first determining where funding will come from.

What Ferguson proposed is a system known as guaranteed renewability insurance, or lifetime insurance. In that system, you start paying at a young age, and your payments are calculated to cover the cost of any future claims you might make on the system.

"You can say that when you are paying your annual insurance premiums, you are actually paying two premiums," explained Ferguson, who noted that the system has been successfully adopted in countries such as Germany.

"You are paying one premium for this year's acute coverage; you are paying another premium against the probability that, at some point in the future, you will develop one of these chronic illnesses. So what you are looking at basically is, in addition to buying this year's acute coverage, you are buying a futures contract, which will pay off if you develop, at some point in your later life, a chronic illness."

Ferguson stressed that government would have a role to play in such a system, but suggested it should be restricted to providing a reinsurance pool, and to subsidizing premiums for the lowest income groups in Canada to ensure everyone is covered. He also advocated for transparency in funding so that future tax burdens are made clear.

"You've got to have very clear intergenerational accounting on any kind of a structure like that if you want to avoid winding up with the kind of boom-bust funding cycle that all kinds of our social programs are subject to now."

The full transcript is available at **this link**.

David Griller, is a partner at SECOR Consulting, and has a Ph.D. in Chemistry from the University College London.

"The best strategy for a national plan is one where patients' needs come first." – David Griller

"Not necessarily because it is nice from a moral and ethical point of view, but it actually makes sense from an economic point of view."

Griller told participants that medical literature has consistently demonstrated that the use of drugs in the health care system leads to overall savings because it reduces downstream costs, such as hospitalization. He suggested several ways to optimize the use of drugs by the system, starting with updating Canada's physicians on best practices.

"In diabetes, for example, there's a recent study out of the University of Western Ontario, which shows that physicians under-medicate diabetics 38 per cent of the time. There's also a very strong age bias in treatment. The elderly tend to be under-treated. So there's considerable sub-optimal use of drugs," he said. He praised companies like Pitney-Bowes for having the foresight to ease employee access to drugs by reducing insurance co-

payments noting that this led to lower overall healthcare costs.

"Just from a purely economic point of view, you do better by paying the upfront cost, which is really the spirit of catastrophic drug coverage for chronic disease," said Griller.

Given that every patient reacts differently to medicines, Griller also stressed that patients must have access to a broad range of drug options. "(T)heir doctors know this. If (patients) respond poorly to drug A, they get put on drug F. So if you reduce diversity, you actually degrade outcomes. What you need to do is match patients and pills. There are new diagnostic tests coming forward which allow you to do this quite explicitly."

Griller offered up Quebec as a model to follow. The province has been very supportive of the pharmaceutical industry, and has used its reimbursement policy to encourage investment. In fact, Griller noted that the rate of industry investment in research and development in the province is twice that of Ontario, which is tightening drug budgets and limiting drug options available to doctors and patients.

Griller pointed out that Canada as a whole does not follow Quebec's example. The nation has a strong science and innovation agenda but a very poor environment for the commercialization of research. "We do have a very strong life science innovation agenda, but less than 40 per cent of the drugs approved by Health Canada as being safe, efficacious and of good quality are actually covered by provincial insurance. So 60 per cent of the new drugs are toast in the system as we have it now."

Click here to read the complete transcript.
To view the slide presentation, **click here**.

Bryan Ferguson is a Partner and Vice President of Applied Management Consultants, a Fredericton-based health care consulting firm.

"Atlantic Canadians have poorer coverage and our governments are spending less on catastrophic coverage than the rest of Canada." – Bryan Ferguson

"Costs of benefits for employees and retirees are higher," said Ferguson. "As Ken Fraser pointed out, we have a higher, by necessity, rate of private coverage in Atlantic Canada than they do in the rest of Canada. (And) the arbitrary nature of government policy making on delisting and downloading has an impact on employers who have to accommodate this within their current business models."
Ferguson, who is also co-author of Canadians' Access to Insurance for Prescription Medicine, offered five possible solutions to improve the situation in Atlantic Canada, starting with putting high deductibles in private and public plans as has been done in British Columbia.

"The analogy I like to use is that of buying insurance for a car," explained Ferguson. "That, 'Any time you have a flat, we'll fix it. Any time your windshield breaks, we'll put in a new one. But if someone steals your car, we are not there for you. And to a certain extent, that's the way some of our programs are run," explained Ferguson.

Members of the first panel at AIMS' *When Tea and Sympathy are not enough* conference

"So why not look at some redesign of (these plans) to put in higher deductibles and pay for some of these higher cost needs at the back end?"

Ferguson further suggested addressing the lack of fairness in the current coverage system. He noted that people with retiree plans are footing the bill for their own benefits and for other seniors through taxation. And individuals who buy non-group coverage pay their premiums with after-tax dollars while employees have their premiums paid by their employers with no tax consequences.

"Could we require everyone without coverage to take catastrophic insurance, spreading the risk across the entire population, but give them the same tax breaks on premiums as group plans?"

On the health care side, Ferguson called for reallocation of spending, suggesting that we look at drug expenditures in the same light as we would when making investments in new equipment or technology.

"We've tended to, I think, in the Atlantic region, look at putting priorities on MRI machines and

other technology investments while perhaps neglecting to a certain extent the amount that we should be looking at this as a technological investment in the same context."

Ferguson also suggested basing coverage on need – those who face ongoing financial hardships due to illnesses and health conditions – not demographics. He told attendees that coverage could be funded in part by a 'drug dividend,' which may be generated in the wake of Ontario's new Bill 102 legislation. While the emphasis is on cost containment and limiting access to drugs, Ferguson said it would result in quicker adoption and reduced prices for generic drugs.

"In Ontario we should actually see what I'm calling a drug dividend that some of the other provinces will benefit from as well," said Ferguson, who recommended Atlantic Canada reinvest it in catastrophic coverage.

A copy of the complete transcript is available **here.** The PowerPoint presentation is available **here.**

10:45 Panel - Covering Atlantic Canada: Regional Dimension of Catastrophic Drug Coverage

Rob Weld is a partner with the employee benefit consulting firm Sinclair Billard + Weld.

"The cost of catastrophic drugs is pricing health plans beyond the reach of many Atlantic Canadian companies, and limiting their options when it comes to providing the best possible plan for their employees." – Rob Weld

Weld predicted that by 2014, the family rate that employers and employees will have to pay for health and dental benefits could be well over $500 a month, compared to about $200 in 2004.

"Many of our clients spend in excess of seven per cent of payroll on group insurance," said Weld. "And we have some fairly large ones that are now in excess of 10 per cent. And 10 per cent of payroll as a common number for group insurance benefits covering health and dental? I don't think that's far away at all."

Weld's experience has been that few people understand how private plans work, particularly how rates are set. He explained that two factors drive rates – insurer expenses and – more significantly – claims. For example, a company with 50 employees with a premium of $80,000 and claims of $70,000 for 2006 could expect to see a 20 per cent increase in rates for 2007. Data from Atlantic Blue Cross Care suggests that over half of those claims – approximately 55 per cent – are for prescription drugs.

While demographics, new medications and public plan downloading all have an impact on drug costs in any health plan, the catastrophic category has the biggest impact. Weld recalled how one such medication drove the costs of a health plan for a group of ten to the point where it had to be cancelled.

Insurers, Weld said, have taken several steps in recent years to address the situation, including Individual Large Amount Pooling, where claims that exceed an established cap (e.g., $10,000) are removed from the rating calculation. "That typically adds three to eight per cent to the expense part of (rate calculations)," observed Weld. "It helps, but this is still a problem." Even with the cap, the first $10,000 of a $30,000 catastrophic drug goes on the books, and having such a large claim makes it difficult to switch insurers for a better rate or plan.

"So that means the client, the customer, the group, is tied to the insurer they're with, and is pretty much at the mercy of the insurer they're with," explained Weld, adding that issues of long-term disability and the lack of early retirement programs are also driving up group rates in Atlantic Canada.

Weld voiced support for the creation of a federal programme, suggesting it could provide medications for any individual where the annual cost is over $5,000. He also recommended that the region consider look at programs like Ontario's government-sponsored, low-premium Trillium initiative and how they might work here. And he suggested insurers could look at offering better arrangements for employees on early retirement or disability, while addressing plan portability issues for small groups.

A transcript of this presentation can be found **here**.
The PowerPoint presentation is available **here.**

John Abbot, Deputy Minister of Health, Government of Newfoundland and Labrador

"I certainly ask that AIMS make sure that the presentations and findings of this conference be distributed to all ministers of health and deputies across the country." – John Abbott

Abbot explained that prescription drug coverage proved to be too important an issue to the health of Newfoundlanders for the government to wait for a Canada-wide solution. The government has taken steps to address the issue by expanding its drug plan.

Still in the design stages, the plan is expected to provide prescription drug coverage to families with an annual income of up to $30,000. That will add approximately 100,000 more people than currently covered under the provincial government plan. Abbott said it will be based on escalating co-pay. Statistics suggest the average cost per client will be in the $500-600 range, increasing with age but decreasing with income and employment. Abbott credited the amended Atlantic Accord for paving the way for expanded drug coverage in the province. He described the previous plan as 'the best that a minimalist plan could provide,' covering approximately 100,000 people, mainly seniors and those on income support.

Although Newfoundland and Labrador's drug plan has since been expanded to include more of the medications approved in other provinces, Abbott said government has more work to do on this front. And he stressed it would be good public policy in today's economy to ensure all Canadians have access to necessary prescription drug coverage. However, Abbott cautioned attendees that only the right drugs should be prescribed to patients for the right clinical reasons.

"We can improve health outcomes with fewer drugs and at less cost, but for the consumer, he or she should not be denied coverage because of income or employment status," explained Abbott.

More than demonstrating his government's commitment to addressing a pressing priority, Abbott suggested that Newfoundland and Labrador's plan could serve as a bridge for a national plan.

"We feel that our government has taken up the gauntlet and other governments in Atlantic Canada are facing similar challenges. The federal government has acknowledged a need and it is time that a comprehensive approach be adopted."

Yet the jury is out on whether the federal government will provide support for the province's program, said Abbott: "The federal minister would have preferred not to be engaged. We do not know where the prime minister is; we do not know where the federal government is collectively. So it is something that we collectively have to be conscious of moving forward."

A complete transcript of these remarks is available **here.**

Linda Wilhelm is a patient advocate, member of the Canadian Arthritis Patient Alliance, and chair of the Arthritis Society in New Brunswick.

"The ten year cost for my treatment, and we did this as a case study on myself when I was trying to get access to the drug, was $576,826. The ten-year cost of Enbrel was approximately $150,000." – Linda Wilhelm

Linda Wilhelm, a New Brunswick-based patient advocate who lives with rheumatoid arthritis, said she lost a year of her life to a wheelchair because she could not get access to a catastrophic drug. And she placed the blame on government for her situation.

"Patients in Atlantic Canada are being harmed by the government's not addressing the catastrophic issues, and I think we all know that," Wilhem told attendees. "We know

there is no programme in place to help those facing high drug costs, and I hear from these people on a weekly basis."

In New Brunswick, patients who are employed full-time but have no insurance must apply for coverage through Family and Community Services. Yet Wilhelm said few are willing to do so because of the stigma attached to making such an application. The irony is that these patients are more likely to become disabled, rely more heavily on the health care system and wind up on income assistance eventually anyway.

Wilhelm described a process that is confusing and intimidating to people forced to apply to Family and Community Services. She said applicants face considerable scrutiny, not to mention a complicated and confusing process.

"Many people don't know they're eligible. People don't know there's a programme to help them. When I tell people to apply through Family Community Services first, they don't know where to begin. They don't know how to negotiate through the bureaucratic system."

Linda Wilhelm speaks during the second panel discussion of the day of her personal experience as a arthritis patient in need of costly drugs to manage her disease.

Wilhelm said she learned how to navigate the system through her own efforts to gain access to Enbrel, a medication for arthritis patients. She credited the drug for getting her out of a wheelchair and keeping her arthritis in check for the past six years where other government-approved medications failed. And she questioned where the cost savings are for government to deny patients access to the medications they need.

"In Atlantic Canada, right now, many people with inflammatory arthritis are not receiving appropriate medications. Physicians are reluctant to prescribe them because they know the battle that they're going to have to go through. The costs to the health care system and to society are enormous."

Wilhelm called on government to create a more patient-centred health care system, and to ensure that patients are included in developing any drug coverage plan.

"Governments in Atlantic Canada have excluded patients from the table in discussions on health policy development and implementation. This is happening in other areas, but not here. Without input from all stakeholders, health promotion and disease prevention strategies will not be successful," she predicted.

To read the complete transcript, **click here.**
To view the PowerPoint presentation, **click here.**

Insuring the Uninsured: Lessons from the field

Grace-Marie Turner is the founder and President of the Galen Institute, a think tank in Washington that specializes in the policy problems around insuring the medically uninsured. She played a major role in the design of last year's Medicare Bill in Washington. In July of 2005, she was appointed to the Medicaid Commission, charged by Congress with making recommendations to modernize and improve this program that serves the poor, the disabled, and the elderly. Turner is also a member of the National Advisory Council of Healthcare Research and Quality.

Echoing comments made by other presenters, Grace-Marie Turner closed the conference with her prescription for providing coverage to the uninsured in Atlantic Canada. She advocated smarter spending of our health care dollars and giving patients more options and control over the care they receive.

Turner also encouraged more collaboration between the U.S. and Canada, and around the world, on the issue in dealing both with the rising costs of health care and how best to provide insurance to the uninsured. This is a particularly important issue in the U.S. where an estimated 46 million have no insurance, and Turner expressed doubt that little progress could be made so long as U.S. hospitals and private clinics are mandated to provide care to the uninsured.

"It's a very bad system. And, in fact, one of the explanations for at least some part of the uninsured is that they feel they don't need insurance because they know they are going to get

medical care," explained Turner. "Pharmaceutical companies have programmes in which they give away their drugs free to the uninsured, in many cases. So there is a sense that we have set up an incentive structure that discourages people from getting health insurance."

Cost is another issue, making it difficult for employers to balance a competitive salary with the expense of a coverage plan.

"The Kaiser Foundation did a study in 2004 and found that if you were an individual with job-based coverage, that policy was worth about $4,000 a year. If you had a family policy, almost $11,000 a year. So that is an add-on to someone's salary and a lot of small businesses just can't afford those costs."

She added that the costs associated with Medicare,

the multi-billion dollar federal-state program that ensures care for seniors and low income Americans without insurance, are threatening to bankrupt state governments. There are other problems. While she characterized the benefit program as generous, she added that many physicians are refusing to see Medicare patients because they lose money treating them. And the program pays for acute care, but not to keep patients well.

Turner says there are a number of attempts underway to reform the system in the U.S. that could be adapted here in Canada. For example,

Florida has established a program called Cash and Counseling, where people in the Medicare program have accounts and can control how money in their account is spent.

> *"All told the federal state governments and private sector will spend $2-trillion on health care services this year in the United States, a figure equaling one-sixth of our economy." – Grace Marie Turner.*

"This program is saving money because people are using all this long list of services they didn't really need. They're using what they need. One of the things that was required was really trusting people to use that benefit wisely and beginning that experiment."

Turner discussed how the $400-billion Medicare D program would change the way that benefits are delivered through a public programme. It uses private competing companies to provide benefits to seniors, which gives them added choice. There is a $250 deductible, everything is covered up to $2250, and where costs are over $5,000, patients only pay five per cent. Turner said companies have been competing for business, negotiating the best price for drugs so they can offer the lowest premium and attract the most members.

"So you are starting to see, just in this one pocket of one program, injecting choice and competition and having that begin to produce the kinds of results that people ultimately want."

To read the complete transcript, **click here.**

The Atlantic Institute for Market Studies (AIMS) is an independent, non-partisan, social and economic policy think tank based in Halifax. The Institute was founded by a group of Atlantic Canadians to broaden the debate about the realistic options available to build our economy.

AIMS was incorporated as a non-profit corporation under Part II of the Canada Corporations Act and was granted charitable registration by Revenue Canada as of October 3, 1994; it also received US charitable recognition under 501(c)(3) effective the same date.

Atlantic Institute for AIMS Market Studies
2000 Barrington St., Suite 1006
Halifax NS B3J 3K1
Telephone: (902) 429-1143
Facsimile: (902) 425-1393
E-mail: aims@aims.ca
Web site at: www.aims.ca