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

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

This is the transcript of remarks made by Rob Weld during the second panel of the AIMS "When Tea and Sympathy are not Enough" conference.

Rob Weld is a partner with the employee benefit consulting firm of Sinclair, Billard and Weld, which is a firm of recognized experts in the design, administration, financial underwriting, marketing and overall management of comprehensive group insurance programs, money purchase pension plans, and group RRSP's. They have offices in Halifax and St. John's, and provide consulting advice throughout the region. Prior to Sinclair, Billard and Weld, Rob worked as regional account executive, group marketing with the Mutual Group, and prior to that, he was an assistant vice-president with the employee benefit and actuarial consulting firm of Morneau, Coopers and Lybrand

Rob Weld:

Sinclair, Billard and Weld is an employee benefit consulting firm, or brokerage firm, based here in Atlantic Canada. We do business here in Atlantic Canada, and as such, we touch base with a lot of Atlantic Canadian employers. Our market focus is on private sector companies ranging from 20 to 500 employees. So as such, my perspective today is going to be a little bit different than some of the others that you've heard. But I think it is important for participants, in this whole issue to understand where business and/or small business fits. And when I say that, I'm talking about costs of benefit programs in general, but also as is the topic today, specifically, catastrophic drugs.

So my introduction is, or my agenda today is just a brief introduction, talk about how costs are going up and some reasons why and then we are going to drill down into where catastrophic drugs fit in all that. Talk about some solutions, briefly some solutions, and then summarize from there. The focus of my presentation, as I mentioned, is on the perspective of the small business in Atlantic Canada. This is a big topic, this catastrophic drug issue, and we only have or I only have a little bit of time, before Barbara comes and gets me. So I am going to focus on, as I said, on small and medium size business, in Atlantic Canada.

Just to give you a little perspective on where small business fits in our economy,

these are some stats from a 1998 Stats Can employee dynamic survey which outlines the number of businesses in Atlantic Canada. What this shows is the number of businesses varied by size of employer ranging from under five employees to 500 plus. What you can infer from this sheet is how important the sector of businesses with fewer than 100 employees is to our economy. You can see that in 1998 there were over 50,000 businesses with under five employees in Atlantic Canada, and 12,600 businesses with between five and 20 employees. These are big numbers, and this is an important contributor to our economy. Issues like this affect the ability of these businesses to compete within Atlantic Canada and outside.

So let's talk about what's happening in the background. Before we get into catastrophic drugs, I want to talk about some things that are influencing costs for benefits in Atlantic Canada. Costs are on the rise. Health plan costs are increasing at a rapid pace and it doesn't look like there's much relief in sight. This is from our own client database. We took 50 employer groups of various sizes for which we had data going back to 1994, and we calculated the average family, health and dental rate that was paid through in the period from 1994 to 2004. You can see the cost increase there. And this is just from our database. If we then take these numbers, and inflate them by what insurers and other participants in the business are telling us we should expect as regular inflation on these benefits over the next ten years, costs might look something like this- a family rate for health and dental benefits (in Atlantic Canada typically split between the employer and the employee) might be somewhere north of $500 per month. That's significant dollars, and I think that's something we all need to be aware of.

Many of our clients spend in excess of 7% of payroll on group insurance. And we have some fairly large ones that are now in excess of 10%. 10% of payroll as a common number for group insurance benefits, covering health and dental, may not be far away at all.

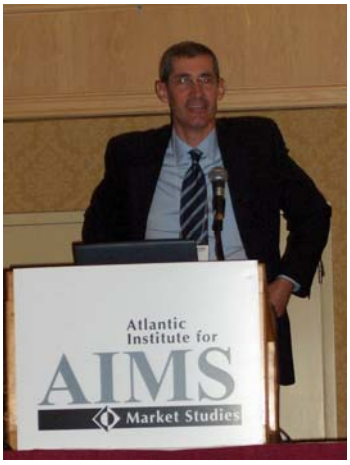
Now let's just look at how group insurance plans work. I think this is important, because a lot of stake holders in the public/private discussion don't realize how private plans work, particularly small private plans. A lot of employees that participate in these plans don't understand, and we often hear things like, well, you are covered under your insurance plan at work, just have it paid by that. The assumption is that it is a big black hole and the expense will just go away. But it doesn't work that way. Health and dental renewal methodology for a group between 20 and 150 employees is called experience-rated non-refund, which really isn't all that important, unless you are an actuary. But the important point is that current claims are used as a predicator to set next year's claims. This is how the rate process works. And rates are set to cover anticipated claims plus the insurer's expenses. So graphically, let's look at it this way.

Let's say you had a group with 50 employees and the health premium was $80,000 a year. The way that the insurer would set the rates next year if you had claims, let's say, in the range of $70,000. They would take that $70,000 in claims, they would add what they figured would be normal inflation on that amount of claims. They might add in some reserves. Then they would add in the insurer's expenses, which would cover their cost of doing business, premium taxes to the various provinces, and advisor fees, if they're built into that part of the equation. The difference between the total anticipated cost for the next year, which is this amount here, and

the premium that was paid last year, would be the rate change. I'm oversimplifying a bit here, because some insurers will use two year weighted average, etc. The point is that in this circumstance, we would, if you had this type of premium and this type of claims, you would get a 20 percent increase in rates.

There are two areas of cost: expenses and related costs, and claims. But obviously, as you can see from this slide the biggest portion, and the biggest driver, is the claims themselves.

To remind those who don't live in Atlantic Canada, something is a little different here than it is in other parts of the country, particularly Ontario. Here, particularly with private business, a significant majority of employers ask their employees to contribute half the cost of premiums through payroll deduction. That's not the case in other parts of the country. For example, in Ontario a much higher percentage of the premium is typically paid by the employer. By the way, those parts of the country are trying madly to change more to our model.



Rob Weld brings the small business perspective to the conference.

Now let's drill down a little bit further into health and dental, a breakdown of claims. This is data from Blue Cross, and it shows what percentage are drugs for a typical plan looking at the whole health and dental piece. In this case it is 55 percent.

Let's look at three things that impact drugs. One is demographics, the second is new medications that are coming on the market all the time, and the third is public plan downloading.

Let's look first at demographics. This is from a report that was done several years ago, but I think the point is still very valid. This came from the Merck Frosst handbook on private drug plans that was done by Brogan Inc., for the years 1997 to 2000. It looks at cost per claimant, by age, in private drug plans across the country. See how steep the curve gets as age becomes a factor in a group, where in this data, average claims for a 25 - 35 year old were just under $200. And when you got up to a 55 - 65 year old, claims were in excess of $700. I understand from recent reports that these numbers for the higher age bracket are getting closer to $1,000.

Let's talk about new medications. New patented maintenance medications have a huge impact in our business, where new drugs come out at a significant multiple of cost compared to the therapies that they replace. This is an old example, but it is such a classic that I have to keep putting it up. Blockbuster drugs like Celebrex, and its less fortunate cousin VIOXX. Drugs that are not all that expensive in themselves but replace therapies that were a fraction of the cost. Wonderful drugs, but we saw how in a couple of years they went from nothing to being in the top five drugs in most health plans. Now that's changed somewhat in the past couple of years, but this is the kind of thing that impacts our business quite a bit.

And now the topic we are here today to talk about- catastrophic drugs. Drugs like Enbrel, Remicade, Gleveck, Tracleer. These are drugs that I've put up because

they're drugs that we've seen in our book of business in Atlantic Canada for specific drugs. When I talk to our clients I call these drugs “low incidence wonders,” because we don't see them all that often, statistically. When we do see them, they're typically wonderful for those that need them, but their financial impact on the benefit plans is huge.

Enbrel and Remicade for rheumatoid arthritis and Crohn's disease. Gleevec for a type of leukemia, and Tracleer for a condition that I can't think of the name of right now, so I'm going to move on. Glevec- I've got an employer in Halifax that's paying for that drug, and the utilization could be over $100,000 a year. Tracleer, we've got two of them, in our book of business. That drug is in excess of $50,000 a year. The first time we saw it was several years ago before the insurers had re-designed their businesses around this kind of catastrophic risk. We saw it in a group with ten employees, and it ruined the plan to the point where the costs went up so much, based on what I showed you before, that the plan had to be cancelled for all participants.

So what are insurers doing? Over the past two years, most have introduced what we call individual large amount pooling. And what that means is that claims in excess of the pooling level, for example, $10,000, are removed from the rating calculation. That typically adds three to eight percent to that expense part of the portion I talked about. It helps, but this is still a problem.

“Tea and Sympathy” conference participants use a break in the agenda to discuss topics of mutual interest.

Let's look at a typical renewal. In this case, this would be a group with about 25 employees, which we initially priced for health benefits of $30,000 a year. And you can see this same map, year in, year out, where the calculation is done, the claims increase by normal inflation, and we've got anticipated inflation increases and expenses added on, and the premium might increase like this. Now what goes on here is that we would often do a market study in year three. If we stayed with the insurer we'd expect the expenses to be here. Maybe in year three, if we did a market study, market competitiveness might mean that if we changed carriers we could get rates in about here and then we start the process over again.

But what happens if you have a catastrophic claim? Let's say if we had a drug that was $30,000 a year, and we had pooling, like we talked about, over $10,000. So the first $10,000 are going to be charged to the plan. Well, for a small employer, that has impact. In this case, if we add that in to that same equation instead of being $42,000 a year for this benefit in the fourth year, it is going to be in excess of $55,000. Right now, the way the market works in group insurance, having a large claim like this on the books makes it very difficult to move to another insurer. And so

that means that the client, the customer, the group, is tied to the insurer they're with, and is pretty much at their mercy.

Impact of employees who are on long-term disability is also a big issue. An employee who is on long-term disability is continued on the health plan, and although they're gone from the workplace for ten years, their drugs might still be with that employee group and affecting that employee group's rates for years to come.

Early retirees are another concern. In Atlantic Canada there are no early retiree programs and private sector plans typically don't offer benefits to early retirees. Potential early retirees are often talking about staying longer in order to keep access to their group insurance plan to age 65 when they can get on the seniors Pharmacare program and public plan downloading.

So these are some of the things that might be done. A catastrophic drug program. I talked about there's a lot of issues around that, and I'd certainly like to talk more about that. Provincial programs similar to other parts of the country, for example, could we make a Trillium program here in Atlantic Canada work. Could insurers do a better job of arrangements for employees upon early retirement or disability, and could there be a way to correct the portability issue, for small groups.

Thank you very much, and I look forward to questions. (Applause)