

A Primer on Private Health Benefit Plans

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Introduction

This is not about two-tier medicine. It is about the invaluable role played by private health benefit plans, funding that ensures access to medically necessary treatments and services.

While the notion of private healthcare has been widely vilified, it is clear private insurance is essential. Governments could not afford to replace this critical, 20 billion dollar contribution to our national health. Nor can they afford to marginalize this community.

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Private drug plans were conceived almost forty years ago when the average prescription drug cost just a few dollars. No one thought these plans would ever cover truly high-cost medications, or provide catastrophic protection. With each passing year, employers and insurers have seen claim costs rise rapidly, but have continued to invest without recognition by governments and their agencies and institutions. Today, private drug plans account for about \$9 billion, or 36 per cent of Canada's total expenditures on prescription drugs¹, and cover an estimated 20 million Canadians.² As a nation, we pay almost \$5 billion more out-of-pocket, making a total private contribution of almost \$14 billion, or 55 per cent of total prescription drug costs. The private side

is no small matter, but so far a largely silent partner at the health policy table.

For many years, the private payer community of employers, their advisors (meaning fee-based consultants and commissioned brokers), insurers, and pharmacy benefit managers have offered very high quality plans, and talked about cost-shifting and cost containment. Built on the skills of actuaries and underwriters, it is the financial dimension that generally dominates, sometimes at the expense of the patients. This does not augur well for benefit plan members (employees and their families) facing catastrophic health costs due to advancing medical technology without the benefit of either a public or private safety net.

Benefit Plan Design

Health benefit plans that supplement Medicare and reimburse dental costs are essentially unchanged since the 1970s. The maximum for some benefits, such as vision care, have increased, some benefits have been added, like acupuncture. Others, seen as less essential or abused, have been controlled.

The core of the plan is prescription drug coverage, and generally, this has remained very generous. There are still some plans with deductibles of \$0.35 per drug, dating from when the average price of a drug was about \$3.50. The average cost per prescription was approaching \$60 in 2007.³

There are differences in plan design by region, by industry, by employer size, and by insurer. Regional Blue Cross organizations and some specialty companies tend to have more restrictive plan designs, and more drugs reimbursed only with prior authorization – case-specific review against criteria of varying quality, fairness, and transparency. There are no industry standards for these reviews.

In contrast, the national insurers, such as Great-West Life, Manulife and Sun Life, tend to have plans with broader lists of eligible drugs. The top three insurers control over 60 per cent of the employee benefit marketplace. Each contracts with specialty companies, called pharmacy benefit managers (PBMs), that electronically adjudicate drug, dental, and other health claims on-line and in real time. Paper-based reimburse-

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ment plans are slowly disappearing, since they lack convenience and the breadth of plan design and cost control tools available to plans managed by PBMs.

Most plans have patient cost sharing, typically of about 20 per cent, which for most employees makes the “average” drug reasonably affordable. Employees also typically pay a share of the monthly premiums through payroll deduction. The challenge comes with biologic drugs, and specifically oncology drugs, where the cost can be \$10,000, \$25,000 or even more per course of treatment. Twenty percent of \$25,000 means \$5,000, if a full course of therapy is required. Few employer plans outside Quebec have caps on the out-of-pocket expenditures, so most Canadians face serious financial hardship for any such drug not provided by the province or hospital formulary. This is exactly why there is a need for a truly national—and not just public—pooling mechanism to protect patients. For many of the sickest among us, serious or prolonged illness presents a significant, and sometimes catastrophic, financial hardship.

And this is Canada, 40 years after the introduction of Medicare.

Benefit Plan Quality

The good news is that employers know benefit plans are highly valued by plan members, and beneficiaries are highly satisfied with their plans. In the 2008 sanofi-aventis Healthcare Survey, 57 per cent of 1,500 respondents said their benefit plan was excellent or very good. Though they obviously cover different things, by comparison, just 35 per cent described Canada’s public healthcare system as excellent or very good.⁴ A year earlier, the same survey indicated a majority of plan members believed all Canadians should have access to benefits similar to those they had through their employers.⁵ Access to both public *and* private health plans is the true standard of care, protection, and security.

Benefit plans are important as a recruitment and retention tool for scarce skilled labour. Good quality benefits are linked to job satisfaction, loyalty, and employer image.⁶ While our current economic woes will undoubtedly affect hiring plans, the longer-term

trend suggests benefit plans will remain high quality and comprehensive.

The Demographics of Cancer

Cancer is justifiably associated with aging; in fact, about 70 per cent of all cancers are diagnosed after age 60. That leaves about 30 per cent occurring in the working age population, those ages 18-60.⁷

There are two implications from these statistics. First, in a recent national survey, 54 per cent of Canadian employees believed their employer-sponsored health benefits continued after retirement. Industry estimates put this figure at closer to 15–20 per cent⁸, although those employed in the public sector, in large companies, or with collective bargaining agreements are more likely to retain their benefits, at least in part. As more of the working population nears retirement, there will be some rude awakenings.

Second, with almost one-third of cancers diagnosed among the working age population, many employers are likely to be surprised to learn they have a significant, devastating, and emotionally-charged disease to integrate into their health strategies. One large insurer reports cancers are the third largest cause of long-term disability.⁹

Benefit Plan Funding

The largest cost of these plans is borne by the “plan sponsor”, typically an employer, but sometimes a union, or a joint management-labour trust. The employer pays the insurer a monthly premium depending on the plan design, the spread of risk (i.e., the number of people covered and the cost of claims), and the administrative cost. Provinces also charge taxes on insured premiums for life and health benefits.

Larger employers, those with at least 100 employees, may choose to self-insure their drug plans, and retain an insurer to provide administrative services only (ASO). The employer does this believing the year-to-year costs are relatively predictable, to pay lower administrative fees and to gain more control over the plan design.

A major irritant for the private payer community has been a sense that governments are constantly off-loading costs from health ministry budgets without regard to who will ultimately pay.

Since most small employers, those with 50 or fewer employees, cannot handle the cost of anything other than routine claims, they typically get a standard plan that is entirely the risk of (“fully insured” by) the insurance company. They pay a monthly rate based mostly on the claims experience of a group of similar employers (the “pool”), plus an administration fee that often includes a commission for the broker or agent, as well as taxes. One widely held perception is that those “rich insurance companies” absorb all the claim costs, not the employer. People therefore might think they can claim with impunity. However, this is not true except for the smallest companies. Sooner or later, your employer will pay, so sustaining these plans becomes a shared responsibility of plan sponsor and member alike.

Benefits by the Numbers

Benefit plans, like their public Medicare and Pharmacare counterparts, are under serious financial strain; annual costs escalated at 400 per cent of the Consumer Price Index between 1985 and 2007. Private drug plan costs doubled between 2000 and 2007.¹⁰ Like government plans, this is not sustainable. Unlike public plans, private health benefit plans are not mandatory, and changes can be made except where governed by collective bargaining and for people already retired.

Employers face huge pressure to maintain the status quo, and there is evidence that significant attempts to weaken health benefit plans may be met with serious resistance by beneficiaries. The 2005 sanofi-aventis Healthcare Survey reported that 71 per cent of private plan members agreed that government regulation and minimum standards were needed for health benefit plans. Two years later, the same question garnered 78 per cent agreement. We can safely conclude that companies cannot act in a vacuum, and most will not take a decision to curtail coverage lightly...unless and until they are desperate.

A major irritant for the private payer community has been a sense that governments are constantly off-loading costs from health ministry budgets without regard to who will ultimately pay. Too often it will be patients,

Why does pooling matter?

Imagine you’re the decision-maker at a small or mid-sized company. A cancer patient, or someone with rheumatoid arthritis (RA), could benefit from access to one or two biologic drugs. This class of drugs is often highly effective... and incredibly expensive. It would be easy to spend \$25,000 annually for each course of therapy

Even if you can afford it, you’re thinking of trade-offs. If \$25,000 bought a biologic drug that would allow an employee disabled from RA to return to work, that could be a wise investment. What if that money bought a drug not provided by your provincial cancer agency that would extend the life of a terminal cancer patient by a few months? But is either better than spending \$25,000 to vaccinate 50 young women against HPV, the cause of cervical cancer? Perhaps those funds could buy some new equipment that would improve your plant’s productivity and pay for itself in three years.

It can get more complicated. What if the cancer patient were the company owner; what if the drug was for a secretary who had worked for you for twenty years? A shipper with just three years’ experience? This is not a rare event for companies. There are no wrong choices, but there are winners and losers. This is the outcome of drug policy that is stuck in silos, started forty years ago, and that hasn’t kept up with drug costs, patient needs, or employer realities.

many with high cost drug regimens. Out-of-pocket expenditure on prescription drugs was estimated at nearly \$4 billion in 2007; fortunately, individuals have faced the slowest growth in their costs, though still up 52 per cent between 2000 and 2007.¹¹

Government v. Employers?

There is another factor that could affect costs and therefore access: a much more dynamic marketplace. Changes to Ontario's public Drug Benefit programs, under the ironically-named *Transparent Drug System for Patients Act*, and British Columbia's PharmaCare plan have introduced "competitive bidding" for certain drugs. In each case, the tendering process requires the drug manufacturer to pay a confidential rebate to the province in exchange for being granted a period of market exclusivity by the public plan.¹² While this has affected only one drug in BC, olanzapine, competitive bidding has affected both brand-name and generic drugs in Ontario. In addition to reducing the price to the province, the Ontario deal has also reduced the mark-up and professional fees paid to pharmacies. The combined effect is a cost reduction of \$260 million to the Ontario government in 2007-08.¹³

While this has successfully reduced the government's cost, it has also left their "silent partner" private drug plans behind. Pharmacies and some drug manufacturers have been quick to hit private plans with higher costs to compensate for the margins they no longer receive from government plans.

In fact, the Competition Bureau estimated in 2008 that Canadians could save up to \$800 million annually on generic drugs—20 per cent of the \$4 billion Canadian generic market—with the largest part of that potential (\$540 mm) resting in the private market.¹⁴ To the extent private plans do not demand their insurers, pharmacy benefit managers, and/or consultants negotiate similarly reduced drug prices—brand-name or generic—higher prices can only increase the pressure on employers to control costs and limit their exposure to a newly competitive marketplace.

One way this will play out is through increased scrutiny of medications that are expensive, that are commonly misprescribed by physicians or abused by patients, or deemed unsuitable for employer plans. On this last point, intravenous cancer drugs are ineligible under most employer plans because they are typically infused in-hospital and are therefore seen to be a publicly insured service.

Everyone into the Pool

Pooling is an important element of plan design and financing. Especially for the smallest group plans, risk is too volatile to be borne by one or a few employers, so it is shared among many.

Eventually, whether large or small, most plans will be

hit with a large claim. To protect against this, insurers offer optional protection against high-cost claims, called stop-loss pooling. When an unexpectedly large claim occurs, e.g. over \$10,000, the risk transfers from the employer to the insurer. This works well, until the second large claim hits, and then insurers tend to significantly increase the cost of the pooling protection. Sometimes, the employer can no longer afford it, so the plan terminates or transfers to another insurer. The second insurer, however, rarely takes on a risk without knowing as much as possible about it. Typically, claims experience is provided, and with a smaller group of insurers these days, there are few secrets. The employer will invariably end up paying more.

The Better Way

Quebec has had a province-wide, public-private drug regime since 1997. Employers there are required by law to offer a drug program with coverage at least as extensive as the government plan if they offer any other health benefits. The insurers active in that market support a high-cost (catastrophic) drug claim pool that spreads risk across all players and reduces pool charges in both cost and volatility.

Outside Quebec, neither private insurers nor governments have yet developed adequate, integrated protection from catastrophic drug costs. As a result, there are large and growing gaps in coverage, and cancer patients are among the most exposed.

It is time that void was filled.

Healthy Workplaces

Traditionally, employers, their consultants and insurers have focused on managing costs after illness and injury occur. Absence and disability are expensive; data from Statistics Canada indicates the wage-only cost of absence for illness and disability can be estimated at \$13.8 billion in 2007.¹⁵ One insurer reports that each new long term disability claim requires a reserve of about \$60,000.¹⁶ After seeing the incidence and duration of absence and disability climb relentlessly for many years, employers have begun to turn to the idea of prevention.

The risk factors for many cancers are the same or similar as for most chronic diseases: poor diet, excess weight, too much alcohol, smoking, sedentary lifestyles, and chronic, high levels of stress. In fact, research indicates the last factor can quintuple the incidence of colorectal cancer.¹⁷ Almost any strategy or program that addresses these root cause issues will benefit cancer prevention efforts as well as heart disease, diabetes, obesity, osteoarthritis, hypertension, asthma, and other conditions.

At this point, a preliminary search of published studies and articles suggests that cancer is not a primary driver of these workplace health promotion programs. A

comprehensive approach does not appear to exist, though at least one approach is under development and should be launched in 2009.¹⁸ Some organizations, particularly hospitals, have organized screening programs for their staff, but results are not generally known, measured, or communicated externally.

Illness and injury manifest themselves not only through the habits of workers on and off the job, but

What is Critical Illness coverage?

A recent BMO Nesbitt Burns survey reported just 26 per cent of Canadians have a plan to deal with a future need for health-related assistance*. Plan members are beginning to see alternatives to employer-paid plans emerge. Individual plans for Medicare Supplement have been available for some time, traditionally through Blue Cross organizations across Canada.

But new types of voluntary coverage are needed, particularly for critical illness (CI). In the 2007 sanofi-aventis Healthcare Survey, 62 per cent of 1,700 benefit plan members said they were willing to pay personally for this kind of coverage. CI plans provide a lump-sum benefit upon diagnosis of a listed serious illness and after survival for a minimum period of time (e.g., 30 days). The most common diseases are cancer, heart attack, and stroke, but plans vary in their coverage. Primarily sold to individuals, group CI coverage is new and sales have been limited. Consequently, several conditions exist.

Basic plans have a minimum amount (e.g., \$10,000 or \$25,000 for larger groups) usually mandatory for all employees, but available without proof of good health in larger groups. More employer-funded coverage is usually offered after providing additional health information, up to \$50,000 for smaller groups, and up to \$100,000 for larger groups. There are often exclusions for pre-existing conditions. Voluntary plans, fully paid by the employees, may also be available; again, proof of good health is required.

* News release, March 29, 2007: Caring for Aging Relatives Taking Toll on Boomers According to BMO Study.

also the way work is organized (control, demands, pace), and how people are selected and prepared for their jobs. So, health promotion programs are not enough. Much of the stress in today's workplaces is actually controllable by management and leadership, through their policies and practices.¹⁹ Organizations that carefully select, train, and support workers in their jobs tend to mitigate stress and have healthier work environments. These considerations can propel a company from being an also-ran towards being an "employer of choice" in the race for scarce talent.

And this is what company sponsorship of employee benefit plans and health promotion programs is all about: high performing organizations are dependent on a healthy, productive, engaged, and loyal workforce. This motivation is entirely honourable and is the mark of good corporate citizenship, but it is very different that what compels governments to provide health services to a population. Disease management strategies and advocacy needs to be adjusted accordingly.

Trends, Established and Emerging

Benefits have been remarkably stable, and increasingly valued by those who have them. In 2007, a national survey reported that 61 per cent of 1,500 Canadian benefit plan members would rather have their health benefit plan than \$20,000 in cash.²⁰ By all measures, that is an irrational amount but shows the tremendous security and peace of mind these plans deliver. People know there are gaps in Medicare, and those gaps can be financially crippling. This incredible perceived value, added to 15 years of economic growth, plus demographic changes and a shrinking labour pool, has made Canadian executives loathe to cut these entitlements. Now that recession is upon us, is this likely to change?

For longer-term and strategic decision-makers, the economic malaise will pass, though the next year or two may be quite painful. However, the demographic pressures will remain for many years, particularly since the average age of retirement in Canada is now 62, and the oldest Boomers turned 62 in 2008.²¹ The younger generation, sometimes affectionately labelled Generation Y, has been reported as fickle about their jobs and very mobile given their relatively small numbers. Hence, employee loyalty and engagement are terms now very well known to every Canadian Chief Executive.

Managing benefits remains largely an administrative role, and the economy and global competition will ensure continuous pressure to trim costs. However, considering the larger demographic and workforce trends, access to good quality health benefits is unlikely to be seriously affected. That noted, smaller employers will be considerably more likely to make changes to protect their cash flow. Those approaching retirement are likely to see their entitlement to health benefits diminish or disappear. And, if the number of companies going into

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receivership and bankruptcy significantly increases, then another segment of the labour force will lose access and be exposed to financially catastrophic health care costs.

In this newly tumultuous marketplace, ethics will probably emerge as an important factor. Patients who need cancer drugs and other services deserve fair and appropriate access. Right now, entitlements vary according to whether coverage is private, public, or both; employment status; employer plan design and eligibility, and what the patient can afford. Under most plans, treatment location matters (hospital or clinic), and so does the form of the medicine (oral pills versus infusion). To add more variability, personal awareness, assertiveness, and health literacy also factor in. The various combinations and permutations of these factors mean not all patients will get what they need when they need it.

The Outcome

For twenty years and more, there has been a continuous stream of issues and threats, but the result has been minimal change. The benefits community is very conservative, but its diversity and proprietary aspects mean major trends are hard to detect and study. It could be that talk of more restriction will remain just that.

Where to From Here?

Given the tremendous importance of health care among Canadians, and our innate sense of fairness, the status quo is unlikely to be acceptable for much longer. Drug budgets will ultimately have to be restructured and resources reallocated to those most in need at the expense of others. We need to bring governments and the private payer community together, and the Cancer Advocacy Coalition of Canada (among others) has suggested that just such a forum be convened.

The goal of this dialogue cannot be more study. Beyond building trust, dialogue, and mutual respect between employers and government, the goal must be comprehensive, cross-Canada action to create standards and sustainable solutions. The beneficiaries are the parties themselves—payers who might generate significant public goodwill and finally play on the same field with clear, consistent rules, and the patients who may finally receive the protection they need from unaffordable drug costs.

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