

Does Private Insurance Protect Canadians from the Cost of Cancer Drugs?

by CHRIS BONNETT

Private health insurance, the largest part being prescription drug coverage, has become the security blanket for over twenty million Canadians.¹

The vast majority of private health insurance plans are sponsored and funded by employers, but this is voluntary and not their core product or purpose. In almost all cases, employees pay an important share of the cost to cover themselves and eligible family members. Employees place high value on their health benefit plans: a major national survey regularly reports most plan members are unwilling to trade them for \$15,000 or \$20,000 cash.²

In aggregate, privately insured drug plans now pay almost as much annually as provincial drug plans, \$9.3 and \$9.5 billion respectively.³ Although some Canadians have access to both plans simultaneously (e.g., those living in provinces with universal Pharmacare plans, and some retirees), there is generally limited overlap. Mostly, they work together in a complementary manner.

Disparities in coverage exist among and between those with private insurance, and those without. Importantly, another often very significant gap exists between what federal and provincial governments provide to their own employees and legislators, and what they provide to their residents. There is also an inequity when only some (about 20 per cent) have access to post-retirement health benefits. Most others must rely on Medicare plans, or personal resources, neither of which may be adequate for serious or prolonged illnesses like cancer.

RESEARCH QUESTION

Does private insurance protect Canadians from the cost of cancer drugs?

Methodology

Major insurers (Manulife, Alberta Blue Cross, Pacific Blue Cross, Medavie Blue Cross, Sun Life, Great-West Life, and Green Shield) were approached and/or their websites reviewed to understand typical prescription drug coverage available to small and large businesses. Two large national pharmacy benefit managers were contacted, with one response (Telus). Each provincial government was asked to outline the drug plan offered to their civil servants and legislators. The Public Service Health Care Plan for federal government employees was reviewed and the Trust contacted. Some plan administrators compared their plans against the 43 newer “take home cancer drugs” described in the 2008 *Report Card on Cancer in Canada*.

The web was the major source of basic information for all plans available to provincial civil servants, as well as employees of the federal government. More information is available at www.canceradvocacy.ca. Plans for legislators are more difficult to obtain; they are sometimes not published externally or available on the web. Telephone calls were therefore made to each province to obtain general information on MLA/MPP/MNA plan design. Only the province of Ontario was unwilling to disclose relevant information on their legislators’ health benefit plan.

FINDINGS

1. Private Employer Drug Plans

Small employer plans now offer reasonable flexibility in plan design, with basic and enhanced packages available. However, coverage decisions are made by the insurer, and internal limits can be reached quickly in the face of major illness. The insurer bears the risk because small groups have more volatile claims experience and employers can leave the insurer in a deficit at any time. An employer might invest in a good drug plan, but skip or skimp on disability coverage that replaces income when someone is off work sick. Cancer patients need assistance in both areas. Many small employers have no health or disability benefit plan.

Plans for larger employers, especially those with at least a few hundred employees, provide coverage flexibility to the limits of insurance company claim systems, which are generally quite sophisticated. Exceptional situations can be handled administratively; the insurer will accommodate their employer client’s direction because that employer will ultimately pay for the full amount of claims. There was very little difference found in the benefits available to active employees in either private or public sector organizations.

2. Public Employer Drug Plans

Legislators and civil servants in almost all provinces are as well or perhaps slightly better protected than other employed Canadians with health benefits. Most often, legislators shared a plan design with their province’s management (“exempt” or “out of scope”) employees. Management and union plans for government employees are very similar. Among private plans, it is remarkable that Manitoba government employees and legislators get just \$700 per family per year to pay for prescription drugs, with a 20 per cent co-pay.

TABLE 1

SUMMARY OF DRUG BENEFITS

	Prior Authorization	Annual / Lifetime Max	Annual Out-of-Pocket Limit	Legislators Eligible	Retired Employees Eligible	Retired Legislators Eligible
Federal PSHCP	No	Unlimited	\$3,000	Yes	Yes	Yes
NL	Yes	Unlimited	None	Yes	Yes	Yes
NS Plan A/B	No	Unlimited	\$492 / None	Yes	Yes to age 65	Yes to age 65
PEI Active/CUPE	No	Unlimited	\$30 / None	Yes	Yes	Yes
NB	Yes	Unlimited	None	Yes	Yes	Yes
QC Union/MNAs	No/Yes	Unlimited	\$2,500 or \$3,500 / 100% reimbursement	Yes	Yes	No
ON Employees/MPPs	No/Unknown	Unlimited/Unknown	None/Unknown	Yes	Yes, after 10 years' pensionable service	Yes, after 5 years' service
MB	No	\$700/Family/Yr	None	Yes	Yes	Yes
SK	No	Retirees \$1,700/Yr	None	Yes	Yes	Yes
AB Core/Enhanced	No	\$25,000/Yr./Unlimited	None/\$1,000	Yes	No	Yes to age 70
BC Union/Mgmt/Retiree	No	\$100,000/\$250,000/\$100,000 All Lifetime	None/None/\$2,000	Yes, Union plan	Yes	Yes, after 6 years' service

Notes

- (1) Under the Public Service Health Care Plan (PSHCP), Senators are eligible only until age 75.
- (2) NS retirees pick up the provincial Pharmacare plan at age 65.
- (3) PEI provides retirees with three drug plan alternatives.
- (4) QC MNAs have 100 per cent reimbursement of all eligible drugs. Among the CACC list of 43 take-home cancer drugs, only Iressa and Gleevec are subject to prior authorization for MNAs. There are different drug plans for different units within the QC public service.
- (5) The plan for ON legislators could not be released. MPP 'retiree' eligibility: If re-elected in 1995, age plus years of service must equal 55. If newly elected in 1995 and after, the later of retirement/defeat/resignation, or age 55. There are different drug plans for different units within the ON public service. Information was available for OPSEU and AMAPCEO members.
- (6) MB retirees have an annual maximum of \$1,250 per family. The drug formulary is identical to Pharmacare.
- (7) In SK, Pharmacare is first payer. The drug formulary is identical to Pharmacare.

This would not cover the average annual per capita drug claim, which CIHI forecast at \$756, before coinsurance, for 2008.⁴ Once that \$700 is spent, there is significant exposure to individuals and families before the provincial Pharmacare plan kicks in. For example, for a single income of \$40,000 with no children, the Pharmacare deductible is 4.22 per cent, or \$1,688. For two people, each with incomes of \$40,000, and three children, the deductible would be \$3,450.60.

Government retirees most often remain covered by their former employer, though maximums for certain costs may be reduced. There are two exceptions. First, Alberta MLAs who leave the Legislature remain covered until age 70, but there is no plan for retired bureaucrats. The reverse holds in Quebec, where MNAs who leave the National Assembly lose their benefits, but retiring bureaucrats are eligible for continued coverage. The only exception was in Alberta, where MLAs who leave the legislature remain covered until age 70, but there is no plan for retired bureaucrats. Fortunately, Manitoba retirees are somewhat better off than their active counterparts, and better off than Alberta retirees too. Their annual family drug coverage increases to \$1,250.

3. Coverage Relative to the CACC List of 43 “Take Home Cancer Drugs” (THCD)

Comparisons were made in four instances:

- The Quebec government drug plan, the *Régie de l'assurance maladie du Québec*, provides drug coverage to residents without a private plan, and also serves as a mandatory baseline coverage model for private plans in that province. There were just four THCDs not covered (Faslodex, Iressa, Ergamisol, and Nexavar).
- Telus Health Solutions, a large national pharmacy benefit manager, did not provide a specific review of each

product, but stated their “open” plans, the majority of their drug plan business, include coverage for all but one of the 43 drugs.

- The Alberta government employee drug plan uses the Alberta Blue Cross Drug Benefit list, which is also a model plan for many small and medium enterprises in that province. That List includes all but one of the 43 THCDs (Emcyt).
- A representative of Green Shield, an independent pharmacy benefit manager, reviewed the CACC list and identified six drugs that would be currently subject to its prior authorization process.

Note the above information is subject to change without notice.

4. General Observations

Plans with any type of annual or lifetime maximum payout are relatively rare (<20 per cent), and they apply mostly to retirees.⁵ They are also common in the plans of small and medium-sized organizations in Alberta.⁶ Plans with a cap on out-of-pocket costs are also relatively rare outside Quebec where it is mandatory. There are no firm figures available on this plan design feature. When three-quarters of all new cancer medicines cost \$20,000 or more⁷, the out-of-pocket cost for a plan with a 20 per cent patient co-pay (i.e., $0.20 \times 20,000 = \$4,000$) is very significant, and sometimes unaffordable.

Some insurers also provided their standard adjudication process for cancer medications. Only Great-West Life allows claims for intravenous cancer drugs in their standard plans as long as they are not available in hospital; all other insurers consider them to be hospital-based treatments and therefore ineligible.

Prior authorization (PA) is the most common cost control feature affecting cancer drugs. For most plans, Alberta Blue Cross (ABC) and Medavie Blue Cross require PA for essentially all cancer drugs. ABC also advised that it has been their practice for many years to generally wait for listing decisions from the former Alberta Cancer Board before they allow new cancer drugs on to their standard formulary. Other insurers and PBMs would typically reimburse a new drug shortly after it received its Notice of Compliance from Health Canada, and may (but generally don't) review that decision once government reviews are completed. Pacific Blue Cross would review and consider reimbursing a drug that had been previously declined by the BC Cancer Agency, but this is rare.

Private insurers, as a rule, have not invested the same way in reviewing new drugs as their provincial counterparts. Most regional Blue Cross organizations do provide rigorous review, as does Green Shield for their standard plans. All insurers offer more restrictive drug formularies or plan designs, though the big three (Great-West Life, Sun Life, and Manulife) still have generally open plans where almost all prescription drugs approved by Health Canada are soon made available to plan members. This is in stark contrast to most public Pharmacare and cancer agency plans, where new drugs are subjected to exhaustive review of clinical and economic evidence...often taking years when joint (i.e., Joint Oncology Drug Review) and separate province reviews are completed.

Generally, private plans provide better access to cancer medications. However, there are still important gaps in protection.

Private health plans usually provide access to drugs that provincial plans consider ineligible; increasingly these are cancer medications. However, they:

- Are usually the second payer, after provincial plans.
- Are sometimes the first payer, until provincial drug plan co-payments are fulfilled.
- Are always the first payer, i.e., in NS, NL, and QC.

“Standard” provincial drug plans in Ontario and Atlantic Canada do not offer coverage until age 65. However, since the average age of retirement in Canada is 62⁸, residents in those five provinces who leave their private drug plans for any reason (e.g., early retirement or termination of employment) may face several months or years without any type of coverage. For cancer patients, the odds are worse, since 70 per cent of all new cancers are diagnosed, and 82 per cent of all deaths occur after age 60.⁹

There are tens of thousands of employer-sponsored plans, and each has unique features that make it impossible to provide hard and fast rules about what drugs are eligible. These plans are also subject to ongoing review and occasional changes in cost-sharing or coverage. The findings and conclusions in this report are applicable only in general, except where otherwise indicated, and reflect a moment in time only.

Fortunately, there is plenty of plan information available from employers and from insurer websites and toll-free telephone numbers. It is much harder to find drug eligibility and coverage conditions for most public cancer plans.

Analysis

Though generous under most circumstances, there are several concerns with private plans:

1. Lack of protection against catastrophic costs: This is the biggest concern, and one that transcends the issue of public or private payment. Some plans protect beneficiaries from high drug costs relative to their income, but most do not. Without a mandatory national high cost claim pooling mechanism, it is more likely employers will implement or continue caps on their financial obligations, rather than those of plan members.
2. Significant variations in coverage quality: Just as in public plans outside Quebec, there are no minimum standards regarding formulary breadth, prior authorization, or level of reimbursement. Promulgating standards and tracking trends requires industry-level data, but almost none exists. One senior industry contact summed it up this way: “No one knows!” when asked about typical plan designs. The same applies to co-pay levels, industry or sectoral trends, or the implications and effects of prior authorization.
3. Tremendous disparity between private and public plan coverage: Private health plans available to civil servants and legislators provide reimbursement of cancer drugs that are not yet, or not ever, available to beneficiaries of their provincial drug plans. Those who have access to both private and public plans, or to two private plans (as both

employee and spouse), usually get full reimbursement of their costs—a huge advantage when costs are high.

4. Access to Post-Retirement Drug Benefits: Public sector plans, and plans in unionized workplaces typically extend coverage throughout retirement, although sometimes with lower limits. Most private plans do not cover retirees at all, and many have severely curtailed coverage in recent years.¹⁰ Though health plans are available to employees when they leave a workplace, such elections must be made within 30 or 60 days of departure, and those plans often have low maximum drug benefits, often less than \$2,000 per person per year.¹¹ However, no evidence of good health is required as long as the person previously had group health coverage. These plans are expensive because they tend to attract those in poor health who have no other options.

Recommendations

1. **Implement a national catastrophic drug plan:** This is a fundamental solution, proposed by various government commissions, including the 1997 National Forum on Health, the Senate Committee on Social Affairs, Science and Technology (2002), the Romanow Commission (2002), the 2003 First Ministers' Health Accord, and the 2004 "ten year plan to strengthen health care". It is time to move this idea to implementation, but in full partnership with the private payer community (see 2c below).
2. Generally, private plans provide better access to cancer medications. However, there are still important gaps in protection. The following steps would help address these shortfalls:
 - a) **Explicit out-of-pocket cost limits:** As in Quebec, drug plans need to protect individuals from financially catastrophic drug bills. Standards of coverage, a model drug formulary, and a mandated minimum level of reimbursement should be studied for implementation within two years.
 - b) **A national claim pooling mechanism** should be developed by private insurers in close consultation with employers of all sizes to absorb high-cost private drug claims.
 - To protect the viability of employer plans, employers should have a maximum liability on their health plans, perhaps expressed as a percentage of their paid claims. Claims above this level should be covered by the insurance industry pool.
 - In exchange, employer plans should provide a minimum level of annual or lifetime protection to plan members, whether active or retired. Consideration is needed to ensure this minimum does not become a ceiling.
 - c) **Improve the coordination of public drug programs with private plans:** To eliminate gaps in coverage, private insurers and employers should work with the federal and provincial governments to

improve the coordination of public drug programs with private plans. At least two organizations¹² have sponsored payer forums in recent years, but much more effort is needed to build trust, create goals, and move the discussions to action.

- d) **Oncology expertise required for PA:** When private plans use prior authorization for cancer drugs, the insurer or PBM should always consult an oncologist before refusing to pay for any cancer patient's recommended drug therapy. The rationale for PA should be only to control prescribing behaviour. Cost control would be handled by the pooling mechanism described above.

3. Eliminate disparity between private and public plan coverage: In all provinces except Manitoba and Alberta¹³, civil servants and legislators have an extra level of financial protection not available to citizens without employer-sponsored drug plans.

- a) Taxpayers have a right to know what their governments provide to civil servants and legislators, both active and retired. We commend and thank most governments for their transparency in this area. Ontario legislators, like those in all other provinces, should disclose their plan designs, and formulary coverage information should also be available from Blue Cross plans for government employees, e.g. AB, MB, NB.
- b) The playing field must be levelled: Governments should invest in public drug programs to ensure their citizens have coverage commensurate with what is available to government employees.

4. Data for good decision making: Private, employer-sponsored drug plans now spend almost as much as provincial drug plans. However, there are virtually no data collected on plan designs, funding, or plan sponsor values, attitudes, and preferences.¹⁴

- There is a clear need to analyze the past, present, and future of employee health plans and assess their role in funding a significant portion of medically necessary health services.
- The voice of employers and private insurers must be heard in drug policy and program decisions made by federal, provincial, and territorial governments.
- There are almost no public studies of employee benefit entitlements; the most recent comprehensive, national study is now ten years old and conditions have changed. The portion of Canadians (then less than 20 per cent¹⁵) with access to post-retirement private drug plans has undoubtedly decreased. Costs have more than doubled. Oncology drugs are the largest and fastest-growing therapeutic class¹⁶, and take-home cancer drugs are now half the market. Current, comprehensive data are needed.

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- Telus Health Solutions

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- 3 Canadian Institute for Health Information, 2009. *Drug Expenditure in Canada, 1985-2008*. Table A, p.60.
- 4 Ibid CIHI, 2009.
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- 9 Canadian Cancer Society, 2009. *Canadian Cancer Statistics, 2009*.
- 10 The most recent broad examination of coverage was published by Health Canada in March 2000: *Canadians' Access to Insurance for Prescription Medicines*.
- 11 Great-West Life (PlanDirect) offers plans with \$1,000, \$1,200, or \$1,750 annually for prescription drugs. Manulife (FollowMe) plans offer annual drug benefits of \$400-\$1,600 annually. The Medavie Blue Cross (Select Conversion) drug plan has no overall maximum, but is not available to those age 65 or older and who are eligible for a public drug plan. Sun Life (My Health CHOICE) offers either \$1,000 or \$2,000 annually for prescription drugs.
- 12 The Canadian Council on Integrated Healthcare sponsored a Payer Forum in Toronto in November 2006, and the Canadian Cancer Action Network, the Canadian Cancer Society, and the Public Policy Forum hosted a joint public-private session in Ottawa in September 2009. The Cancer Advocacy Coalition of Canada has also called for a payer forum.
- 13 For civil servants only; Alberta MLAs have retiree coverage until age 70.
- 14 The sanofi-aventis Healthcare Survey is undertaken annually and has collected the views of almost 20,000 health benefit plan members across Canada since its 1998 inception. Employer commentary is occasionally included.
- 15 Op cit. Health Canada, 2000. *Canadians' Access to Insurance for Prescription Medicines*.
- 16 IMS Health, 2009. News release, November 11. IMS Health to Launch *Oncology Quantifier*, Delivering Integrated Insights for Enhanced Market Measurement, Commercial Strategies. Available at: www.imshealth.com.