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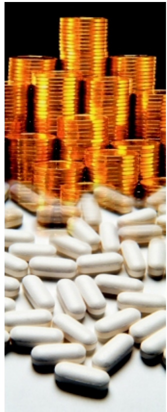

Drugs strain plan costs

Remicade® approval raises drug cost concerns

In June, Health Canada approved the sale of Remicade® for the treatment of rheumatoid arthritis. Previously approved only for the treatment of severe active Crohn's disease and fistulising Crohn's disease, Remicade® (also known as infliximab) is the first monoclonal antibody used to treat rheumatoid arthritis.

It is an extremely expensive medication, with conservative estimates of its annual prescription costs ranging in the area of $15,000. With Canadian Arthritis Society data indicating that one in seven Canadians is affected by rheumatoid arthritis and with an average of over 100,000 new cases of the disease reported every year, the potential impact of Remicade® on drug plans could be substantial.

At the moment, Remicade® use is confined primarily to in-hospital treatment of moderate to severely active rheumatoid arthritis, with prescription costs borne by provincial health care plans. However, some insurers are introducing pre-authorization or other monitoring processes to ensure that it continues to be covered under in-hospital treatment programs. Coughlin & Associates Ltd.'s Claims department plans to proceed in a similar fashion.

We will continue to monitor developments regarding this new medication.

Reports suggest drug plan costs could double in 5 years

The spectre of plan sponsors paying tens of thousands of dollars for one prescription medication is not confined to Remicade®.

According to the October 17 edition of *The Globe and Mail*, employers across the country could face a doubling of drug plan costs within the next five years, thanks largely to the high cost of the new drugs being introduced to the marketplace.

Examples of other new medications now making their way onto the market include: Todmodal®, a cancer medication estimated to cost as much as $37,000 per year, Enbrel®, for arthritis, estimated at $19,000 per person per year and Celebrex®, also for arthritis, at $15,000 per person. Plus, with the baby boom population, those born between the years 1946 and 1964, entering the lifecycle when prescription drug use becomes long-term or permanent, drug plans everywhere are now facing the prospect of more people being prescribed more expensive drugs.

According to *The Globe and Mail* report, **employers should expect drug plan costs to account for four per cent of payroll within five years,** compared to today's level of two per cent.

Solutions to this problem continue to stymie health care experts.

In September, federal and provincial health care ministers met in St. John's to consider a range of options to address the issue. Among the options considered: developing a national drug formulary of standardized drugs that governments across the country would cover in their

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The high cost of

substance abuse

The news media, charitable and non-government organizations frequently talk about the high social and economic impact of drug abuse or misuse.

But what is the total impact of substance abuse on Canadian society?

Drug abuse affects all areas of society, placing strain on health care, police, rehabilitation, legal, social and other services. And, its source is not confined to illicit drugs. The abuse of "social" drugs such as tobacco and alcohol also has a deep and economically powerful impact on all of us. According to the Canadian Centre on Substance Abuse (CCSA), alcohol and tobacco abuse has a greater impact on the social and economic health of the country than any other form of drug abuse.

The 1996 CCSA report *The Costs of Substance Abuse in Canada* showed that substance abuse consumed a minimum $18.45 billion of economic resources, or 2.7 per cent of the Canadian gross domestic product (GDP). That figure represented the direct and indirect costs of services such as hospitals, ambulance, law enforcement, administrative, social services and welfare, customs and excise, court, fire damage, corrections and pharmaceutical costs as well as the impact of lost productivity.

Tobacco led the way, accounting for over $9.6 billion in economic costs, or 1.38 per cent of GDP, the bulk of which involved hospital costs and productivity losses due to mortality.

Alcohol abuse followed closely behind, representing $7.5 billion, or 1.09 per cent of GDP. Law enforcement, prevention programs, hospital expenses, mortality and morbidity costs accounted for the largest portion of those expenses.

Illicit drugs cost the Canadian economy $1.37 billion, or 0.2 per cent of GDP, according to the CCSA, with lost productivity, law enforcement, prevention programs and hospital expenses leading the way.

Put another way, on a per capita basis, drug abuse cost each Canadian $649 in 1996 alone, according to the CCSA report.

For plan sponsors, these data confirm that the impact of substance abuse, including the abuse of tobacco and alcohol, has a real and direct cost that is reflected in lost productivity, higher taxes, disability and mortality expenses. It also reinforces the dollar value of smoking cessation and employee assistance programs. By offering programs to curb alcohol, tobacco and drug abuse, plan sponsors ultimately save money, reduce taxes and help society.

Your Coughlin & Associates Ltd. consultant can help your organization develop an employee assistance program.

The Costs of Substance Abuse in Canada can be found on the CCSA website at www.ccsa.ca/docs/costhigh.htm

Make that Freedom 67 and counting

A looming shortage of workers may force the government to consider moving the retirement age to age 67 from 65, according to reports published in the September 7 edition of *The Globe and Mail*.

With the baby boom population now on the edge of retirement, employers and plan sponsors are facing a sudden shrinkage of their work forces, unless they provide incentives or penalties to encourage workers to remain on the job beyond the normal retirement age of 65. Studies released by the Toronto-Dominion Bank suggest that unless new technology or increased immigration are able to offset the loss of productivity that will result when the largest demographic segment of the population retires, programs that encourage early retirement will likely be curtailed in the coming years.

Already, some jurisdictions are beginning to adjust their mandatory retirement ages in anticipation of the pending labor bust. For example, in the United States, the retirement age for those born after 1960 has been adjusted to age 67 from 65. The TD report suggests that similar moves in Canada are inevitable.

The Globe and Mail article goes on to state that labor force growth is expected to reduce to 1.5 per cent per year, compared to today's level of 3.0 per cent. At that rate, and at today's level of immigration, the shortfall of skilled workers to jobs could top the 1 million mark by year 2020.

Keeping skilled workers on the job past age 65 will likely require a carrot and stick approach to compensation and benefits planning. It appears safe to assume that the penalties for early retirement and incentives for employee retention will likely increase over the course of the coming decade.

In any case, expect compensation, pension and benefits programs to be dramatically overhauled as employers and plan sponsors address this issue.

Who pays for hospital-administered drugs?

With cost pressures and funding cutbacks taking their toll, many hospitals are considering or have implemented programs where the cost of some hospital-administered drugs and services, such as intravenous infusion to out-patients, are passed to private health care plans.

Until now, drugs administered within hospitals have been provided without charge as part of patient treatment plans. As such, their costs were covered by government health care plans, as mandated by the Canada Health Act.

However, some hospitals now state that drugs administered in out-patient clinics cannot be considered "hospital services." The result: benefit plans and insurers are being asked to cover new and unplanned expenses.

Group benefit plans have been designed and priced to *supplement* health care costs. That is, cover all or some of the costs not covered by your provincial health care plan. They were never designed to *replace* our universal health care plan.

The "Who pays?" debate between hospitals, governments and insurers is likely to continue for some time. However, until it is resolved, it is safe to assume that group insurers and plan sponsors will consider any drugs administered in a hospital, whether to in-patients or out-patients, to be the responsibility of the provincial health care plan.

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health care plans. Adherents of the plan suggest that a national formulary could provide the health care system with the ability to demand lower drug costs from pharmaceutical companies. It could also allow provincial health care providers to be in a better position to resist increasing cost pressures.

Also under consideration is the possible establishment of an advisory council to determine whether new drugs that offer marginally better results than previously approved drugs but at a substantially higher cost, should be covered by government-sponsored health care plans.

Rising drug costs are not a new phenomena. According to the September 23 edition of *The Ottawa Citizen,* prescription costs rose from an average $12.35 in 1985 to $39.85 last year, an increase of more than 300 per cent. However, today's health care system is faced with an alarming combination of rapidly increasing drug costs and increased patient loads. According to IMS Health Canada's *Annual Report on Diagnoses, Treatment and the Pharmaceutical Industry,* patient visits to physicians increased by 8.6 per cent in 1998, double the rate of increase recorded in the previous year. The total number of prescriptions dispensed jumped by 6.3 per cent to 270 million.

According to the IMS Health report, in 1999, baby boomers accounted for 52 per cent of 22 million new visits to doctors recorded in that year. In 1998, they accounted for only one-third of the 11 million new visits to doctors. In other words, it appears the first wave of the demographic bulge has hit the health care sector, resulting in the dispensing of significantly more prescriptions of vastly more expensive drugs to an increased number of patients. If left unchecked, that trend will continue to strain the health care system as the remaining portion of the baby boom bulge begins to use health services.

The IMS Health report adds that hypertension, diabetes and depression were the three leading reasons why Canadians visited doctors in 1999, accounting for 31 million of the 288 million diagnoses reported in that year. These conditions are frequently treated by prescription drugs. More information on the IMS Health report can be found on the Canadian Institute of Health Information web site at www.gdsourcing.com/works/CIHI.htm.

For plan sponsors, drug benefits and their attendant costs will continue to be a major compensation issue over the next several years as more of their employees and members born in the 1946-64 period use prescription drug services.

Your Coughlin & Associates Ltd. consultant can develop benefits programs to help your organization contain the rising cost of prescription drugs.

How old?

Many of today's social programs were developed in years when life expectancy was considerably shorter than today. In other words, the programs were never designed to be used by as many people or as long on a per capita basis as they are today.

When you compare the life expectancy of the average Canadian in the 20th century to today, is it any wonder why everything from health care budgets to government pension plans are under financial strain?

Canadian life expectancy at birth

Year	Males	Females
1920-22	59	61
1930-32	60	62
1940-42	63	66
1950-52	66	71
1960-62	68	74
1970-72	69	76
1980-82	72	79
1990-92	75	81

Source: Statistics Canada, catalogue no 82F0075XCB
For more information, see the Statistics Canada website at www.statcan.ca

September 11 attacks expected to affect plan costs

The terrorist attacks of September 11 are expected to result in increased costs for group benefit plans across the US and Canada, according to insurance industry reports.

The attacks represented the single largest catastrophic event ever faced by the insurance industry. While group life and health insurance providers were not as severely affected by claims costs as property insurance companies, their reinsurers estimate their losses at between $50 billion and $100 billion US, according to data issued by the Lloyd's of London group. Estimates by the Tillinghast-Towers Perrin group estimate losses at between $30 billion and $58 billion US.

Reinsurance is a device used by insurance companies to spread the risk associated with high volumes of insurance among several companies. While most large group policies are reinsured to some degree, property insurance policies, such as those used to cover buildings from fire and other damage, also tend to be reinsured by the same reinsurers. With property insurance claims from the attack projected to be in the tens of billions of dollars, reinsurers everywhere are setting aside funds to meet these obligations. US life and health insurers are also facing a larger than expected number of catastrophic claims, which also places strain on the reinsurance market.

With so many resources being directed to paying claims, reinsurers are likely to be less open to assuming new risks, including those associated with group benefits programs. With reduced amounts of reinsurance available, and less competition in the market, premiums for group life and health policies are expected to increase, possibly by as much as 10 to 15 per cent, according to reports. As well, these pressures may also cause insurers to rethink or re-price some of their product guarantees, the Tillinghast-Towers Perrin report suggests.

While the solvency of life insurers and their reinsurers will not likely be threatened by the results of the September 11 attacks, it is safe to assume that the insurance industry in general will adopt a more conservative posture in its risk evaluations and pricing. Ironically, in the aftermath of the September 11 disaster, this will occur at a time when many insurers are reporting increased sales activity, thanks largely to greater consumer awareness of the need to have adequate insurance coverage.

With increased product demand and reduced capacity, price increases appear inevitable.

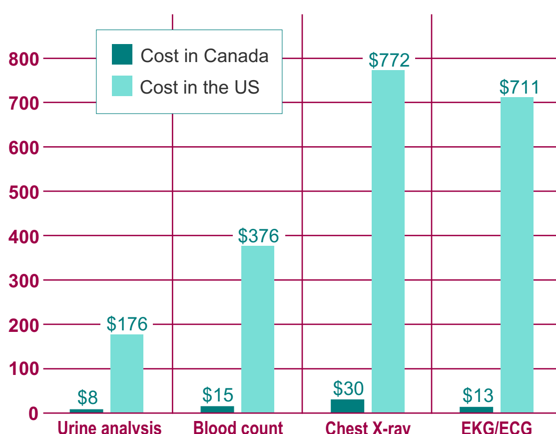
More information on these developments will be provided as it becomes available.

US medical costs

make travel assistance necessary

Travelling to the United States is almost always an experience to remember. However, without out-of-country emergency medical coverage, a trip south of the border could end up costing tens, even hundreds of thousands of dollars if an employee or plan member is hospitalized.

Following are some cost comparisons between the United States and Canada for the following medical tests, courtesy of Global Excel Management:



Source: Global Excel Management Inc., June 2001.

Major medical procedures can also be surprisingly high. For example:

Procedure	Days in hospital	US hospitals' billed charges ($ CDN)
Coronary by-pass surgery	10	$323,745
Angioplasty	3	$135,465
Stroke	5	$74,564
Pneumonia	6	$64,548
Gastro-intestinal bleed	5	$59,424
Urinary tract infection	5	$47,816

Source: Average of billed charges from US hospitals in Arizona, California, Florida and Nevada in years 2000 and 2001.

Assumed exchange rate: $1 US = $1.55.

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With US medical costs so high compared to those of Canada, having an out-of-country emergency travel assistance program as part of your benefit plan only makes sense. Contact your Coughlin & Associates Ltd. consultant for more information about out-of-country group coverage.