Private Payers

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Institute for Health Economics Symposium
Biologic and Biosimilar Therapies
The Future of Biologic and Biosimilar Therapies
for the Management of Rheumatoid Arthritis
in Alberta Health Care

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The Westin Hotel, Edmonton, Alberta

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Disclosure

- I am a independent Private Health Plan Strategist and bridge the group insurance and pharmaceutical industries.
- I don’t work for a private payer or pharmaceutical company – but consult in both areas.
- My comments are based on my own observations and don’t represent any other organizations.

Overview

Objective: Outline private market and drug plan designs and pressures, including emerging trends on biologic treatments in rheumatology

1. Private vs Public Drug Plans
2. Private Market Overview
3. Drug Plan Designs
4. Private Drug Plan Cost Pressures
5. Emerging Trends
6. Deciphering the code
7. Comparing costs
8. Questions and Discussion

Private vs Public Plans

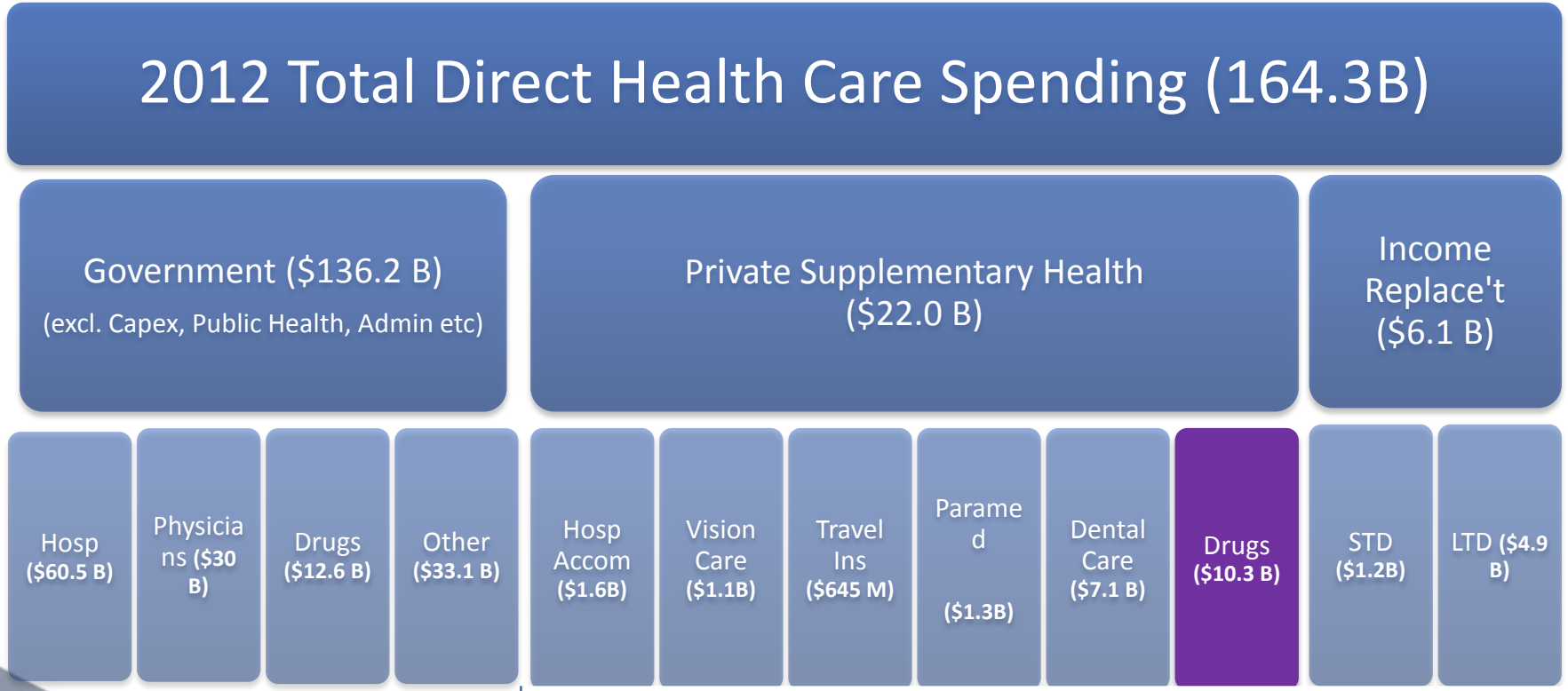
- Employers view drug coverage as part of compensation package, not for health.
- Private payers don't have the same transparency as public plans
- Confidential *"Business to Business"* transactions
- Concern about competitors gaining market intelligence

Private vs Public Plans

- Insurer's specific drug coverage decisions or criteria rarely communicated publicly
- Confidential communication targeted at their customers: Plan Advisors and Plan Sponsors
- Plan Members can access their own coverage information via insurer call centre or secure web portal

Key stakeholder in healthcare system

- Supplementary health insurance takes over where government coverage ends, and accounts for roughly 13% of total direct health care spending (17% if we include income replacement costs)



Source: CIHI, CLHIA

Drugs are just one component - employers balance all of their benefits to attract and retain employees, as well as to ensure a healthy and productive workforce

Employers pay for health benefits

1. **Premiums** based on the makeup of their group and claims experience from previous years.

2. **Pool charges** for extra risk protection for claim costs that go over a threshold e.g. $10,000 per year

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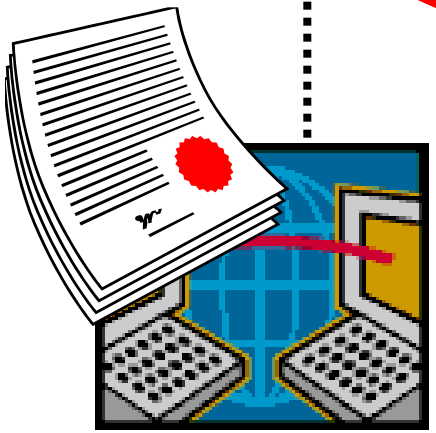
Drug Benefits are not insurance

When it comes to group drug benefit coverage, there is no real “insurance”:

1. If drug claims increase - the insurer will increase the premiums at renewal to reflect the increased costs.

2. If the volume or size of claims in the pool go up – so will the pool charges

PBM + Insurer
~8



Plan
Advisors
~3,000

Plan
Sponsors
~400-600K

Unions

Pharmacies
~8400

Plan Members
~ 19M

Distribution of Private Drug Plan Members in Alberta	
Alberta Blue Cross	45%
Sun Life	21%
Great West Life	15%
Manulife	10%
Standard Life	3%
Desjardins	1%
Green Shield	1%

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Source: TELUS Health Analytics Insurer Snap Shots 2013

Plan Sponsor Plan Design Decisions

Formulary	Frozen /Custom Formulary	Managed Formulary	Provincial	Prescription /Open	Prescribed
Co-pay	% Coinsurance	Flat co-pay	Deductible	Sliding Coinsurance	Multi tiered plans
Limits	Ther. Class Incl/excl.	Ther. Class Limits	Trial Script	Days Supply	Quantity Limits
Pricing and Maximums	Allowable Price	Generic Pricing	Annual Maximum	Lifetime Maximum	Disp Fee Caps

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Private drug plan costs

44% had health benefit rate increase[1]

Health Benefit Cost = 9.44% of payroll[1]

Private drug plan avg Rx cost down 0.73%[2]

1- Group Benefits Prescription Drug Outlook

2-Express Scripts Canada 2012 Drug Trend Report

Specialty (biologic) drugs

- 22% of drug spend
- 1.2% of claims
- Avg cost per Rx is $1,240
  [vs $46 for other drugs]
- 13.3% per year increase
  [vs 4.2% decrease for other drugs]
- 55% of new drug approvals
  64% of pipeline drugs
- Est. to be 25-30% of spend in 2017

Express Scripts Canada 2012 Drug Trend Report

Emerging Trends

Biologics and SEBs: Potential impact

1. **Case management** may require patients to try lowest cost drug. Could be SEB's prior to brand biologic medications
2. **Generic/Therapeutic substitution** may include SEB's
3. **Step Therapy** - may require patients to lowest cost drug before access to other medications Could be SEB's prior to brand biologic medications
4. **Therapeutic class pricing** – payer may reference lowest cost drug. Could be SEB price
5. **Managed formularies –** payer chooses a preferred drug as listed drug or preferred drug (higher reimbursement %). SEB could be chosen as preferred drugs over brand biologics

Deciphering the secret code….

- What is each payers criteria for biologics in RA or preferred drug?
- What is the basis for criteria or selecting preferred drug?
- How is this information shared with:
  - Plan Sponsors
  - Plan Members/Patients
  - Physicians
  - Pharmaceutical companies

Comparing costs of medications

- Cost per vial?
- Cost per treatment?
- Cost per patient (average or actual)?
- Cost per indication?
- Induction year vs. maintenance year?
- Cost per year? Over how many years?
- Adherent vs. non adherent patients?
- Cost vs benefit? Value?

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Questions and Discussion

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