A SOLUTION FOR PRIVATE DRUG PLANS

An Innovative Approach to Mitigating the Adverse Effects of High Cost and Recurring Drug Claims

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INTRODUCTION

In recent years, private drug plan sponsors[†] have been faced with a serious issue: an increase in the number of covered individuals claiming very expensive drugs for several years. The impact on private plans is significant and is even threatening their sustainability.

A large portion of these drugs is used to treat conditions like cancer, multiple sclerosis, rheumatoid arthritis and Crohn's disease. And because these drugs have been proven effective, they will not be going anywhere. In fact, there is every indication that their consumption will increase substantially over the next few years.

The reimbursement of high cost drugs by private plans is now similar to a life annuity. The similarity with long-term disability benefits is striking. These two types of risks are, however, underwritten very differently, which begs the question why.

This document aims to spark a discussion on the way in which high cost drugs reimbursed by private plans are underwritten by insurers, ensuring appropriate protection for sponsors and covered individuals.

First, we will see that the variables that determine the cost of drug insurance (frequency and severity) have changed a great deal in recent years. The concern here is the transformation of risk associated with drug insurance: the severity of a single drug claim can now exceed $500,000 per year, reaching several million dollars within a few years. This is a risk private plan sponsors are exposed to, through no fault of their own, because of developments in research and drug therapies.

The concern here is the transformation of the risk associated with drug insurance: the severity of a single drug claim can now exceed $500,000 per year.

Second, we will look at how plan sponsors are currently protected against this risk through pooling. Is pooling an effective and lasting solution?

And, finally, we will propose an alternative that could be a lasting solution to the issue of high cost drug claims: underwriting the risk associated with high cost drugs in the same way as the risk associated with long-term disability benefits is underwritten.

There is an urgent need to question the current method for underwriting this risk because it is clear that covering drugs now means covering the risk that may have the most serious consequences for private plans.

[†] In this document, the term sponsor refers to an employer, union, professional association or any other organization that offers a private drug plan to its members.

PHARMACOLOGICAL REVOLUTION

More and more drugs...

The place of drugs in the Canadian health care system has changed a great deal over the last number of years. According to the *Canadian Institute for Health Information*[1] (CIHI), an organization that collects and analyzes information on health and health care in Canada, total prescription drug spending in Canada was $8.5 billion in 1997. This total climbed to $25.9 billion in 2010, a stunning 205% increase. These figures do not include drugs administered in a hospital setting and drugs sold over the counter. In 2010, around one third of expenses were reimbursed by insurers through private drug plans.

Searching for explanations, the CIHI conducted a study[2] of the drivers of prescription drug spending in Canada between 1997 and 2007. During this period, the average annual rate of growth was 10.1%. The key drivers studied were:

- population growth;
- population aging;
- general inflation;
- price effects (including the impact of switching to the generic version of a drug whose patent has expired);
- volume effects; and
- mix of drugs.

Contrary to what one might think, the study revealed that population aging was not a significant driver of the growth in drug spending during this period. Volume effects (annual growth of 6.2%) and mix of drugs (annual growth of 2.0%) accounted for close to 80% of the growth. In other words, people are looking more and more to drugs for therapeutic treatment, and more and more drugs are available. It could also be assumed that a greater number of people are getting at the pharmacy drugs that were previously administered in a hospital setting and thus paid for directly by the public plan.

It therefore comes as no surprise that private plan sponsors witnessed a significant increase in drug claims in recent years. Moreover, sponsors for whom the covered population is aging considerably undoubtedly observed an even greater increase.

…more and more expensive!

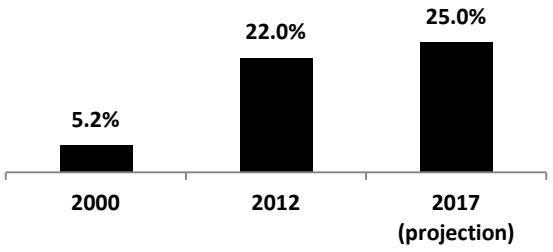
The CIHI study on drivers of prescription drug spending also revealed that drug classes associated with the treatment of common conditions such as high blood pressure, high cholesterol, ulcers and depression, grew rapidly in the 1990s and the early 2000s. This is not surprising given the arrival of several blockbuster drugs like LIPITOR, CRESTOR, NEXIUM, CIPRALEX and LYRICA, to name just a few. It should be noted that patents on these blockbuster drugs expired recently or will be expiring soon, allowing for the production of far less expensive generic equivalents.

More recently, drugs used to treat less common conditions, or specialty drugs, have posted the highest growth rate. Because these drugs are typically biological products, they are very complex to design and very expensive.

Express Scripts Canada (ESC) and *TELUS Health* (TELUS) are two large private plan drug claim adjudicators, in partnership with the major insurers in Canada. Every year, ESC and TELUS publish statistics on drug claims paid under private plans. Their findings are unequivocal.

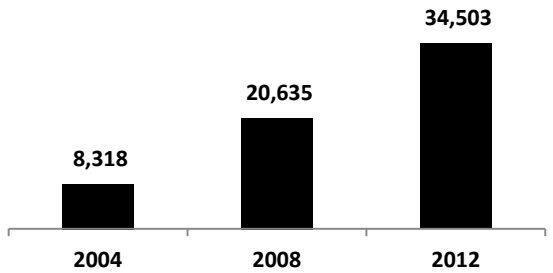
According to ESC, speciality drugs costing more than $500 per month ($6,000 per year), accounted for 5.2% of drug expenses in 2000[3]. They accounted for 22% of drug expenses in 2012, and this number could climb to between 25% and 30% in 2017[4].

Figure 1 - Percentage of specialty drugs in private drug plans in Canada according to ESC (> $6,000 per year)



According to TELUS[5], the number of certificates[‡] claiming more than $10,000 per year in drugs grew by close to 20% per year in Canada between 2004 and 2012. REMICADE and HUMIRA, two drugs used to treat conditions such as rheumatoid arthritis, were ranked number one and number three respectively on the list of the most expensive drugs used by TELUS clients. These drugs cost tens of thousands of dollars per patient and are administered for several years.

Figure 2 - Number of certificates claiming more than $10,000 per year - TELUS clients



It is becoming clear that the emergence of high cost drugs has changed the face of drug insurance in Canada.

In 2012, *Medical Billing and Coding* listed[6] the 11 most expensive drugs in the United States. The annual cost of all of these drugs exceeded $200,000 per year. To date, six of these drugs have been approved by *Health Canada*. SOLIRIS made the top of this list with an annual recurring cost exceeding $400,000. This drug is used to treat patients with Paroxysmal Nocturnal Hemoglobinuria (PNH), a disorder that destroys red blood cells. Claims for SOLIRIS have already been incurred under private plans in Canada and some claims have exceeded $500,000 per year. Although these drugs are not frequently used, the severity of this type of claim could jeopardize a private plan that does not have adequate safeguards in place.

Table 1 – The 11 most expensive drugs in the United States according to *Medical Billing & Coding*

Drug	Annual cost	Approved by Health Canada*
SOLIRIS	$409,500	√
ELAPRASE	$375,000	√
NAGLAZYME	$365,000	-
CINRYZE	$350,000	-
ACTH	$300,000	-
FOLOTYN	$30,000 / month	-
MYOZYME	$300,000	√
ARCALYST	$250,000	-
CEREZYME	$200,000	√
FABRAZYME	$200,000	√
ALDURAZYME	$200,000	√

* According to the Health Canada Drug Product Database.

[‡] Covered employee and dependents.

What is the impact of a recurring high cost drug claim?

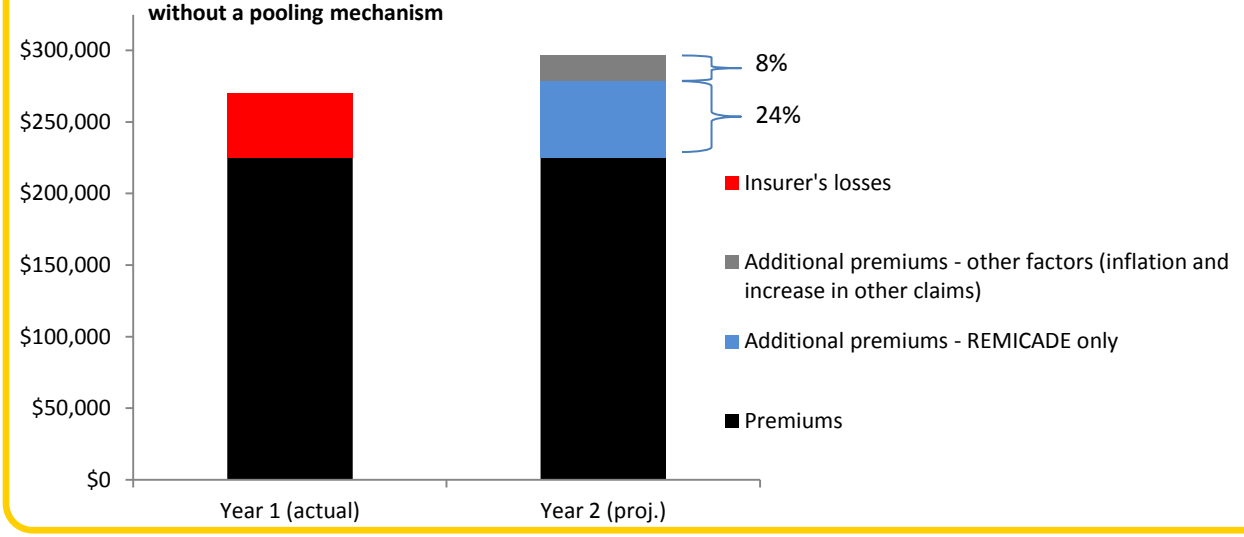
First, it should be noted that the premium required by the insurer is generally adjusted annually when pricing is renewed. This adjustment depends on several variables, but essentially on the experience of the covered group, or past claims paid, as this remains the best indicator of future claims. A high cost drug claim therefore directly impacts the premium charged.

Let's look at the example of an organization with 150 employees and an annual health care premium (including drug coverage) of around $225,000. An employee submits a $45,000 claim for REMICADE. Figure 3 illustrates the impact of this type of claim, assuming that the employer's premium was adequate before this claim was incurred. For now, we will assume that no pooling mechanism is in place.

When the claim is incurred, in year 1, the insurer absorbs a loss of $45,000, which far exceeds its profit margin. Because REMICADE is administered over several years, in year 2, the insurer will require that the premium be adjusted accordingly. The premium would increase by 24%, to cover only this claim. The increase would also take into account inflation (assumption of 8%) and fees charged by the insurer (assumption of 10%) on this claim.

By adding the additional premiums normally required in year 2 to take into account inflation and an increase in other claims (assumption of 8%), the increase would reach 32%. The employer would thus need to choose to either absorb the increase with the current insurer or do a request for proposals to try to find a better offer. However, other insurers would likely demand a similar increase because of the recurring REMICADE claim. This situation would put considerable pressure on this employer's plan costs, which could ultimately cause the employer to terminate the plan. It is easy to imagine the increase that would be required if several recurring high cost drug claims were incurred or if the drug cost $200,000 instead of $45,000.

Figure 3 - Example of the impact of a recurring claim for the drug REMICADE with an annual cost of $45,000 at an employer with 150 employees whose plan is underwritten on a fully insured basis - without a pooling mechanism



Sponsors that are committed to offering a private drug plan suddenly find themselves in a position of assuming more risk. A single claim can threaten a plan's sustainability. It is thus becoming difficult to anticipate and stabilize costs. Small and medium sized businesses that offer a private drug plan to their employees are especially vulnerable.

And there is every reason to believe that this situation will become a major trend because of two key factors: the large number of biological drugs that will soon be hitting the market and the pressure from organizations that advocate for patients suffering from certain conditions who are pushing for the reimbursement of specialty drugs by private and public plans.

We, as an industry, need to reflect on and discuss this issue. How can we adjust to this new risk and better protect plan sponsors and their covered individuals? Some mechanisms have been implemented, but will they be adequate, effective and lasting solutions?

POOLING

To address the risk presented by high cost and recurring drug claims, the industry has put in place pooling mechanisms. Under a pooling arrangement, when a high cost claim is incurred at a plan sponsor, the insurer distributes the portion of the cost that exceeds a pre-established threshold (for example, $25,000) among a portion of or all of its clients. In theory, pooling protects sponsors by making them responsible for only a portion of the claim.

Pooling parameters established by the sponsor and the insurer depend primarily on the size and risk tolerance of the sponsor and the insurer. A pooling premium is also charged to fund the mechanism.

Following the principle of pooling, insurers can also share among themselves the portion of the cost that exceeds a pre-established threshold. This helps to protect insurers that have a large number of high cost claims.

Pooling in Quebec

In Quebec, drug pooling has been partially regulated since 1997. Under section 43 of the *Act respecting prescription drug insurance*, insurers and other drug claim payers must pool the risks associated with the drug plans that they administer. To comply with this act, the industry created the *Quebec Drug Insurance Pooling Corporation* (the Pooling Corporation).[7] Each year, the Pooling Corporation establishes the pooling thresholds and factors used to determine what insurers and other drug claim payers will be required to pay to benefit from the pooling system. The terms and conditions are then submitted to the Health Minister.

Since 1997, pooling thresholds and annual factors have varied by group size. For 2013, all groups with fewer than 3,000 employees are targeted, regardless of the underwriting method used. Insurers and other drug claim payers are required to apply these thresholds as minimum thresholds.

Terms and conditions are established annually based on the experience of the entire Quebec market. This gives credibility to the information collected on claims, providing a clear indication of the risk that high cost drug claims may represent. In 2013, thresholds ranged from $5,100 for groups with fewer than 25 certificates to $100,000 for groups with 1,000 to 2,999 certificates. When claims exceeding the thresholds established by the Pooling Corporation for each group size are incurred, the expense is shared among all insurers and other claims payers.

A sponsor may negotiate a threshold lower than the threshold recommended by the Pooling Corporation, in an effort to better control plan costs. The portion of the claim between the threshold chosen by the sponsor and the Pooling Corporation's threshold is taken on by the insurer.

Even though the thresholds established by the Pooling Corporations are tailored to the size of the group and aim to mitigate the impact of a high cost claim, these thresholds remain high. To manage plan costs according to their capacity to assume risk, many sponsors have thus opted to apply thresholds that are lower than those recommended by the Pooling Corporation.

Ever since the frequency of high cost and recurring drug claims has increased, insurers have been putting pressure on sponsors to comply with the thresholds recommended by the Pooling Corporation by increasing pooling premiums, refusing to apply the lower threshold for recurring claims or refusing to apply a threshold lower than the threshold recommended by the Pooling Corporation. More and more, sponsors are being forced to apply the thresholds recommended by the Pooling Corporation despite their risk tolerance.

Pooling in Canada

On January 1, 2013, the *Canadian Life and Health Insurance Association (CLHIA)* reached an agreement[8] with Canadian insurers to protect drug coverage in Canada by establishing a system for pooling claims among insurers. Before this date, although pooling was a common practice, no official framework existed.

Under this agreement, for fully insured groups, insurers are required to administer internal pools that must include all prescription drug claims exceeding a maximum amount ($25,000 for 2013), while adhering to certain minimum standards. With the exception of these standards, each insurer is free to adjust its internal pools, which are delivered to the competition.

Minimum standards are established to prevent an insurer from requiring a sponsor to pay a premium that is based on the number or the value of its drug claims. The insurer must establish a sponsor's premiums without taking into account the number or value of the sponsor's claims that are subject to pooling. An insurer that submits a bid for a group that has claims exceeding the threshold must also establish the premiums without taking these claims into account.

Insurers have also agreed on a form of reinsurance by implementing a pooling mechanism that allows them to share high cost drug claim expenses among themselves. For the claim to qualify for pooling, it must exceed the pre-established threshold of $50,000 for two years. If that is the case, 85% of the amount exceeding $25,000 will be subject to pooling, up to a maximum of $400,000. These are the parameters that have been established for 2013. They will be reviewed periodically.

This agreement shows that the industry is aware of the issue related to high cost and recurring drug claims and that it is taking strides to mitigate the impacts for private plans and insurers. However, the agreement contains some provisions that could impair its scope.

On the one hand, the agreement does not target all sponsors, only those for which the contract is underwritten on a fully insured basis. Groups underwritten on a retention basis (risk sharing agreement) or on an uninsured basis (administrative services only) are not targeted by the agreement.

On the other hand, the maximum threshold of $25,000 for 2013 remains high and the impact of the first $25,000 may be significant for the sponsor. The impact will vary depending on the size of the group; however, it will continue to be difficult for plan sponsors to anticipate and stabilize costs. The CLHIA is already planning to raise this threshold to $27,500 in 2014 and to $30,000 in 2015.

The agreement gives insurers, who must be legitimately profitable, a great deal of latitude. Insurers are free to adjust all aspects of the internal pools. It should be noted that the insurer absorbs a substantial financial loss when the cost of a high cost drug claim cannot be shared with other insurers. This is the case for a drug whose cost falls between the threshold for the internal pool (maximum of $25,000 for 2013) and the threshold for pooling among insurers ($50,000 for 2013). This amount can represent a sizeable portion of profits and create pressure on the group's profitability, forcing the insurer to recover its losses using different means.

Even though the agreement stipulates that an insurer cannot take into account recurring drug claims exceeding the threshold for the internal pool, it will be difficult to ensure that this does not affect its overall offer. For example, in a request for proposals process, insurers could decide not to submit a bid because of high cost drug claims, without however stating this reason. Insurers could also use factors such as high inflation, high reserves, high administration fees, etc. to submit pricing that transfers the cost of these drugs to the sponsor while complying with the minimum standards of the pooling agreement. Other types of insurance coverage could be directly impacted (e.g.: higher life and disability insurance premiums) to offset the losses linked to high cost drug claims. Who will be responsible for ensuring compliance with minimum standards and ensuring that no discrimination occurs?

In closing, insurers are not obligated to participate in the pooling agreement. They do so in good faith, on a voluntary basis. Some insurers could eventually decide to no longer participate in the agreement.

Is pooling an effective and lasting solution?

The concept of pooling has been around for a long time and, as Figure 4 illustrates, it allows for the effects of high cost drug claims to be mitigated. Going back to our previous example, but this time including a pooling mechanism with a $25,000 threshold, a standard level for a group of this size, the premium increase is reduced from 32% to 20%. We assume that a pooling premium of 5% of premiums must be included. Although pooling reduces the premium increase, this increase remains substantial.

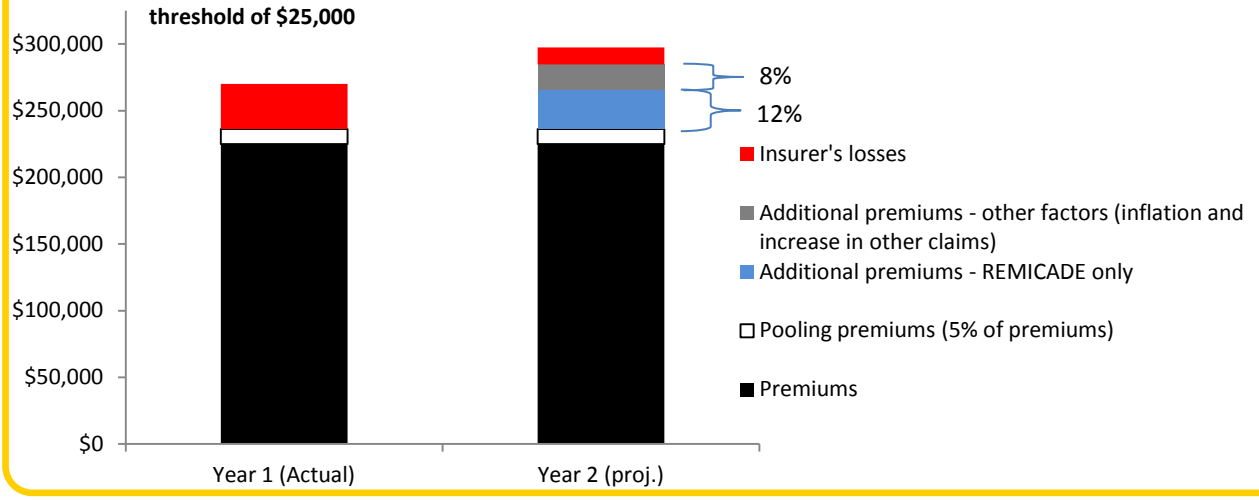
The risk associated with drug insurance has changed dramatically over the last ten years, with the considerable increase in the number of high cost drugs and the severity of the impact that a high cost drug claim can have. Will pooling be the solution for adequately protecting all private plan sponsors?

Pooling could certainly be a more effective and lasting solution if some fundamental improvements are made. In particular, the pooling threshold should be lowered considerably to limit the amount paid by the sponsor and help the sponsor better anticipate and stabilize costs. Applying this same threshold for the pooling of costs among insurers would prevent a single insurer from bearing recurring financial losses, thereby preventing sponsors with an abnormally high proportion of high cost drugs from being adversely affected. Several other aspects of pooling would also need to be reviewed.

In its *Report on Prescription Drug Policy*[9] published in June 2013, the CLHIA recommended developing a high cost drug strategy, acknowledging that the new national pooling agreement is a step in the right direction, but that the industry could do more.

We also need to look to new solutions that could either replace or complement pooling.

Figure 4 -Example of the impact of a recurring REMICADE claim with an annual cost of $45,000 at an employer with 150 employees and whose plan is inderwritten on a fully insured basis - pooling threshold of $25,000



A NEW APPROACH

Should the risk associated with high cost drugs be underwritten in the same way as the risk associated with long-term disability benefits? This new approach warrants careful consideration as it may very well be an effective and lasting solution to the high cost and recurring drug claims issue plaguing private plans.

Currently, when a covered individual claims a high cost drug for several years, the claim is payable by the insurer as long as the contract is in effect. When there is a change of insurer, the new insurer becomes responsible for the benefits payments. And if the plan sponsor decides to terminate the plan, the covered individual will no longer be reimbursed for the drug[§]. The insurer's risk does not extend beyond the contract period, which is not the case for long-term disability benefits. Does the fact that high cost drugs and long-term disability benefits are underwritten differently reveal some inconsistencies in our industry?

Does the fact that high cost drugs and long-term disability benefits are underwritten differently reveal some inconsistencies in our industry?

Insurance products provide for the payment of a benefit when an unexpected event occurs, in exchange for payment of a premium. In the case of a covered individual requiring high cost drugs for several years, the event is the prescription written by the doctor in relation to the diagnosis. Consequently, when the unexpected event occurs, the current insurer would be required to reimburse the drug, even after the contract has ended. This is how long-term disability coverage is designed and how high cost drug insurance could be designed. These two types of insurance coverage underwrite a risk that may entitle a covered individual to tens of thousands of dollars in annual benefits for several years.

More specifically, high cost drugs would be covered under a separate type of insurance that would have its own contractual provisions and pricing. This coverage would no longer be included in the health care plan, as is currently the case. A dynamic list of high cost drugs would need to be established. When an event entitling the covered individual to a benefit occurs (the prescription), the current insurer would pay the claims for as long as necessary. If the contract is terminated, the insurer would continue to be responsible for paying and managing the claim.

This new approach for underwriting the risk associated with high cost drugs would offer private plan sponsors many benefits, including better control of insurance costs, greater ease when changing insurers, more active high cost drug claim management and a healthy employer-employee relationship.

[§] Depending on the public plan in effect, the individual could be reimbursed in accordance with the applicable rules and conditions.

Better control of insurance costs

As we saw earlier, when a high cost and recurring drug claim is incurred, this claim has a sharp impact on the group's drug insurance premium. We saw that, in spite of the pooling mechanism, a $45,000 REMICADE claim can, by itself, generate an increase of 12% for an employer with 150 employees (Figure 4). This is because the adjustment essentially depends on the group's own experience and the first $25,000 of the claim is included in the group's experience, requiring a corresponding adjustment in the annual premium for the next year. Moreover, unless the portion exceeding the threshold is shared with other insurers, a claim can result in a substantial financial loss that forces the insurer to increase other financial aspects of the contract. In this case, it is the employer that indirectly absorbs the full impact of the claim.

By underwriting high cost drug plans the same way that long-term disability benefits are underwritten, the group's experience would be subject to credibility. The credibility level determines whether or not the group's experience will influence the premium rate. There is already reason to believe that no credibility would be assigned to experience for small groups such as the one used in the example. The number and value of high cost drugs would therefore no longer impact the premium. The premium would be established based on the insurer's entire portfolio, thereby ensuring more stable premium rates for all types of health care coverage.

As is the case for long-term disability, when a group reaches a certain size, its experience could influence the premium rate, based on the determined credibility level. Because high cost drug claims are infrequent and may exceed the cost of long-term disability benefits, a large number of covered individuals would no doubt be needed for the group's experience to be considered fully credible, especially since reserves could reach massive amounts. There is reason to believe that the number of life years[**] required for the experience to be fully credible would be higher than that for long-term disability insurance.

In summary, this new approach would stabilize drug insurance premiums by using the experience of the entire portfolio to determine pricing, thereby pooling the risk among all sponsors. This would be especially true for smaller sponsors that have a greater risk of strong fluctuations, because the experience of these groups would no longer be used to determine the premium rates. This would ensure greater stability than that provided by the current pooling mechanisms.

Just as with long-term disability insurance, premiums could be adjusted annually according to different factors: experience of the insurer's entire portfolio, demographic changes in the group itself, the arrival of new drugs, etc. Actuaries will need to come up with a model for determining pricing and subsequent adjustments required.

[**] One year of experience for a covered individual.

Changing insurers with greater ease

Sponsors that have covered individuals claiming high cost drugs on a recurring basis may currently have difficulty finding an insurer that offers good financial conditions. If the impact of high cost drug claims is substantial, insurers may even refuse to underwrite the group. We have noticed that more and more insurers are refusing to submit an insurance bid or are submitting financial conditions that penalize a sponsor that has recurring high cost drug claims. In theory, the pooling framework developed by the Pooling Corporation and the CLHIA's new agreement will reduce this type of occurrence; however, their effectiveness, in all circumstances, remains to be demonstrated.

By extending the insurer's responsibility beyond the contract period, the insurer would continue to be responsible for benefits payments even if the contract has been terminated. Insurers asked to submit bids would therefore no longer take over these benefits payments, and sponsors would no longer be adversely affected on account of these claims. This is the method adopted by insurers for long-term disability insurance coverage.

More active claims management

Insurers are becoming increasingly more aware that high cost drug claims need to be managed more stringently. They are taking concrete measures to improve management of these claims, either by revising their list of drugs requiring pre-approval, working with pharmacists on case management, reviewing reimbursement procedures, or through other initiatives.

Insurers would need to develop better high cost drug management practices, which would contribute to reducing their costs.

Because the insurer would now be responsible for paying the claim beyond the contract period and because the group's pricing would no longer be directly adjusted when a high cost drug claim is incurred, the insurer would assume all of the financial risk associated with a claim. It would thus be in the insurer's best interest to actively manage the claim. Insurers would need to develop better high cost drug management practices, which would contribute to reducing their costs while maintaining adequate drug treatments.

Healthy employer-employee relations

In spite of the discipline exercised to comply with confidentiality standards, through no fault of the insurer, an employer may learn or "guess" the identity of an employee (or employee's family member) that has high drug claims. This puts the employer in a tricky situation and could become worrisome for the employee.

If the employee is terminated, his or her claims are removed from the experience and the premium charged by the insurer is reduced, sometimes considerably. This is not the case for employees receiving long-term disability benefits. Like it or not, this could open the door to terminations whose real reason, although not mentioned, would be the taking of high cost drugs by an employee or a member of his or her family. This situation could result in lawsuits.

Under the proposed approach, the insurer would continue to pay the claim even after employment has been terminated, which would help ensure healthy employer-employee relations. Employees who claim high cost drugs would no longer need to worry about keeping their job or their coverage and employers would be safe from related lawsuits, whether they are with or without merit.

An industry that is making strides!

Finally, sponsors would no longer need to worry about the risk of an employee claiming a high cost drug for several years to prolong his or her life or improve his or her quality of life. The risk would be shared with all plan sponsors, as is the case for long-term disability insurance coverage.

This is a unique opportunity for insurers to develop a new product that meets a real need of private plan sponsors and their covered individuals.

Actuaries would need to develop a methodology and assumptions for this new insurance product so as to determine the applicable pricing. In particular, factors for establishing necessary reserves and credibility would need to be identified. The *Canadian Institute of Actuaries* (CIA) could establish related guidelines.

Insurers should be informed of new drugs hitting the market because these drugs could increase or decrease pricing. A committee could be formed to assess the relevance of adding or removing a high cost drug from the list of covered drugs. This committee could be similar to the *Institut national d'excellence en santé et en services sociaux's* (INESSS) *Comité scientifique d'évaluation des médicaments aux fins d'inscription* (CSEMI) that determines the drugs covered by Quebec's public drug insurance plan.

Contractual provisions would need to be established. Some could come from long-term disability insurance, critical illness insurance and long-term care insurance. The CLHIA could help define the rules applicable to a change in insurers, changes in drugs, termination of coverage, pre-existing conditions, etc.

The proposed change is significant as it targets the way in which high cost drug plans are underwritten. A number of technical, administrative and legal challenges are associated with this change. However, this is a unique opportunity for insurers to develop a new product that meets a real need of private plan sponsors and their covered individuals.

CONCLUSION

The emergence of high cost drugs is creating unprecedented pressure for plan sponsors that offer drug insurance to their members. The pressure varies considerably from province to province. In Quebec, it is especially strong because the *Act respecting prescription drug insurance* forces sponsors to cover a certain number of drugs. This is why the Pooling Corporation plays an important role in the pooling of risk. In British Columbia, there is less pressure because sponsors are protected by a public plan that assumes the cost of drugs exceeding a relatively low threshold based on each individual's income.

In most cases, drugs account for 30% to 40% of the total cost of the group insurance plan. Should sponsors continue to offer drug coverage to their members? Should members have access to high cost drug treatments? The answer is clearly yes because high cost drugs are proven therapeutic treatments and now represent the greatest financial risk ever seen in the health care industry. Coverage for this risk goes hand in hand with the fundamentals of insurance.

Insurance is based on a universal principle: risk sharing. Group insurance is a method used by sponsors to share risk among plan members and also with other sponsors.

More and more, group insurance is presented as a form of compensation encompassing several different types of health care that do not present any real financial risk (glasses, dental check-ups, massage therapy, etc.). The advantages are undeniable: economies of scale, tax benefits, prevention, productivity, engagement, etc. It is important to not lose sight of the fact that the primary goal is to protect individuals in case of an event that has catastrophic financial consequences, such as the need to take high cost drugs. There is no better example to highlight the value of insurance. However, the financial impact of these drugs on private plans is threatening the sustainability of these plans. In 2002, as part of the *Romanow Commission*, the government examined the option of covering these drugs through a national high cost drug plan; however, this did not lead to anything.

The life expectancy of private drug plans is no longer what it once was. The industry needs to get to work quickly to come up with a solution that will ensure the sustainability of these plans.

Experts must examine this issue now. The proposed approach in this document merits reflection and discussion. Whether or not it is ultimately adopted by our industry, discussions will most definitely generate constructive ideas.

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