The End of an Era

• 2011 – 2014 was the greatest era in recent memory for private plan sponsors in terms of passive cost containment within drug plan benefit

• Generic pricing reforms and a wave of patent expirations shielded plans from cost, helped offset impact of specialty therapies

• 2015 – 2018 will be a completely different picture
2014 was the Year of Inversion: Plans covering Canada’s workforce now spend more on specialty drugs than on all generics combined.

Source: Cubic Health Canadian Drug Database, 2015
A lack of adoption appropriate plan designs in the private payer marketplace will have a profoundly negative impact on containing costs moving forward.

In addition, the growing cost of catastrophic claims insurance (stop-loss) will put additional pressure on affordability of existing plans.

There are substantial future financial liabilities that have not been considered by a majority of plans which will further impact plan affordability.
## Growth of Specialty Burden

### % of Plan Spending for Specialty Drugs

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Plans</strong></td>
<td>15.9</td>
<td>18.1</td>
<td>20.4</td>
<td>22.6</td>
<td>25.7</td>
</tr>
<tr>
<td><strong>Retiree Plans</strong></td>
<td>8.2</td>
<td>9.5</td>
<td>10.8</td>
<td>11.6</td>
<td>13.0</td>
</tr>
</tbody>
</table>

Source: Cubic Health Canadian Drug Database, 2015
Plan has current stop-loss threshold at $15,000

- Coverage carries a **current premium of 13.9%**, Carrier wants an increase to 18.25% at renewal
- Carrier B quoting on business wants 7% premium
- Carrier C wants 9.9% premium
- Carrier D wants 10.8% premium

**How does same risk and same stop-loss point warrant such significant discrepancies?**
The inflation of stop-loss premiums will be a significant issue for all ASO plans moving forward.

Example of what 3 separate plans have seen over the last 3 years at different thresholds:

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000</td>
<td>8.6%</td>
<td>9%</td>
<td>12.5%</td>
</tr>
<tr>
<td>$15,000</td>
<td>4.75%</td>
<td>8.75%</td>
<td>9.4%</td>
</tr>
<tr>
<td>$20,000</td>
<td>6.4%</td>
<td>7.3%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>
Whereas public plans have the ability to impact reimbursement of ingredient costs with fixed mark-ups, PLIs, and other arrangements, private payers traditionally have not had access to same.

Example of the wide variation in what private plans paid for specialty drugs in 2014:

- **Remicade**: MLP + 3% to MLP + 17.1%
- **Enbrel**: MLP + 3% to MLP + 16.5%
- **Humira**: MLP + 3% to MLP + 16.7%
### Future (Financial) Risk Profiles

<table>
<thead>
<tr>
<th>PLAN</th>
<th>Age-Related Chronic Conditions</th>
<th>Specialty - Chronic</th>
<th>Total Recurring Annual Future Risk</th>
<th>Recurring Annual Future Risk as % of Current Plan Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Conversion of Existing Claimants</td>
<td>Addition of New Claimants</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>$68,217</td>
<td>$236,405</td>
<td>$410,273</td>
<td>$714,895</td>
</tr>
<tr>
<td>B</td>
<td>$105,000</td>
<td>$193,166</td>
<td>$190,866</td>
<td>$489,032</td>
</tr>
<tr>
<td>C</td>
<td>$22,326</td>
<td>$242,712</td>
<td>$301,424</td>
<td>$566,462</td>
</tr>
</tbody>
</table>

How affordable will plans be moving forward if they have to deal with this degree of annual cost increase due to chronic, recurring therapies only?
The Future

• Plan designs will have to change – dramatically

• Service providers and members will be held more accountable

• There will be a need to consider appropriate cost offsets for plan sponsors through integration of drug & disability data sets
Mike Sullivan, RPh, BSP, MBA
President
msullivan@cubic.ca
@cubichealth
www.cubic.ca