Canadian Drug Insurance Pooling Corporation

High cost drug pooling landscape: Why, what, how, outcomes, challenges & opportunities

For CPBI Saskatchewan and Alberta

November 2019

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Hello!

The journey today

- High cost drugs – **why** we care
  - The pipeline
  - The drug cost environment
- **What** & **how** strategies to manage, pooling, & CDIPC.
- **Outcomes** thus far.
- **Challenges** and opportunities.
-  predictions.

The pharma pipeline
[the driver of “why”]

Preamble

- The issue is how to pay for and who pays for these drugs.
- There is no debate new specialty (high cost) drugs bring significant benefit Canadians.
  - Disease state elimination or cure …some examples:

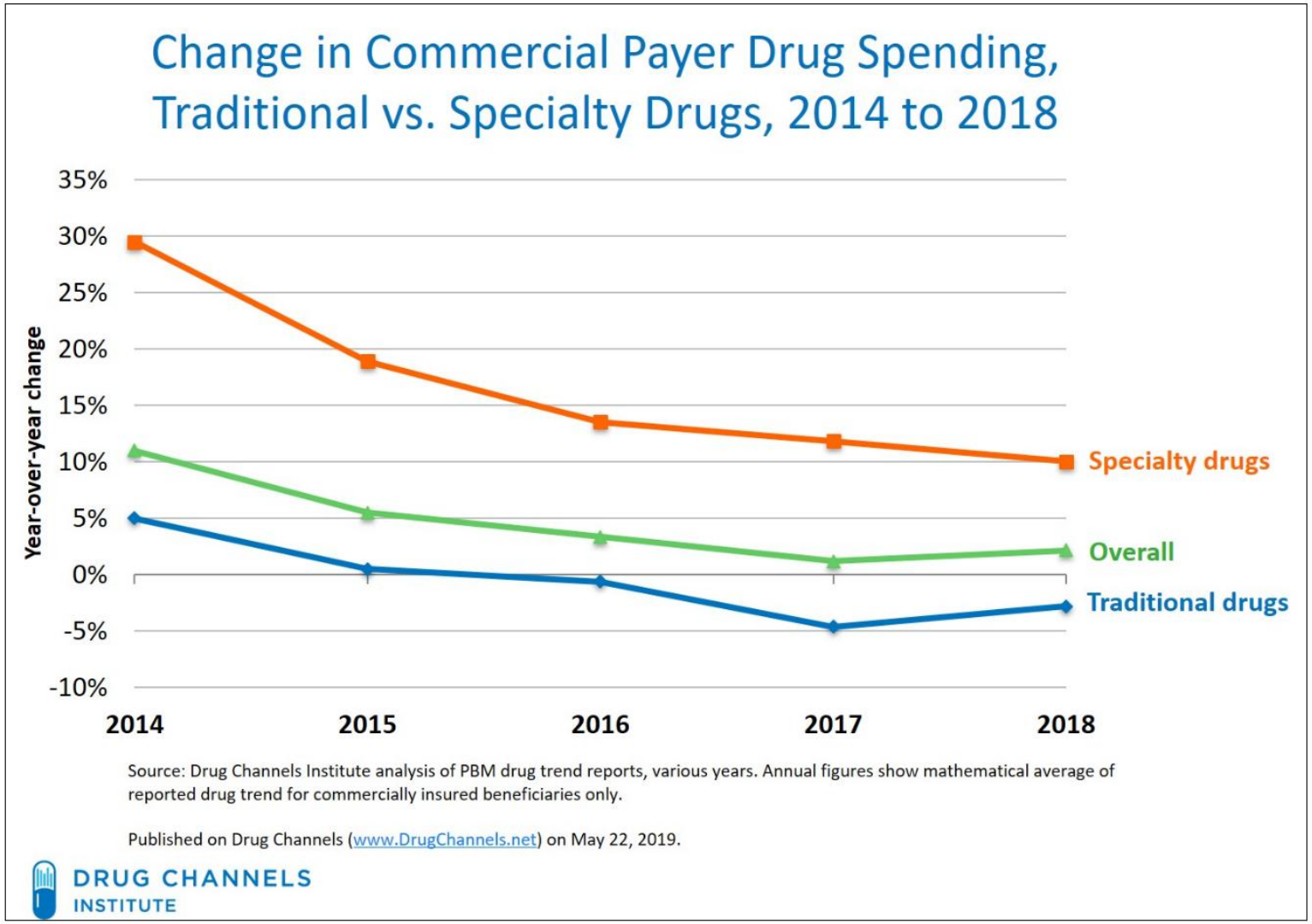
Disease state cured	Hepatitis C
Disease state eliminated or in remission	Various cancers, rheumatoid arthritis, psoriatic arthritis, ulcerative colitis, Crohn's disease, and ankylosing spondylitis
Disease state diminished	Various Cystic Fibrosis treatments, dermatology treatments, growth hormone deficiencies

  - Better drug adherence (specialty compounding)
- Hence the significant & justified growth in drug advocacy nationally and globally by patient groups and disease associations

“Specialty drugs”

- Many definitions. Often oriented to serve the point of the author.
- Wikipedia:
  - Specialty drugs are a recent designation of pharmaceuticals that are classified as high-cost, high complexity and/or high touch.
  - Specialty drugs are often biologics drugs (ie: not chemical based / traditional) “derived from living cells" that are injectable or infused (although some are oral medications).
  - They are used to treat complex or rare chronic conditions such as cancer, rheumatoid arthritis, hemophilia, H.I.V. (but not exclusively), psoriasis, inflammatory bowel disease (ex: Remicade), hepatitis C., and cancer.
  - Drugs are often defined as specialty because their price is much higher than that of non-specialty drugs.
  - They include a subset of drugs called “orphan” or “rare disease” drugs.

The big picture



Specialty drug experience from CPIPC sponsors in ep3 pooling

Year drug's claim experience begins	Reporting threshold *(certs with drugs paid from threshold onward)*	Occurrence yr	# new drugs continueing from originating yr	# certificates w/new drugs from originating yr
2013	$25K	2013	36	59
		2014	19	54
		2015	15	49
		2016	15	50
		2017	10	55
		2018	10	40
2014	$27.5K	2014	21	331
		2015	12	653
		2016	11	302
		2017	10	133
		2018	10	70
2015	$30K	2015	27	74
		2016	15	73
		2017	14	54
		2018	10	54
2016	$10K	2016	29	111
		2017	18	336
		2018	16	264
2017	$10K	2017	22	39
		2018	19	90
2018	$10K	2018	20	56

In 2013, there were 36 new drugs introduced to ep3 pooling for 59 plan members

Significant portion related to Hep C treatment

In 2014, 19 of the 36 drugs were still pooled and used by 54 plan members.

Some Hep C drugs

Confusion on “orphan” or “rare disease” drugs

- No standard definition for “orphan” or “rare disease”.
  - Health Canada suggests 2-3% of Canadians have a “rare disease”. Children have a significantly higher incidence rate (representing 50% of the total population). *1
- These drugs tend to be the most expensive drugs, partly due to very few people globally having the disease, and the need to recoup for pharma companies to recoup development costs. *1
- Pharma companies, especially those focused on rare disease state drugs state “rare disease drugs” are very small part of the drug spend in Canada.
  - 1.5-2.5% has been quoted by pharma reps.
  - But, it is difficult to find independent supporting data (partly because what drugs are represented vary). In this context, “small part” is arguably true, but a small piece, and perhaps distracting, from the overall high cost drug picture.

*1 – House of Commons report: CANADIANS AFFECTED BY RARE DISEASES AND DISORDERS: IMPROVING ACCESS TO TREATMENT (Feb 2019)
https://www.ourcommons.ca/Content/Committee/421/HESA/Reports/RP10349306/hesarp22/hesarp22-e.pdf

“orphan” or “rare disease” drugs - *continued*

- Rare disease drugs are a **segment** of the high cost drug space.
  - Example: Remicade (Imfliximab) and it’s biosimilar equivalents
    - Debated as being a “rare disease” drug since it is used for more than one indication. As such, Remicade is often excluded from high cost drug discussions focusing on “rare diseases”.
    - Yet by far, it is #1 in specialty drugs costing more than $10K/year per certificate.
    - Claims from CDIPC member companies for Remicade in 2018 totaled $85M (15%) of total drugs paid when greater than $10K per certificate.

Key issue:

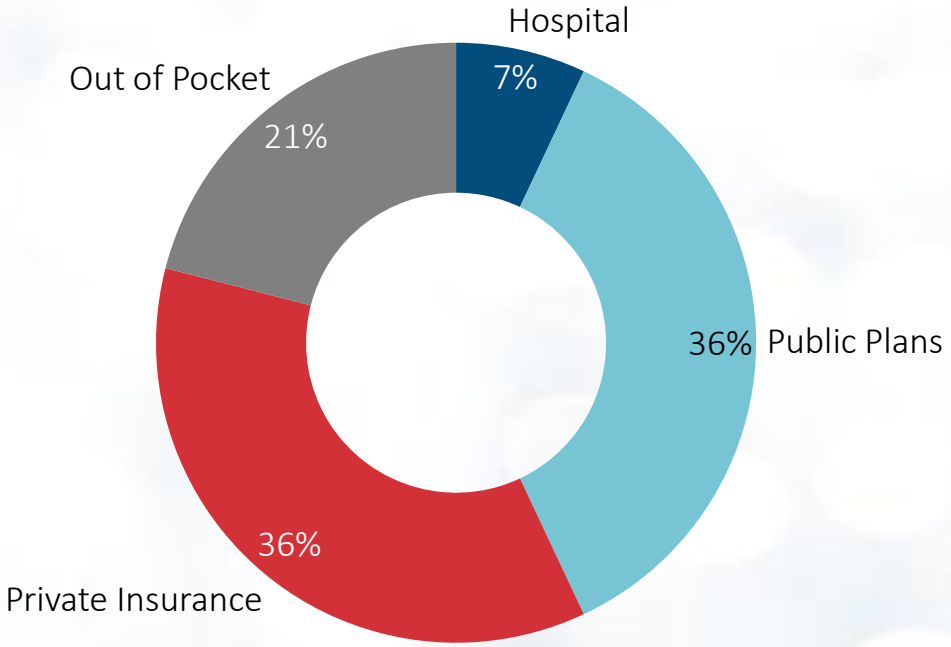
- Consider: From a plan member drug plan funding perspective does “rare disease” even matter?

Environment:
Why the concern & need for pooling?
#'s tell the story

The drug market spend

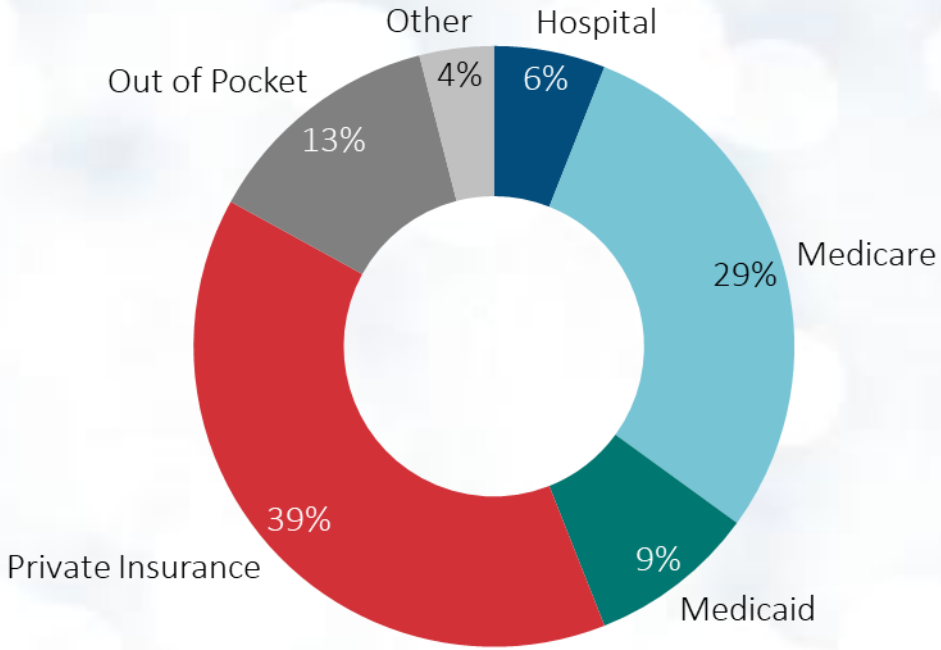
2018 Canada Rx Drug Spend

Breakdown of $33.7 Billions CAD



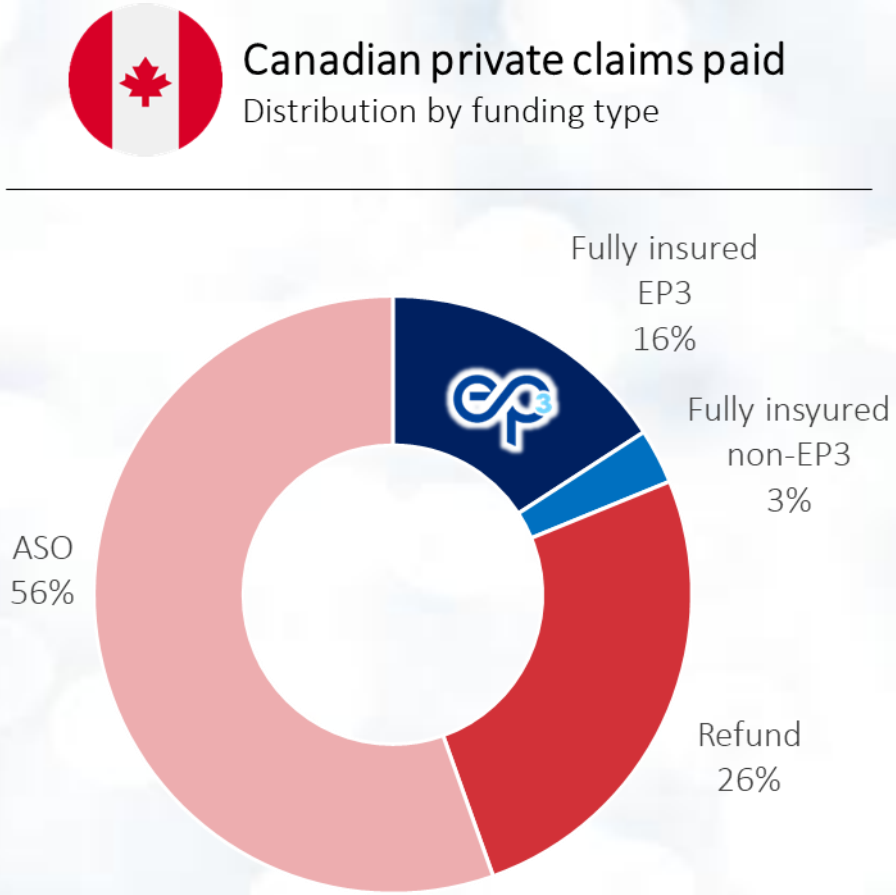
2018 US Rx Drug Spend

Breakdown of $470.5 Billions CAD



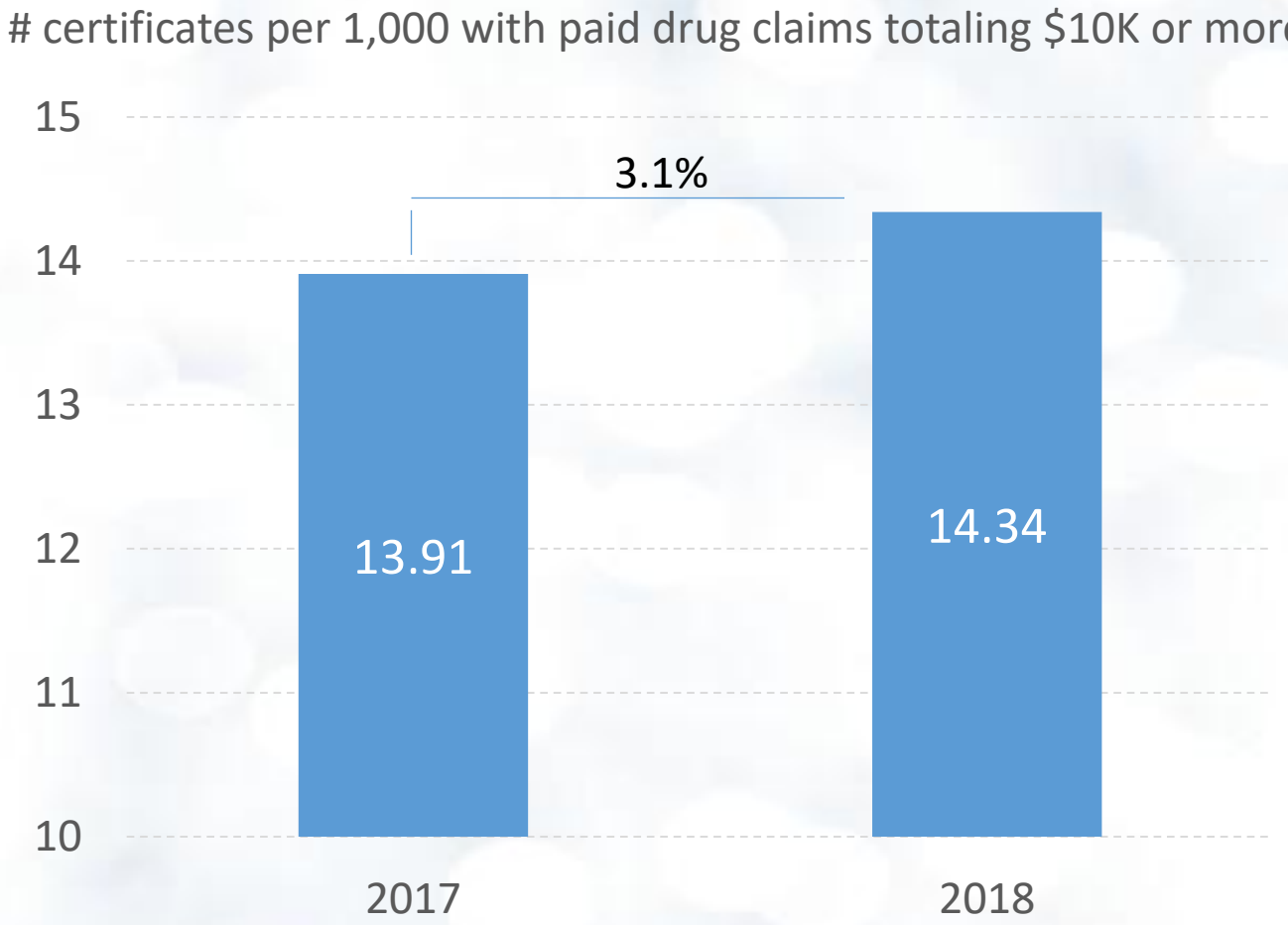
Sources: CIHI, kff.org (Kaiser Family Foundation), OECD, StatsCan, US Census Bureau

Private insurance – drug plan funding



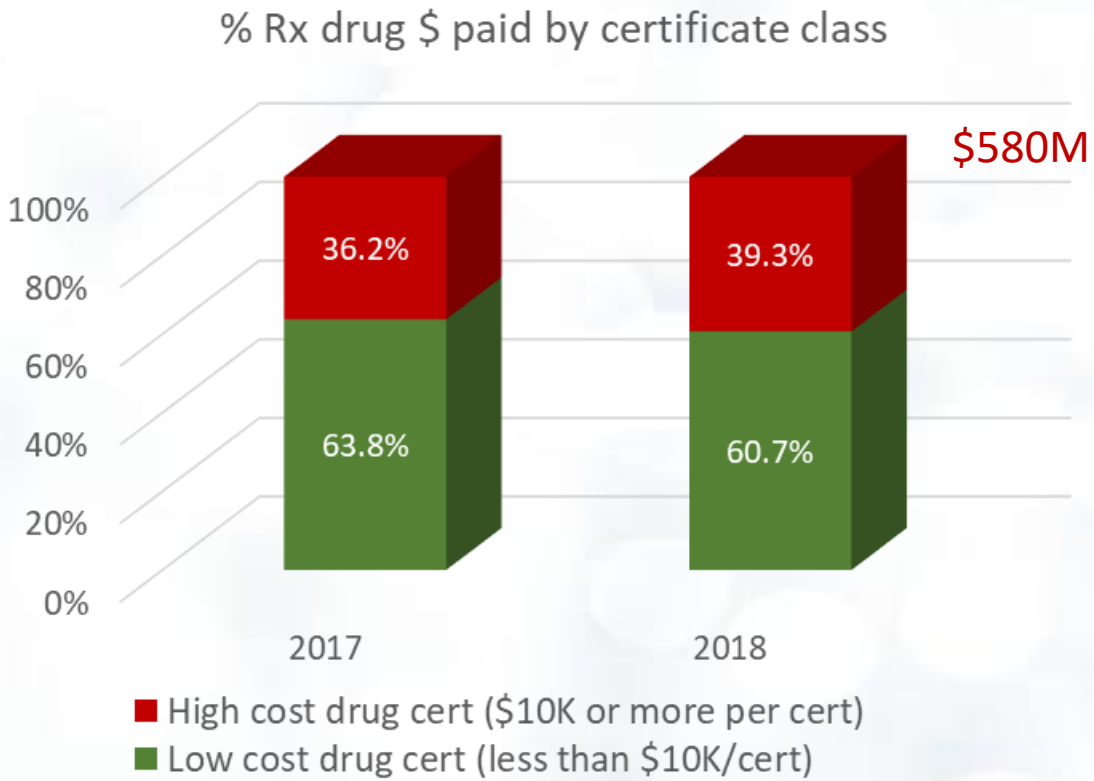
Source: CDIPC market review (2017)

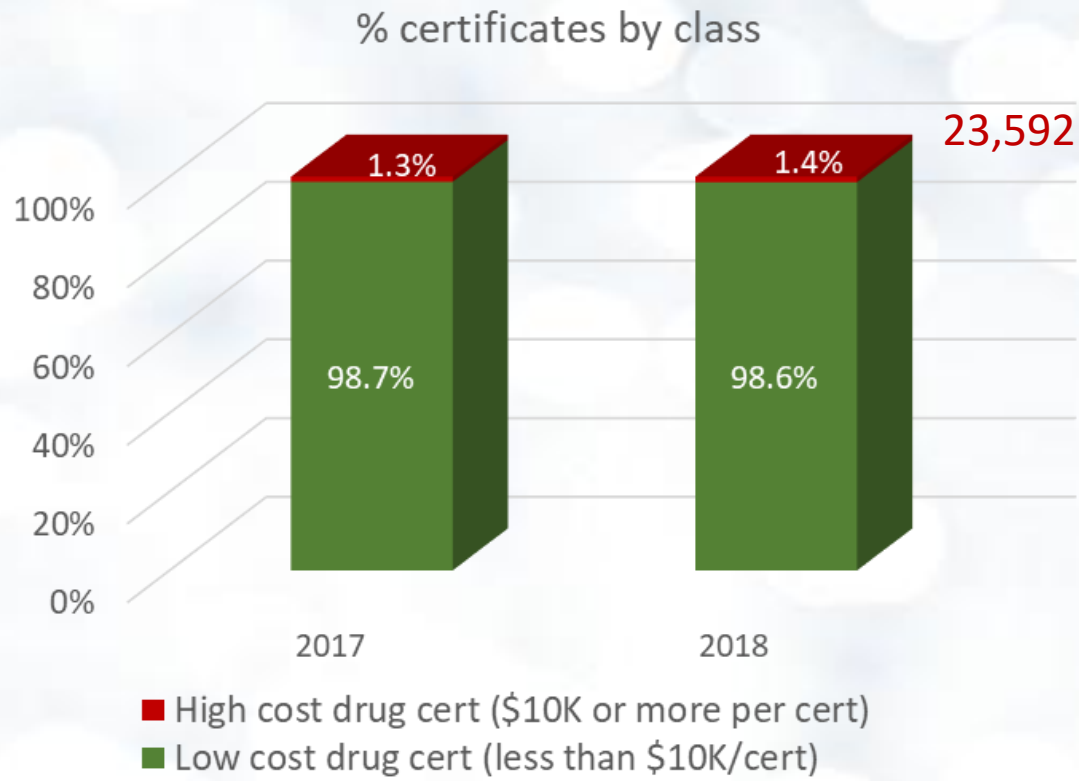
High cost drug incidence rates for ep3 plans



Source: CDIPC

High cost drugs as % ep3 plans

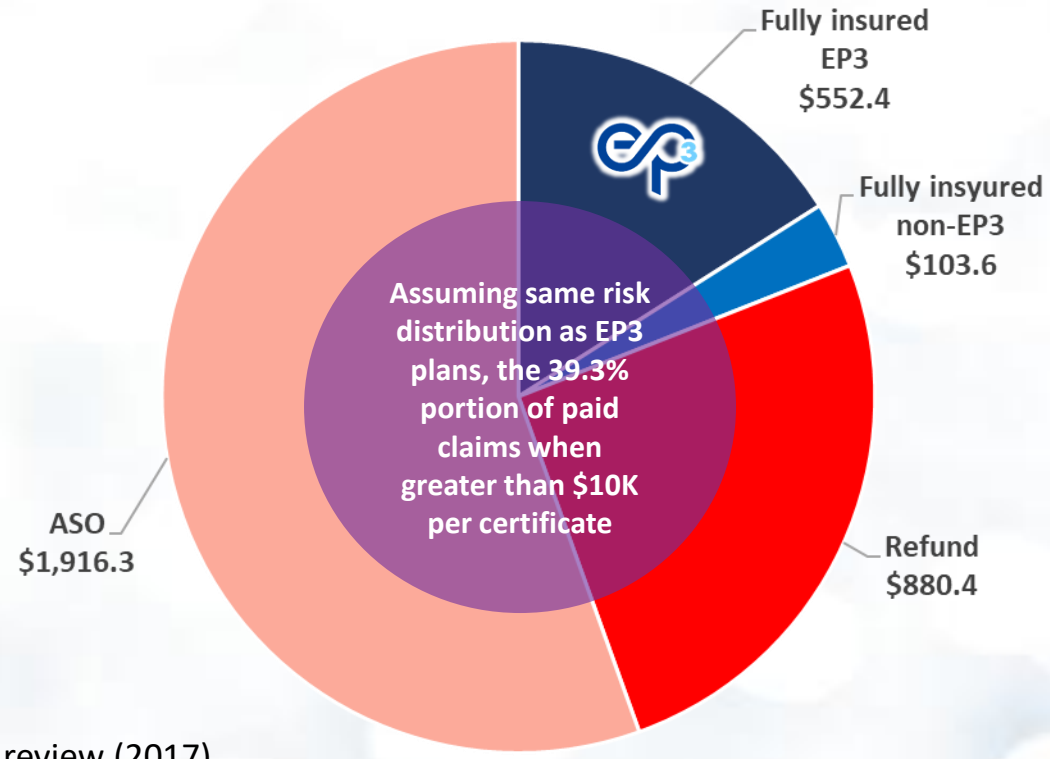




Source: CDIPC

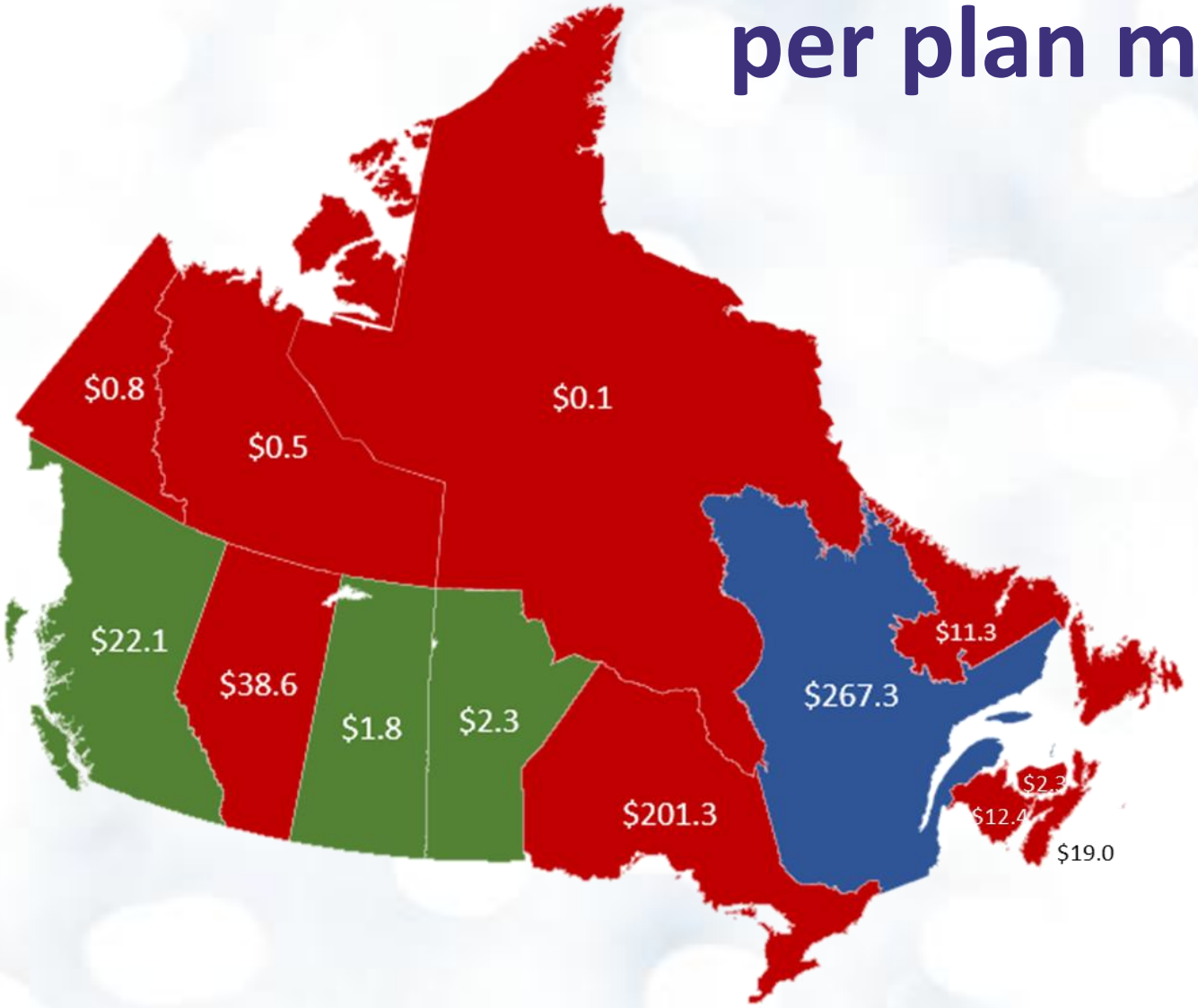
High cost drug risk by funding type

2017 Canadian private drug claims paid
Distribution by funding type & high cost risk component



Source: CDIPC market review (2017)

pooled in 2018 when drugs paid GE $10K per plan member



NB: Quebec understated by est. 15-20%

High cost drug impact “leverage effect”

geo surveys & boundriesacs ltd.
Telemetric & ground samples that keep projects in bound

Lives: **187**
Drug $ paid 2018: **$307,508**

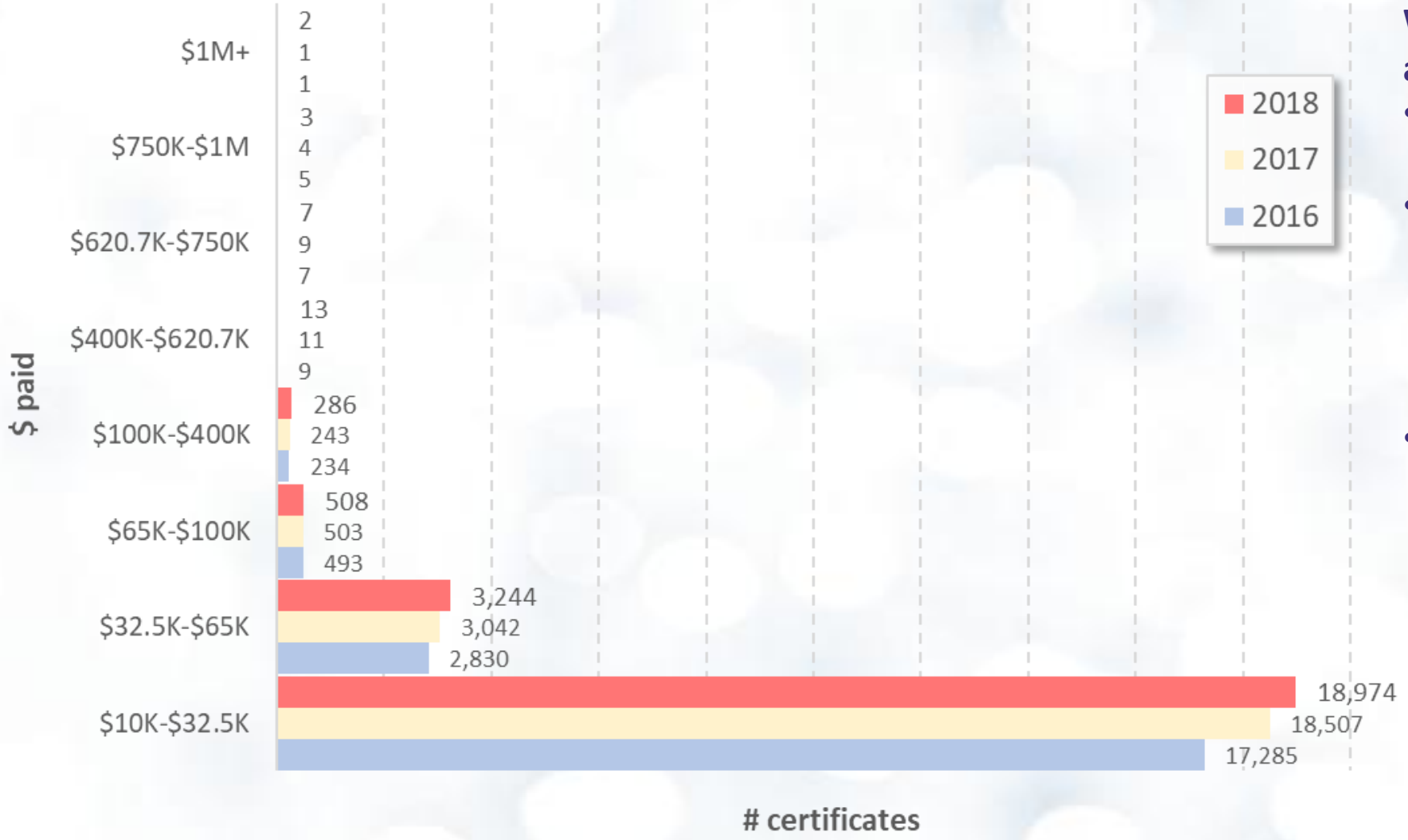
Impact

- Stop loss / LAP insurance or experience rating causes drug benefits to become unaffordable.

Year	Stop loss / large amount pooling (LAP) threshold	Howard (REMICADE) *Rheumatoid arthritis*		
		Paid claims	Stop loss impact	Stop loss % increase over prior year
2015	$10,000	$13,200	$3,200	N/A
2016	$10,000	$36,200	$26,200	719%
2017	$10,000	$32,500	$22,500	-14%
2018	$10,000	$33,000	$23,000	2%

→ Or would these recurrent claims be removed from LAP and experience rated?

experience: # certificates per $ paid

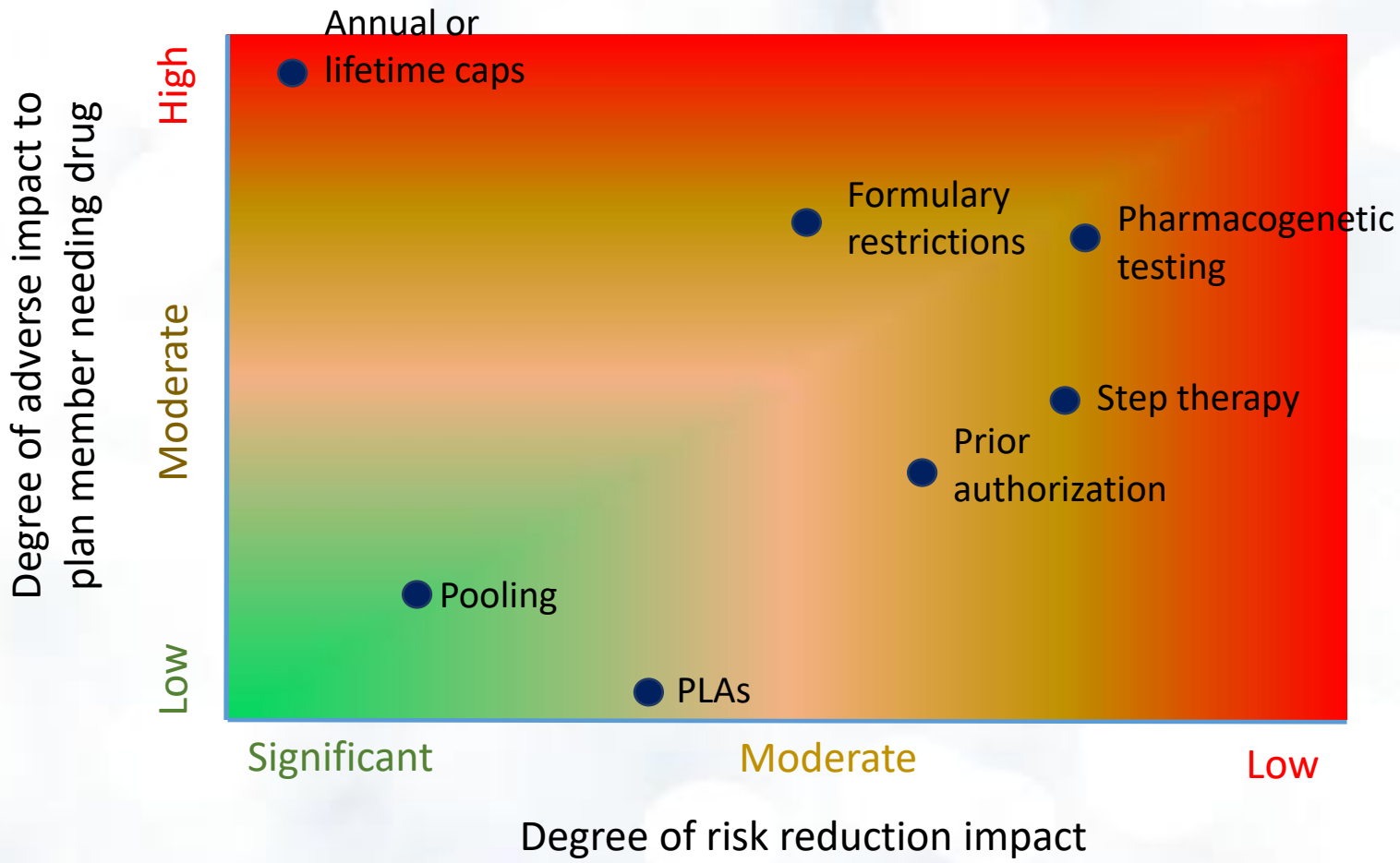


What would this look like for all private drug plans?

- EP3 plans represent 16% of the market.
- There is no real reason why ASO, Refund, and Non-refund/non-EP3 plans would have different disease state exposures.
- **Thus overall Canadian experience is likely in the range of 6.25x what is shown.**

What can be done to lessen impacts? Where and how?

More common strategies to reduce risk



Pooling

What is it?

- Risk sharing.
- Doesn't eliminate risk.
- Shares cost of risks among those exposed. Usually between sponsors but also insurers and/or reinsurers.
- Comes at cost to share risk typically driven by exposure to date.

High cost drugs are most often recurring risks

Pooling mechanism	One time risk event	Recurring risk event(s)
Reinsurance	Good	Not good. Small set of market offerings or partial risk coverage
LAP	Good	Not good – often leads to experience rating, alt funding (if avail), or cost plus coverage
EP3 pooling	Good	Good

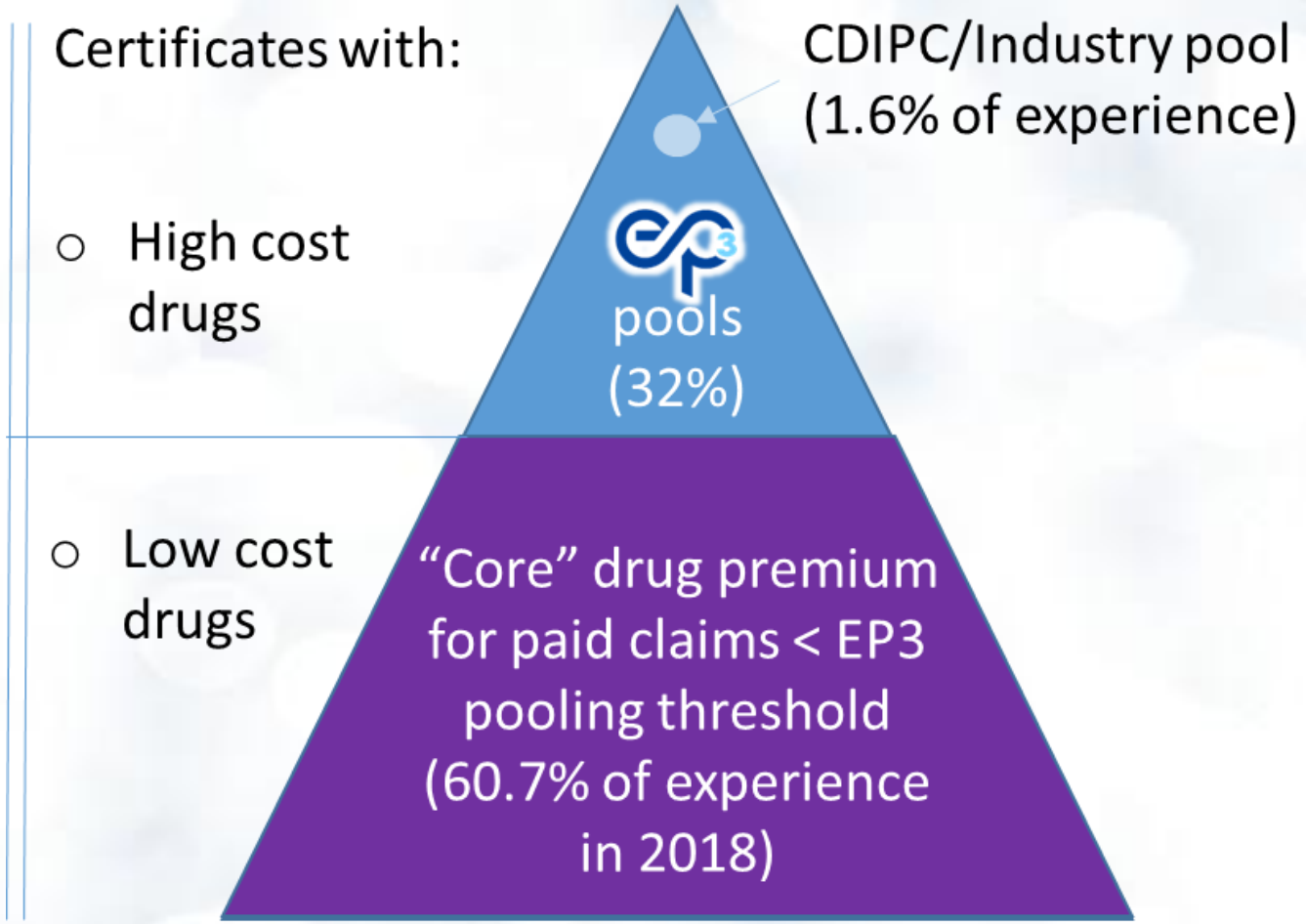
Enter the Canadian Drug Insurance Pooling Corporation (CDIPC)

- Began discussions between insurers in 2010. Formed in 2012.
  - Extensive Competition Bureau review was required.
- First year pooling in 2013.
- Fully insured plans grandfathered in by 24 insurers (even with realized / known risks). Does not include ASO, Refund, or non-refund/non-EP3 plans.
  - If Refund or ASO plan wishes to convert, existing high cost certificates (known risks) will be excluded.
- Two tier pooling structure
  - Sponsor risk sharing via EP3 pooling within insurer's fully insured block
  - Industry risk sharing pools factoring in risks by provinces with a) pharmacare (Manitoba, Saskatchewan, and BC), b) Quebec and c) the rest of Canadian provinces & territories. These pools are not for profit. Money in = money out.

pooling regime

- Each insurer has one or more pools that sponsors belong are slotted into.
- Pools typically arranged based on provincial coverage (pharmacare or not) and other underwriting choices as defined by insurer but can not be experience rated.
- Pools can include non-drug EHC expenses (ex: paramedical and/or dental) at insures discretion.
- EP3 pooling start threshold typically between $8,000 and $15,000 per certificate but can go as high as $32,500.
- Regime fosters plan movement between insurers due through prohibition of experience rating and industry sharing of higher cost certificate claims.
  - But, also reduces need to move insures if driven by costs.
- Pooling charges are used to fund pooling costs to insurers.

CDIPC & EP3 structure



CDIPC and EP3 structure deeper dive

Pooling related risk costs to participating insurers.

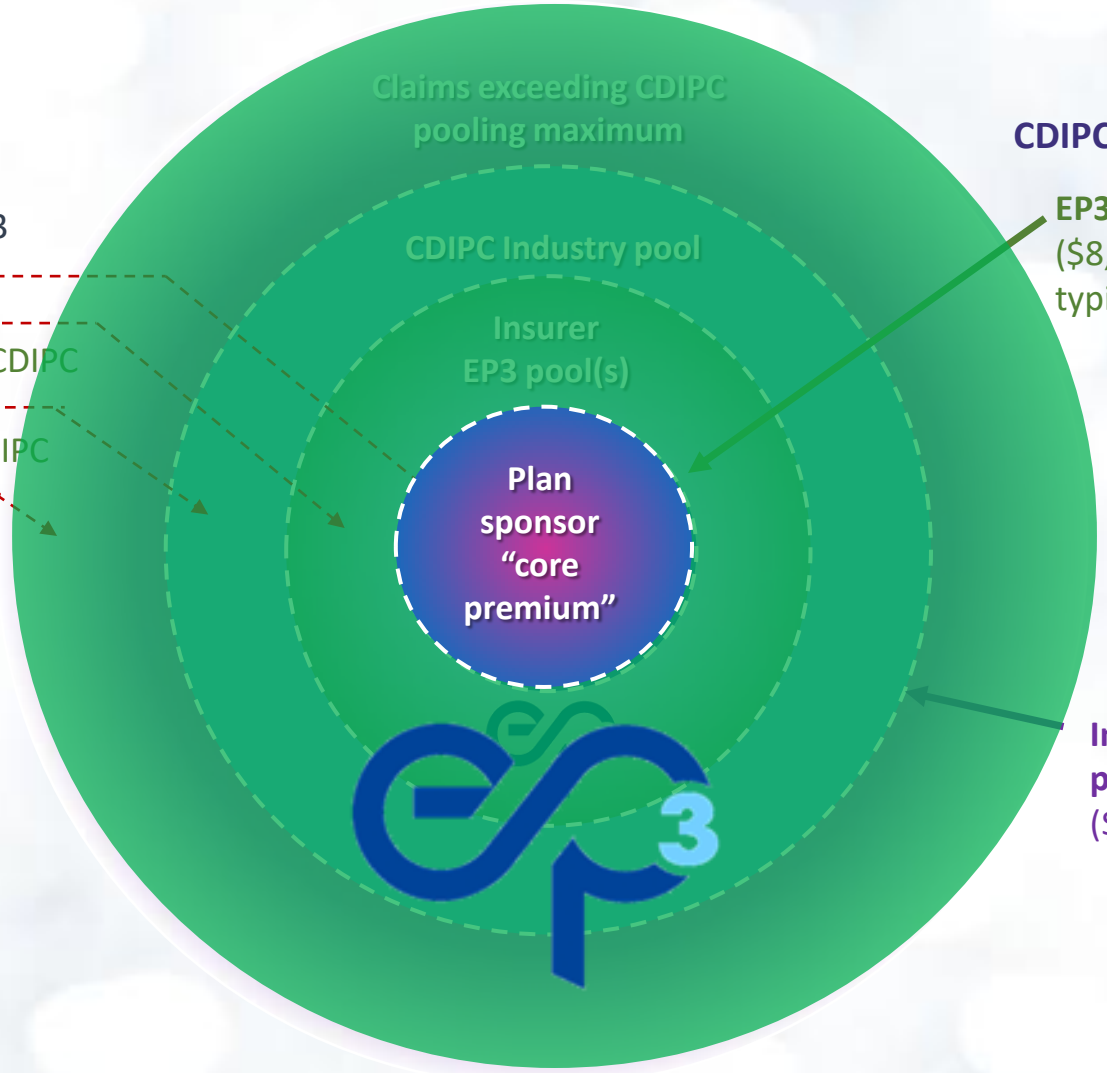
Shown:

- Amounts of claims below EP3 threshold.
- EP3 pooling.
- 15% of claims qualifying for CDIPC pool.
- 100% of claims exceeding CDIPC pool maximum.

Not shown:

- Any costs if insurer pays into CDIPC pool.

Can be pooled in EP3 pools as long as not experience rated



CDIPC pooling structure:

EP3 pooling threshold ($8,000-12,500 is often typical)

Industry/CDIPC pooling thresholds

a) To initially qualify certificate needs 2 years ≥ $65,000

b) Once "qualified" pools at 85% from $35,500 onward to Industry/CDIPC maximum

Industry/CDIPC pooling maximum ($500K in 2019)

Outcomes

Since 2013

Successes	
New specialty drugs pooled	155
Amounting too in paid claims	$3.4B (est)
Representing sponsors	24,000+
Providing drug benefits to members and their family members	45,500

Without CDIPC how many of these sponsors would have been forced to cut back on their drug plans?

Sponsor/plan movement

Annual plan churn rates	
Before	13-16%
After	7-9%

Considerations

- Are the needs to move the plan the same in regime?
- CDIPC does not force insurers to quote on a plan.
- High cost certificates must be disclosed in quote process.
- Unfortunately, plans with one or more certificates having drug costs at $150K+ often do not move.

Challenges & opportunities

Risks associated with pools

Pools created

- Many participants
- Goals:
  - Relatively small contribution per participant (aka pooling charges)
  - Big reward if risk realized

Pools dry up

- Few participants
- Remaining participants may be ones with high cost claims
  - Likely will dramatically push up pooling charges
- Ultimately can lead to direct payment for the “experience”

Pools overflow

- Too many participants with high cost claims
- Often driven by growth of risk
- Will definitely drive up pooling charges
- May cause participants with out risks to leave

Its not perfect…. challenges

- Pooling charge costs.
  - Inflationary pressures.
  - Transparency.
- Movement to cap based plans.
- Movement of plans to new insurer when very high cost claim(s) exists.

Opportunities

- PMPRB pricing impacts.
- National pharmacare.
  - Opportunity for specialty drugs.
  - Political (federal and provincial) landscape
  - Specifics – who, what, when, where, how?
- What about “ like” for ASO & Refund?
    - All cases?
    - Or, smaller life cases?

Fearless predictions

- Pharmacare
- Pipeline impacts
- Genetic / personalized medicine (ex: CAR-T cell therapy)

Questions / discussion