2020 TELUS Health **Drug Data Trends** & National Benchmarks

TELUS® Health

Report foreword:
Trends in the health and benefits landscape

The 2020 TELUS Health Drug Data Trends and National Benchmarks Report (TELUS Health report) comes as we are emerging from the height of the COVID-19 pandemic that is most certainly a defining moment of this year, and likely for the decade to follow.

So much has changed in such a short time in our lives and we await science to guide us with proven treatments and a vaccine.

As we attempt to understand just how much daily life has shifted, we can look to the TELUS Health report for guidance on how these changes might impact health benefits plans. The report considers the major trends in private drug plan costs, utilization and design tool adoption. It is a snapshot in time, but it also provides a roadmap on trends, giving all of us – policymakers, insurers, administrators, employers and employees – a glimpse into the future as we navigate through this COVID-19 world.

Overall, the report found that 2019 saw the biggest increase in average eligible costs for private drug plans over the past five years. One of the main factors – and what is one of the most important findings of this year's report – is the increase in the use of medication for mental health issues, with drugs for depression representing the highest number of claims. And this is pre-lockdown.

In fact, private plans saw double-digit increases in eligible claims costs from insured Canadians under the age of 29 in 2019. This increase is the result of a greater awareness of mental health, a decrease in the stigma of mental illness as younger people openly seek help and a higher prevalence of diagnosed mental illness.

There are lessons here for all of us as we look to the future. Physical distancing, self-isolation and working from home have dominated so much of our behaviour and all indications are that it will certainly contribute to even greater mental health challenges in the months and years ahead.

This has led us, as you will see in the report, to highlight that employers have an opportunity, through their insurers and administrators, to take a closer look at providing more fulsome benefit packages to include mental health and wellness support that go beyond medication reimbursement.

The pandemic may be showing us the way as COVID-19 is transforming the healthcare landscape and virtual care is becoming more prevalent, complementing when appropriate, physical visits to brick and mortar physician offices. The virus has officially pushed the tipping point for a virtual revolution and it will be important to examine the longer-term impact and benefit to patients.

For mental health, we believe virtual care platforms such as Akira by TELUS Health, which offers mental health counselling for employees, will be a critical component of the future of employee care and wellness.

Again, in 2019, we saw eligible costs for specialty drugs continue to increase. Specialty drugs are complex drugs including biologics; they are higher-cost drugs, resulting in about $10,000 per claimant per year and now account for 78 per cent of all eligible costs.

This is the result of the utilization and availability of new drugs and drug classes, including targeted therapies and immunotherapies for previously untreated or undertreated conditions. Of course, we'll have to closely watch the continued rollout of policy changes, including the role biosimilars (a biologic drug product highly similar to another already approved biological medicine) will have on the therapy landscape moving forward.

Rheumatoid arthritis (RA), skin disorders, respiratory conditions and cancer treatments, all of which are chronic conditions, were among the most in demand. The report notes that if current trends continue, specialty drugs will represent approximately 46% of the average monthly certificate cost by 2025.

A closing note, in April 2019, the Ontario government changed the OHIP plus policy to only cover children and young adults up to 24 years old without any private insurance. That policy change is reflected in our report and as expected it contributed to the overall increase in eligible costs for private drug plans.

These are uncertain times, but from uncertainty can emerge many opportunities. We hope the findings and insights contained in this year's report provide an important perspective as we move ahead. We urge all members of our industry to use these insights as a catalyst for innovation and problem-solving, to create a sense of urgency to make our system even better as we look at where we were and where we go from here.

Laura Mensch
Vice President, Health Benefits Management, TELUS Health

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1. Introduction

After a relatively quiet year in 2018, private drug plans saw more action in 2019. Overall eligible costs posted their biggest increase in the past five years, for multiple reasons. Specialty drugs continued to be a dominant factor; however, traditional drugs also contributed, after years of flat or negative growth that served to buffer the cost impact of specialty drugs.

At the same time the numbers reflect an important evolution in drug therapies, with a focus on targeted medications that can significantly improve health outcomes.

The 2020 TELUS Health Drug Data Trends & National Benchmarks Report presents major trends in private drug-plan costs and utilization, and adoption rates of plan design tools such as mandatory generic substitution and managed formularies. The data for 2019 were extracted from the TELUS Health database of more than 13 million insured individuals, who transacted more than 150 million prescription drug claims.

> “The coming decade will continue to see advances in prescription drug treatments, but that is expected to also drive cost pressures within benefit programs which will require new solutions to contain plan costs. However, it is important to not lose sight of the return on investment that more effective treatment can have on downstream costs such as reduced incidence, duration, and severity of absence and disability, says Shawn O’Brien, Principal, Data Enablement and Drug, Health, Dental Product Roadmap for TELUS Health.”

Terminology

Adjudicated amount:	The amount paid by the plan after the application of any plan design fiscal measures.
Biosimilar:	Health Canada defines a biosimilar as a biologic drug that is highly similar to a biologic drug that was already authorized for sale. The biosimilar is produced after patent expiry of the reference biologic drug.
Certificate:	Employee (also referred to as primary cardholder) and his/her linked co-beneficiaries (i.e., spouse, children).
Eligible cost:	Cost of the drug found eligible by TELUS Health, before the application of any plan design fiscal measures (e.g., coinsurance).
Generic:	Bioequivalent copy of a brand-name drug, produced after patent expiry of the brand-name drug.
Insured:	Any covered individual (i.e., employee, spouse, child), whether or not he or she made a claim during the reporting period.
Multi-source brand drug:	Brand-name drug for which one or more generic drugs exist.
Reference biologic:	First-on-market, large molecule specialty drug that contains living organisms, also referred to as “originator” or “innovator” biologic.
Single-source brand drug:	Brand-name drug for which no generic drug exists.
Specialty drugs:	Complex drugs, including biologics, that are higher-cost (defined by TELUS Health as costing $10,000 per year per claimant or more).
Traditional prescription drugs:	Chemically based drugs that are typically lower-cost.
Utilization:	Number of claims paid per insured or certificate, as specified.

2. **Costs &** utilization

Snapshot

Within the past five years, 2019 saw the biggest increase in average eligible costs for private drug plans. The major driving factors were:

- The implementation and subsequent repeal of Ontario's OHIP+ program
- Increased utilization of specialty drugs as well as an increased cost per specialty claim
- Increased overall costs for traditional drugs after years of low or negative growth
- The growing use of drugs for mental health issues by insureds up to 29 years old

Meanwhile, the generic fill rate continues its slow and steady climb, with room for growth in most regions.

Cost trends

Private drug plans experienced an increase of 7.6% in eligible monthly cost across all insured individuals in 2019, compared to a decline of 3.6% in 2018. This sizable shift is largely due to the OHIP+ program in Ontario, which impacted private drug plans from January 1, 2018 to April 1, 2019 (a 15-month period). During that time the provincial government was the first payer for all insureds under the age of 25; after April 1, insureds in this age group with coverage under private plans were no longer eligible for OHIP+.

However, even after removing all insureds under the age of 25, eligible costs increased by 5.1% in 2019 compared to a decline of 0.8% in 2018. This is the highest increase in the most recent five-year period, although it comes close to the 4.6% increase recorded for 2016.

A regional breakdown shows all regions experienced notable increases compared to 2018. Ontario is the outlier with a 10.2% spike in eligible costs due to the discontinuation of OHIP+ for insureds under age 25. Even after removing this age group, however, private drug plans in Ontario still saw an increase of 5.4%, compared to a decline of 2.4% in 2018. Quebec is also at the forefront, with a 5.8% increase across all age groups, compared to an increase of 3.0% in 2018.

Provinces in Western Canada (4.0%) and Atlantic Canada (4.2%) reported lower rates of increase across all age groups for 2019; however, these rates are still well ahead of results for 2018 (decline of 0.3% and decline of 1.1%, respectively).

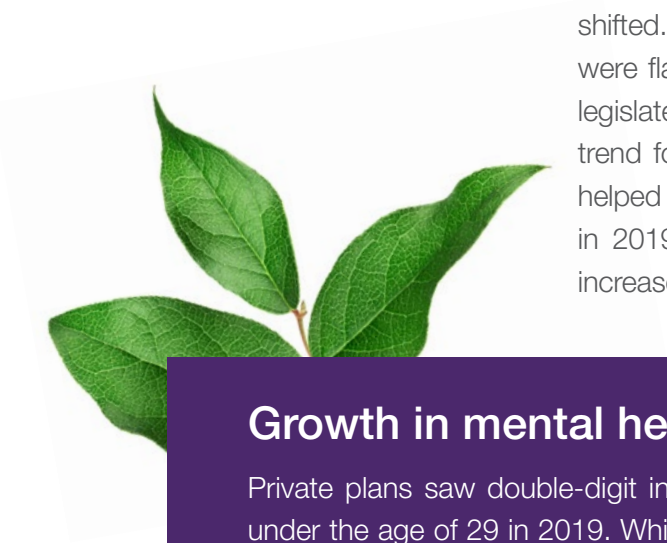
When the results are considered by age group, the biggest increase, as expected due to the changed criteria for OHIP+, is among insureds under age 25 (27.9%). While the jump in results is significant, the average eligible cost per insured under age 25 is also the lowest, at $14.44, compared to a high of $98.60 among insureds aged 60 to 64.

“As expected, costs per insured increase as we age. Younger people claim for more acute therapies like antibiotics, which are very low cost, and as we age we see chronic conditions becoming more prevalent and it’s not uncommon to see someone in their 50s or 60s on several medications to treat a variety of conditions,” says Shawn O’Brien, Principal, Data Enablement and Drug, Health, Dental Product Roadmap for TELUS Health.

The breakdown between specialty and traditional (non-specialty) drugs more fully explains why overall eligible costs increased in 2019 over 2018, across all regions. Average eligible monthly costs per insured for specialty drugs grew by 10.1% for insureds aged 25 to 64, compared to an increase of 2.9% for traditional drugs.

A closer analysis of the data reveals that the average cost per claim for a specialty drug grew by 2.1% in 2019. The rate of growth in utilization was more than triple that, at 7.8%. In other words, "the growth in specialty drugs is really coming from utilization," says O'Brien. "We are seeing more specialty drugs coming to market, some treating previously untreatable diseases, resulting in more opportunity for treatment with these drugs." For more on specialty drugs, see page 31.

At the same time, the trend for traditional (non-specialty) drugs has shifted. During the last 10 years, eligible costs for traditional drugs were flat or declined due to a wave of patent expiries as well as legislated reductions in prices for generic drugs. This deflationary trend for traditional drugs, which account for 98% of all claims, helped offset the high rates of growth for specialty drugs. However, in 2019 eligible monthly costs per insured for traditional drugs increased by 2.9%.



Growth in mental health claims

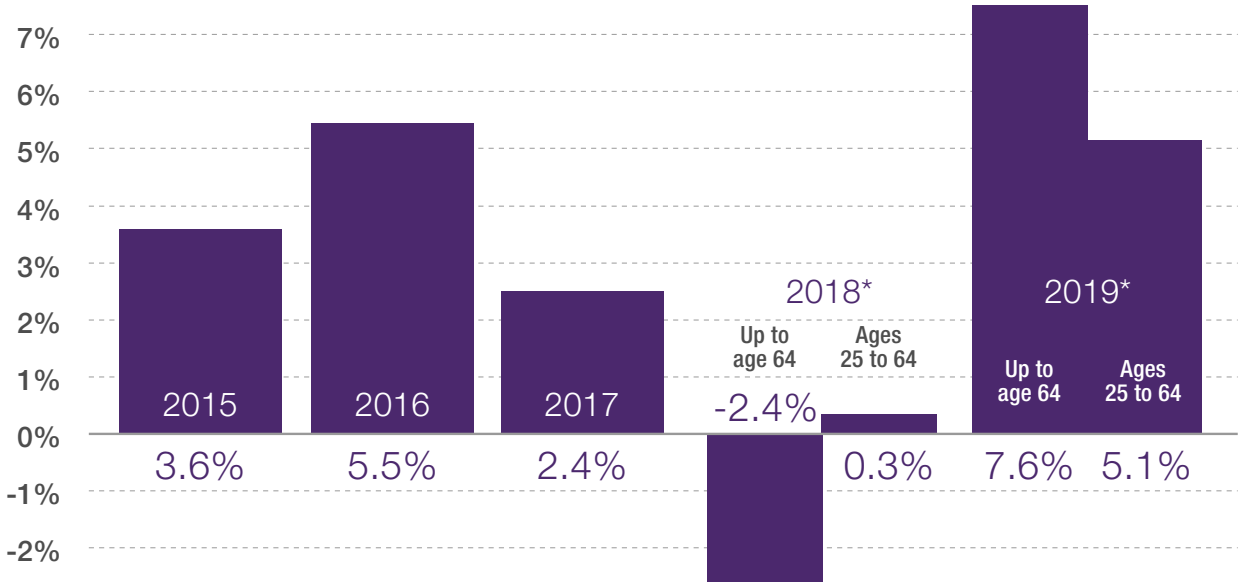
Private plans saw double-digit increases in eligible claims costs from insured Canadians under the age of 29 in 2019. While Ontario's OHIP+ program is a factor for those aged up to 24, it has nothing to do with the 11.6% increase for those aged 25 to 29.

"We are seeing more mental health-related claims, as well as claims for attention deficit hyperactivity disorder in this age cohort," explains Jason Kennedy, Director, Health Business Consulting, TELUS Health.

Is this a cause for concern? To some extent, not necessarily. "Awareness of mental health has grown over the past decade, and feelings of stigma are greatly reduced. Unlike previous generations, younger people today are less likely to think they are invincible and more likely to recognize they need help," says Kennedy.

On the other hand, the relatively high prevalence of mental illness in general, across all age groups, is a growing call to action. "Employers, insurers and associations are starting to fully embrace the need for wellness programs that concentrate on the emotional and mental health and well-being of their employees. They understand it's 'Okay to not be okay' and want to support their employees' well-being. This can have a positive effect on workplace productivity, absence, and team member morale," says Kennedy.

CHART 1 | Change in eligible monthly cost per insured, 2015 – 2019



* Results for 2018 and 2019 broken down by age illustrate the impact of OHIP+ in Ontario, which affected private drug plans from January 1, 2018 to April 1, 2019.

CHART 2 | Change in eligible monthly cost per insured, 2018 to 2019, by region

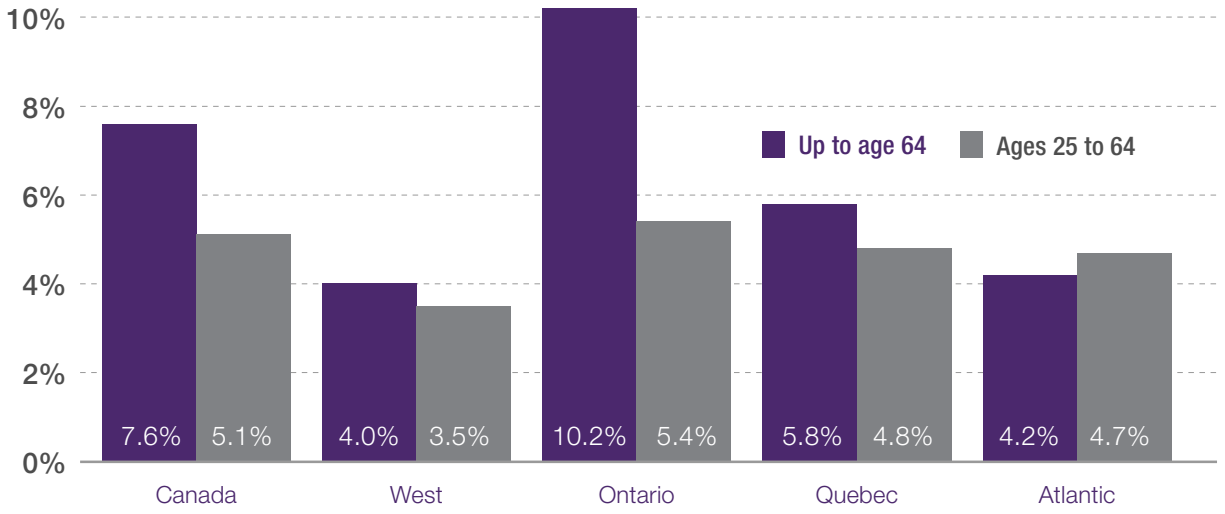


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CHART 3 | Change in eligible monthly cost per insured, 2018 to 2019, by age

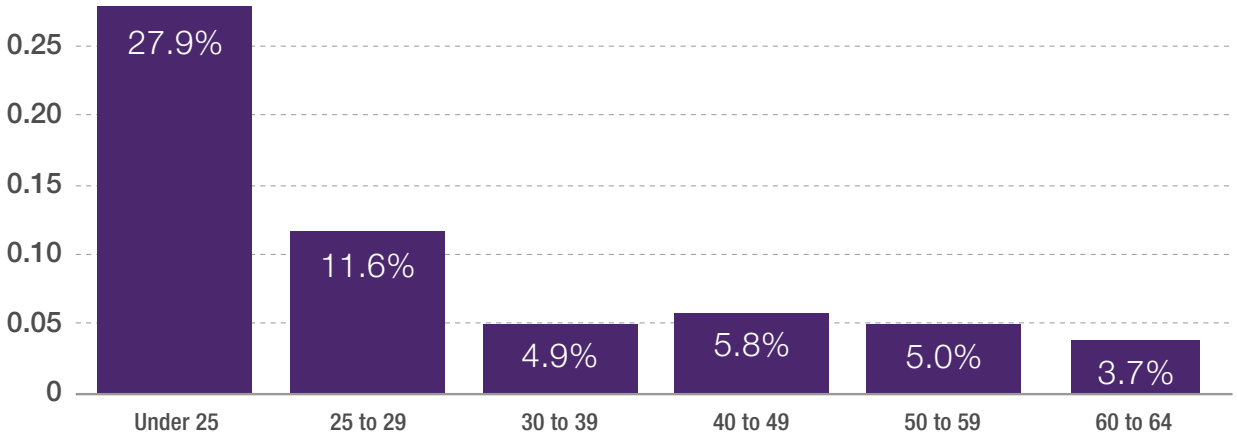
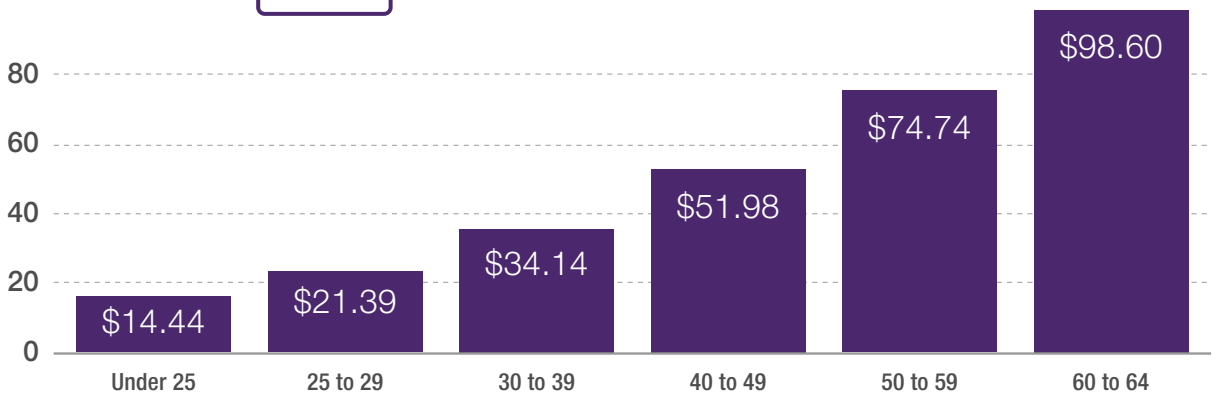


CHART 4 | Monthly eligible cost per insured in 2019, by age group



Utilization trends

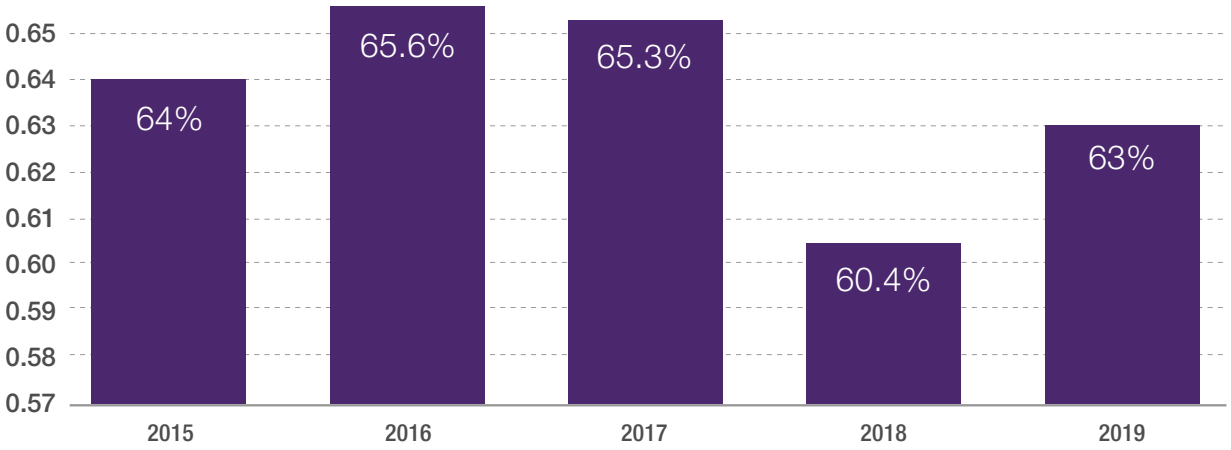
The decisive but short-lived impact of OHIP+ in Ontario is clearly reflected in the five-year trend for utilization rates. The number of insureds who submitted a claim dropped from 65.3% in 2017 to 60.4% in 2018, and then climbed back to 63.0% in 2019.

When monthly claims are divided by all insureds (whether or not they made claims, including all ages of insurers up to age 64), individual utilization has been consistent over the past five years. In 2019, the monthly utilization rate per insured was 0.54 claims, compared to 0.52 in 2018 and 0.52 in 2015.

On the other hand, the average number of claims per claimant appears to be climbing at a slow rate. Claimants submitted an average of 10.3 claims in 2019, compared to 9.8 claims in 2015.

The average eligible cost per claim for all insureds up to age 64 was $74.78 in 2019, a 3.0% increase over 2018 ($72.59) and a difference of 8.4% compared to 2015 ($68.97). When the average number of claims is combined with average cost per claim, claimants submitted claims for $769.13 in total average eligible costs in 2019, compared to $745.54 in 2018 (an increase of 3.2%) and $675.95 five years ago (a difference of 13.8% between 2019 and 2015).

CHART 5 | Number of insureds who made a claim, 2015 – 2019



*The results for 2018 and 2019 illustrate the impact of OHIP+ in Ontario, which reduced claims from insureds up to age 24 from January 1, 2018 to April 1, 2019.

CHART 6 | Number of claims per distinct claimant, 2015 versus 2019

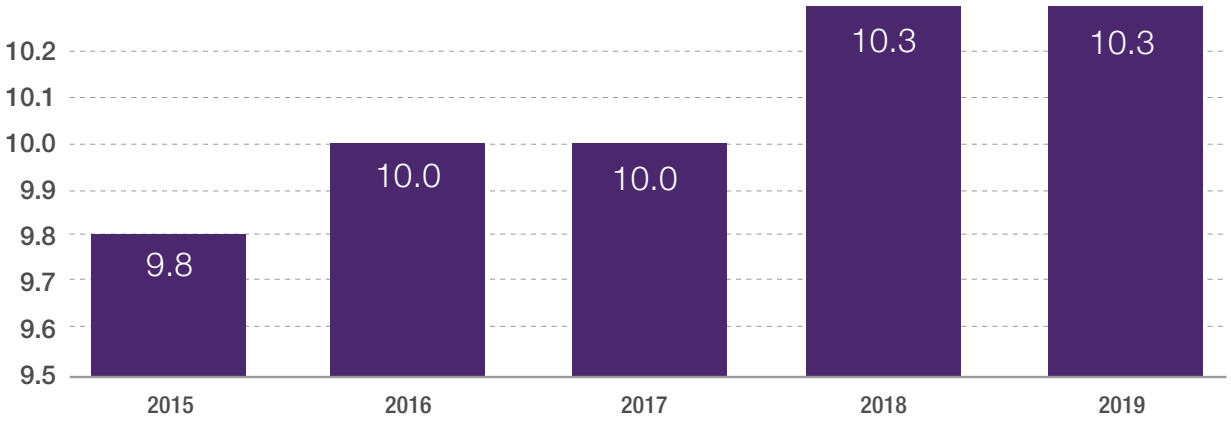


CHART 7 | Average annual eligible costs per distinct claimant, 2015 to 2019

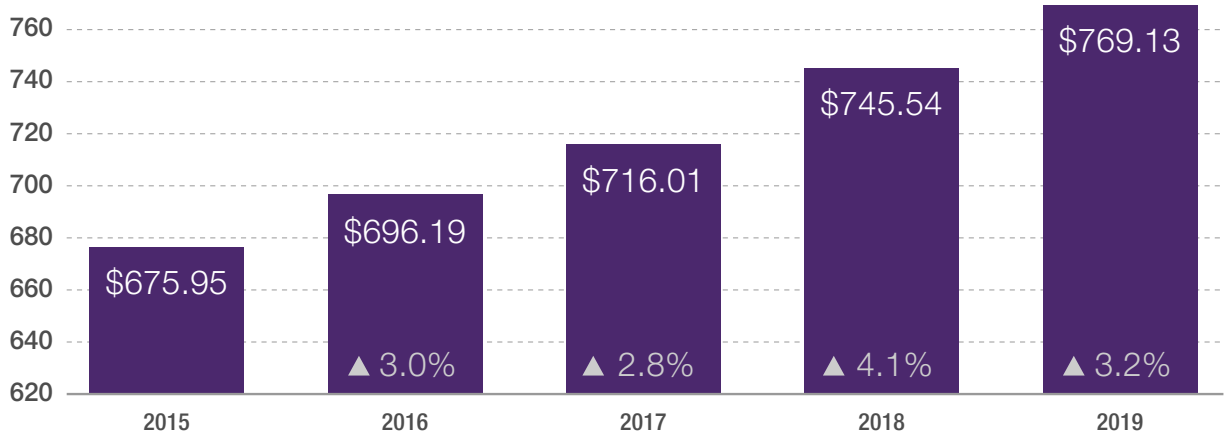


CHART 8 | Overview of costs & utilization in 2019, by region

	Canada	Western Canada	Ontario	Quebec	Atlantic Canada
Eligible monthly cost per insured	$40.36	$30.56[1]	$40.97	$56.20	$51.92
Monthly utilization per insured	0.54	0.44	0.48	0.90[2]	0.62
Insureds who made a claim	63.0%	60.9%	60.5%	72.2%	71.2%
Average eligible cost per claim	$74.78	$69.91	$85.22	$62.62[2]	$84.18
Average claims per claimant	10.3	8.6	9.5	14.9	10.4
Average age of employee/cardholder	42	40.9	42.5	42.6	43.6

1 Western Canada has the lowest eligible monthly cost per insured because provincial Pharmacare/universal drug plans in B.C., Manitoba and Saskatchewan automatically become primary payer once plan members pay an out-of-pocket deductible.

2 Quebec has the highest rate of monthly utilization per insured, the lowest average eligible cost per claim and the highest average claims per claimant because Quebec pharmacies typically dispense chronic medications in 30-day supplies, whereas pharmacies in other provinces typically dispense 90-day supplies.

Utilization of generic drugs

Generic drugs accounted for 63% of prescriptions filled by private drug plans in 2019, compared to 62% in 2018. Five years ago, generic drugs represented 58% of prescriptions filled. Mandatory generic substitution policies drive this trend (see page 22).

Regionally, the generic fill rate is highest in Atlantic Canada, at 70%, and lowest in Ontario at 61%. Quebec experienced the strongest rate of growth, from 55% in 2015 to 63% in 2019. This growth can be attributed in part by RAMQ legislative changes with respect to generic substitution (Bill 28).

(for more on specialty drugs, see page 31).

> “The result for Atlantic Canada marks the first time we have hit 70% for generics anywhere in the country. For Atlantic Canada in particular, that’s an important level to attain to help offset the fact that the region also has the highest rate of specialty drug consumption, notes O’Brien”

In comparison, most private plans in the U.S. see generic penetration rates in the mid 80s. To achieve those levels, U.S. plans actively manage their plans with tiered or managed formularies, which promote preferred utilization of generic drugs (for more on managed formularies in Canada, see page 27).

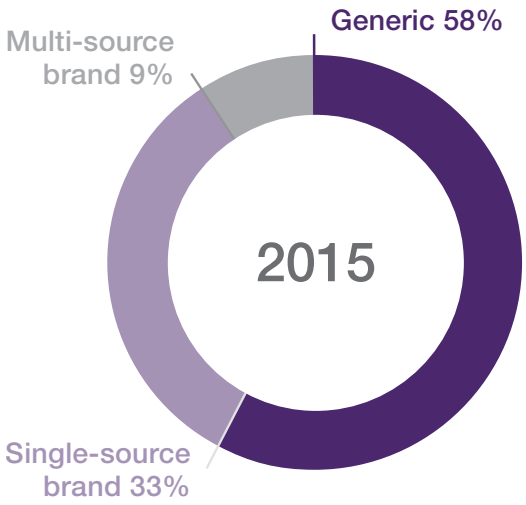
In Canada, the remaining 37% of prescriptions dispensed breaks down into 30% for single-source brand drugs (i.e., for which no generic options are available) and 7% for multi-source brand drugs (i.e., for which generic options are available). The multi-source fill rate tends to go down as generic penetration goes up: Atlantic Canada, which has the highest generic fill rate, has the lowest multi-source fill rate at just 4%. And in Quebec, as the generic fill rate climbed from 55% in 2015 to 63% in 2019 the multi-source fill rate declined from 14% to 8%.

The multi-source fill rate can never drop to zero, for two reasons. First, a small percentage of patients can have adverse reactions when switching from a brand drug to a generic. Second, mandatory generic substitution policies allow for the dispensing of a multi-source brand when the patient pays the difference in price between the generic and the brand drug.

CHART 9 | Utilization of generic drugs, 2015 – 2019, by region

	2015	2016	2017	2018	2019
Atlantic	64%	67%	67%	69%	70%
West	61%	63%	64%	65%	66%
Ontario	57%	59%	59%	60%	61%
Quebec	55%	58%	60%	62%	63%
Canada	58%	60%	61%	62%	63%

CHART 10 | Utilization by type of drug, 2015 versus 2019



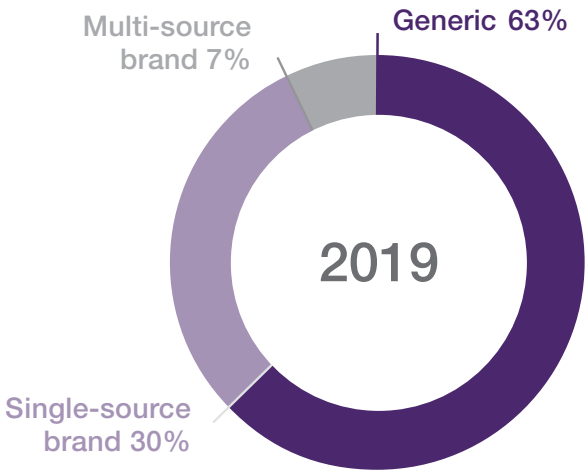
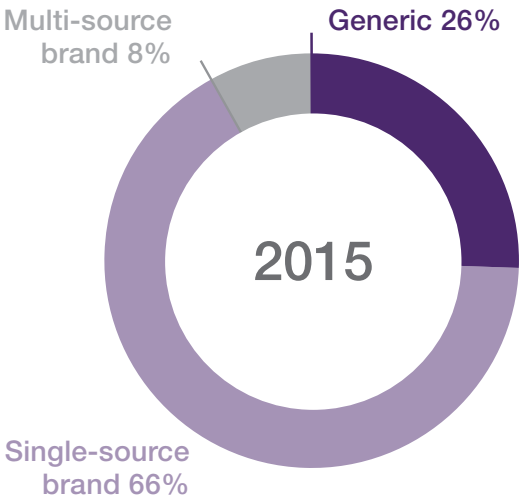
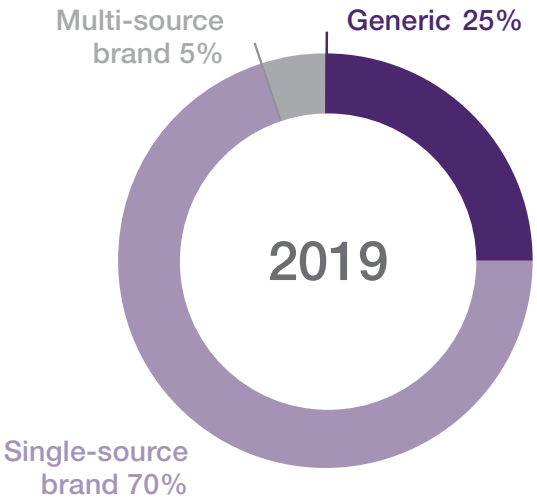


CHART 11 | Eligible cost by type of drug, 2015 versus 2019





Summary & recommendations

Plan sponsors with significant employee distribution in Ontario experienced material increases in average eligible costs due to the discontinuation of the OHIP+ program for insureds under age 25. Even after factoring out the impact of OHIP+, Ontario and all regions across Canada still saw notable increases compared to 2018. One key reason appears to be the end of a deflationary trend in overall costs for traditional drugs, which has helped offset the strong inflationary trend for specialty drugs.

- Implement or evaluate plan design tools that effectively manage utilization and coverage for traditional, chronic medications, which can in turn support the affordability of specialty drugs.
- For private plans that have not already adopted mandatory generic substitution, determine the potential savings, assess the perceived barriers to access and how best to overcome them.
- The increased use of drugs for mental-health conditions among employees under 29 years old warrants a closer examination of what can be done outside of the drug plan to help manage or prevent mental illness. Resilience training, online cognitive behavioural therapy and increased maximums for counselling services are some examples.

3. **Drug plan** design tools

Snapshot

Among the various cost containment plan design strategies presented in this report, the adoption rate for mandatory generic substitution policies has increased the most in the past five years.

- There was little growth in certificates with plans that include coinsurance
- More certificates have drug plans with annual maximums, although only a minority have maximums
- Managed formularies appear to slowly be on the rise; however, the majority of certificates have plans with open formularies

Generic drug policies

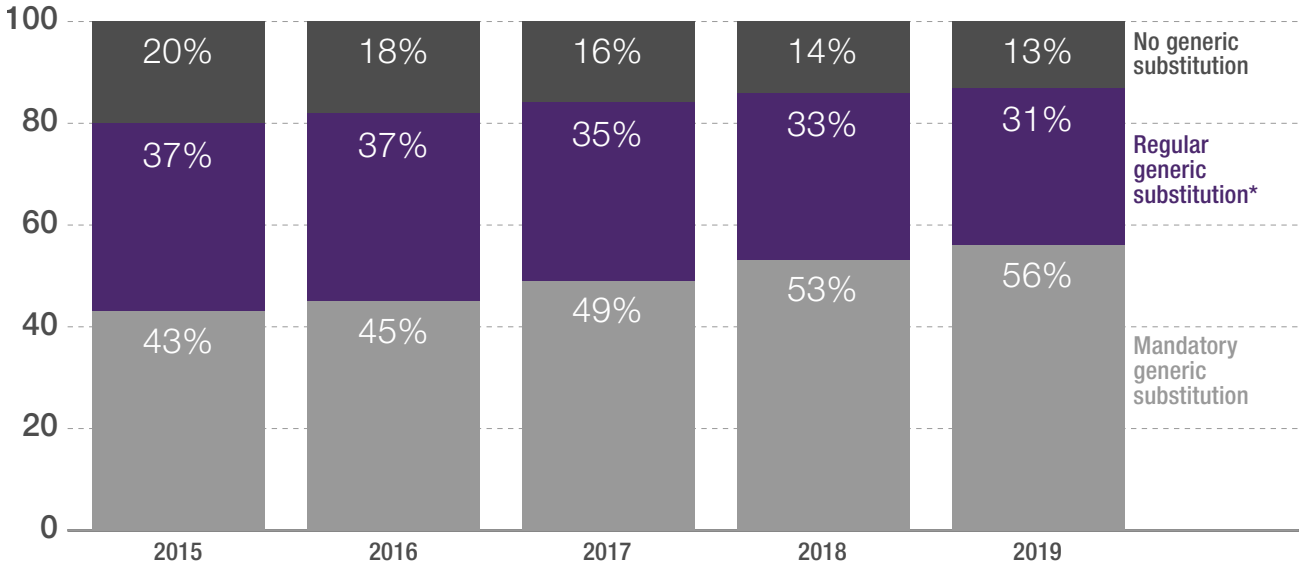
Insureds are increasingly likely to have private drug plans with mandatory generic substitution policies: 56% did so in 2019, up from 53% in 2018 and 43% in 2015. Thirty-one percent had plans with a regular generic substitution policy, which a physician can override by indicating no substitution on the prescription. When regular and mandatory substitution policies are combined, 87% of insureds had plans with a generic drug policy in 2019, compared to 80% in 2015.

The numbers are the same when considered by certificate (i.e., primary cardholder and linked co-beneficiaries): 56% of certificates have plans with a mandatory generic substitution policy and 31% have plans with a regular generic substitution policy.

Mandatory substitution has become the default policy in insurance carriers' contracts over the past several years. Eighty-six percent of group plans now have mandatory policies in place. Eight percent have policies with regular generic substitution, leaving just 6% of groups with no generic policy at all.

> "Those 6% represent 13% of total insureds, which tells us that groups without any generic policy tend to be very large and perhaps unionized. It's harder to make changes when it needs to be bargained into a collective bargaining agreement, says O'Brien"

CHART 12 | Insureds with plans that include generic drug policies, 2015 – 2019



*Under a regular generic substitution policy, the physician can override for coverage of the brand drug by indicating no substitution on the prescription.

CHART 13 | Generic drug policies in 2018, insureds versus groups

	Insureds	Groups
Mandatory generic substitution	56%	86%
Regular (optional) generic substitution	31%	8%
No generic drug policy	13%	6%

Coinsurance & deductibles

Over two-thirds of certificates (69%) had drug plans that incorporated coinsurance in 2019, virtually unchanged from five years ago (68%).

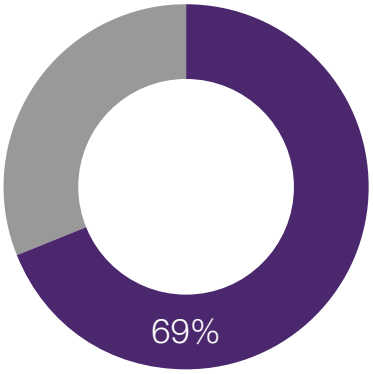
Among certificates with plans that include coinsurance, 20% is the most common coinsurance amount, for two-thirds (66%), followed by a 10% co-pay for one in five certificates (19%). Twelve percent have a copay that is 25% or more of the cost of their prescription drugs.

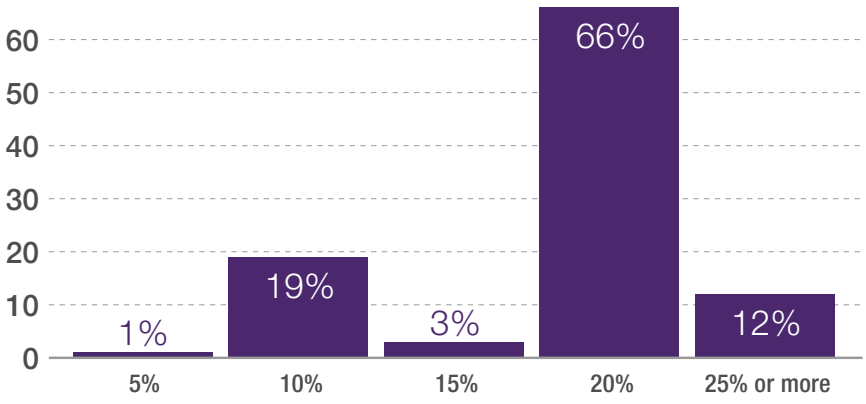
> When plan members pay a portion of the drug cost it helps them see the value of what plan sponsors are paying on their behalf, notes O'Brien. It also helps them become better consumers as they have some skin in the game.

Regarding deductibles, far fewer certificates had plans that require annual (10%) or per claim (13%) deductibles. These numbers have changed very little in the past five years. Among certificates who paid annual deductibles, the deductible amounts were somewhat evenly divided between $50 (31%), $100 (29%) and more than $100 (40%) per year. Among those who paid per-claim deductibles, the majority paid between $4.00 to $5.99 (40%) or $2.00 and $3.99 (27%) per deductible.

"Deductibles are mainly found in much older contracts. They do not provide a meaningful impact on containing or sharing costs—plans have come to forgo deductibles in favour of coinsurance as the amount the plan member is responsible for rises with inflation," says O'Brien.

CHART 14 | Certificates with plans that include coinsurance, 2019





Breakdown of coinsurance amounts (copays) among those with coinsurance

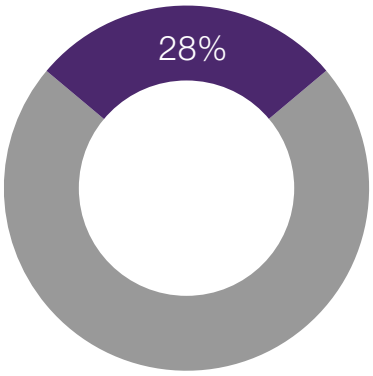
Dispensing fee caps

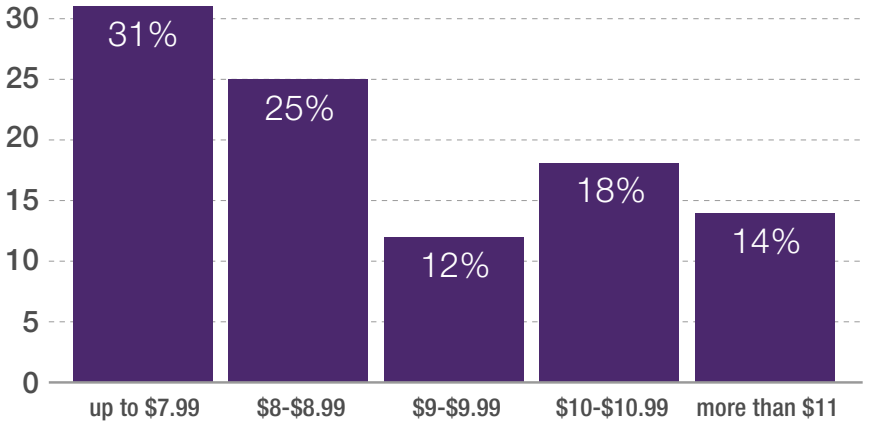
Over a quarter of certificates (28%) had drug plans with dispensing fee caps in 2019, virtually unchanged from five years ago.

Among certificates with caps, coverage of the dispensing fee is most often capped at up to $7.99 (31% of certificates with caps) or between $8.00 and $8.99 (25%).

The lack of continued uptake suggests underutilization of this cost-containment measure. “Dispensing fee caps are a good way to incentivize members to shop around to save out-of-pocket costs or pay out of pocket if they prefer the convenience of going to the pharmacy of their choice,” says O’Brien.

CHART 15 | Certificates with plans that include capped dispensing fees, 2019





Breakdown of capped fees among those with caps

Managed formularies

Managed formularies appear to be slowly increasing in number. Twenty-two percent of certificates had a plan with a managed formulary in 2019, compared to 21% in 2015. Seventy-one percent had drug plans with open formularies, compared to 72% in 2015, which leaves 7% with a plan that mimics the provincial formulary (unchanged from 2015).

CHART 16 | Certificates with plans that include managed formularies, 2019 versus 2015

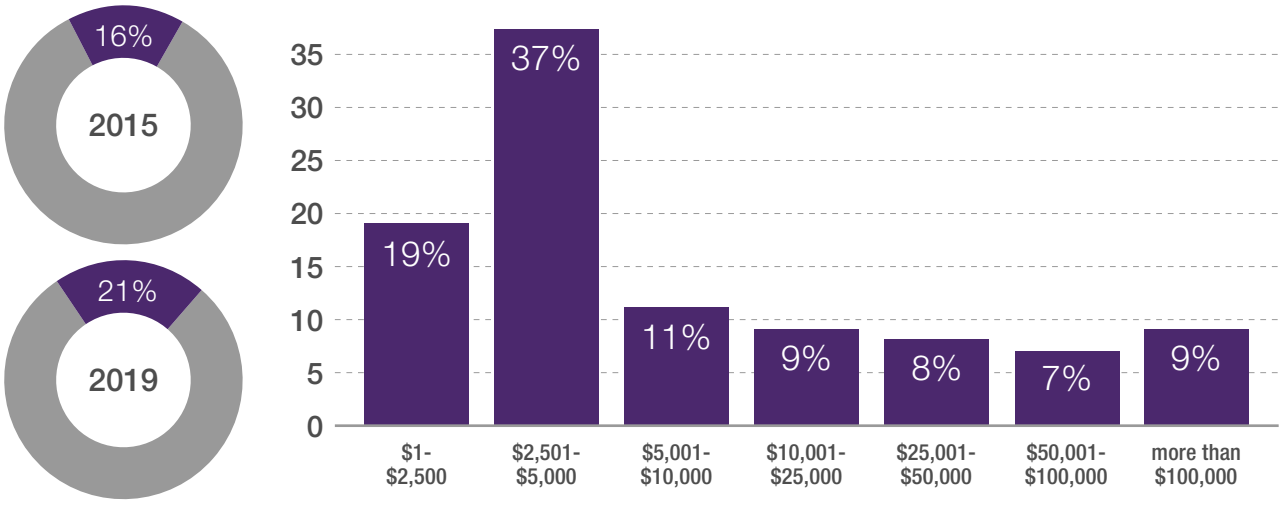
Annual maximums

Twenty-one percent of certificates had drug plans with annual maximums for coverage in 2019, compared to 16% in 2015.

> Small employers are more likely to consider annual maximums given how catastrophic even one high cost claimant can have on the overall drug program costs, notes O'Brien.

Among certificates with drug plan maximums, the most common maximums range from $2,500 to $5,000 per year (37%), followed by maximums of up to $2,500 (19%).

CHART 17 | Certificates with plans that include annual drug plan maximums, 2015 versus 2019



Breakdown of annual maximums among those with maximums

Prior authorization

Interestingly, fewer certificates had plans that included prior authorization in 2019, at 89%, compared to 93% in 2015. This likely reflects a more targeted approach. “When we think back to 2015, prior authorization was geared toward more lower-cost drugs, for example proton pump inhibitors, [to prevent off-label prescribing.] Now it is really focused on higher-cost drugs, to make sure patients get the right drug at the right time to balance that sustainability in the drug plan,” observes O’Brien.

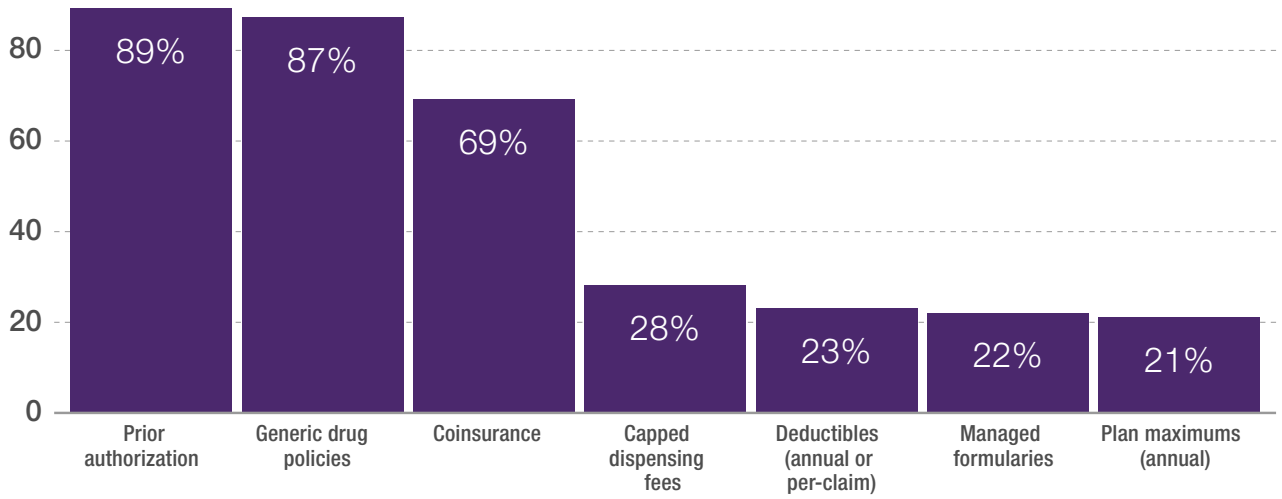
CHART 18 | Certificates with plans that include prior authorization, 2015 versus 2019

Summary & recommendations

Prior authorization is the most common plan design tool, followed by generic drug policy. Within generic drug policies, the industry is witnessing a steady shift towards mandatory generic substitution. Coinsurance is also a popular and effective cost-containment measure, although uptake appears to have plateaued.

- Private drug plans without policies for generic substitution and/or coinsurance can work with their benefits advisor to identify and address the major barriers to adoption.
- As part of coinsurance, private plans can include an out-of-pocket maximum to help ensure that plan members' contributions to claim costs do not exceed a threshold that would create any financial hardship on the member.
- To assess the feasibility and benefits of a managed formulary, plan sponsors can work with their benefits advisor to estimate cost savings and the impact on plan members—and to discuss approaches for implementation that minimize negative reactions from plan members.
- Plan sponsors can review their dispensing fee cost distribution to determine if potential cost savings warrant a capped fee.

CHART 19 | Summary of certificates with plans that include the following drug plan design tools, 2019



4. **Specialty drugs**

Snapshot

Specialty drugs' disproportionate share of total eligible cost continues to grow, and this is expected to continue given Canada's drug pipeline.

- Private plans in Atlantic Canada spend the most on specialty drugs, while the pharmacare provinces in Western Canada spend the least
- Specialty drugs dominate treatments for rheumatoid arthritis and cancer
- B.C.'s biosimilars switch policy appears to be having a positive impact on private drug plans as uptake of biosimilars continues

Share of costs & claimants

Specialty drugs' share of eligible costs has more than doubled in the past 10 years, from 14% in 2010 to 30% in 2019. The number of claimants, meanwhile, continues to hover around 1%. The large gap between costs and claimants dramatically illustrates that pricing and utilization per claimant are the main drivers of growth.

> "While these breakthrough drugs come at a high cost, they are changing the way we treat serious conditions. The technology has come a long way with more targeted drug therapy, such as immunotherapy. In the long term, these targeted therapies may become more cost-effective as they are novel treatment options for diseases that have historically been undertreated, says O'Brien."

As in past years, specialty drugs' share of eligible costs is highest in Atlantic Canada at 38%. This reflects the fact that the prevalence of certain rare diseases, such as Fabry disease, is higher in this population base compared to the rest of Canada.

In contrast, specialty drugs account for a relatively low share of 23% in Western Canada. Unlike in Atlantic Canada, epidemiology is not a factor. Instead, it comes down to funding: the Pharmacare programs in B.C., Saskatchewan and Manitoba automatically become first payer for prescription drugs once plan members have paid an income-based out-of-pocket deductible.

Specialty drugs dominate in two of the top five drug categories by eligible cost and are a growing factor in a third category. Rheumatoid arthritis drugs account for 12.1% of total eligible costs, which breaks down into 12.0% for specialty drugs (namely biologics) and 1% for traditional drugs. Put another way, specialty drugs account for 99% of eligible treatment costs for rheumatoid arthritis. They account for 54% of costs for skin disorders, the number-three category (i.e., the category's 6.9% share of total eligible costs breaks down into 3.7% for specialty drugs and 3.2% for traditional drugs). Specialty's share of costs for asthma/respiratory conditions (such as COPD), which ranks fourth, was 20% in 2019, and that is expected to steadily grow.

For cancer treatments, specialty drugs accounted for 79% of eligible costs in 2019. For more on the top drug categories, see page 40.

When eligible costs are expressed as a monthly average per certificate, specialty drugs represented $29 in average monthly costs in 2019, up from $21 in 2015 (a 38% increase). That compares to $66 in monthly costs per certificate for high-volume, lower-cost traditional drugs, an amount that has changed little in the past five years. Combined, that adds up to an average monthly cost of $94 per certificate (note: numbers do not add up due to rounding).

Over the past 10 years, the cost per certificate for specialty drugs saw an average increase of 10.9% each year, versus an average decline of 1.06% for traditional drugs. When combined, the eligible cost per certificate increased 1.3% annually.

Assuming all factors remain equal, forecasting indicates that the average eligible cost per certificate for traditional drugs will continue to decline, to about $64 by the end of 2025. However, the average for specialty drugs may mushroom to $55, resulting in a total monthly certificate cost of $119. Put another way, specialty drugs may see their share of the certificate cost grow from 31% in 2019 to 46% in 2025.

> “Is this sustainable? While this is a simple forecast and we can expect some offsets, for example from biosimilars, it’s reasonable to say this could create a whole new set of challenges in controlling costs, says O’Brien.”

CHART 20 | Specialty drugs by share of claimants and eligible costs, 2010 – 2019

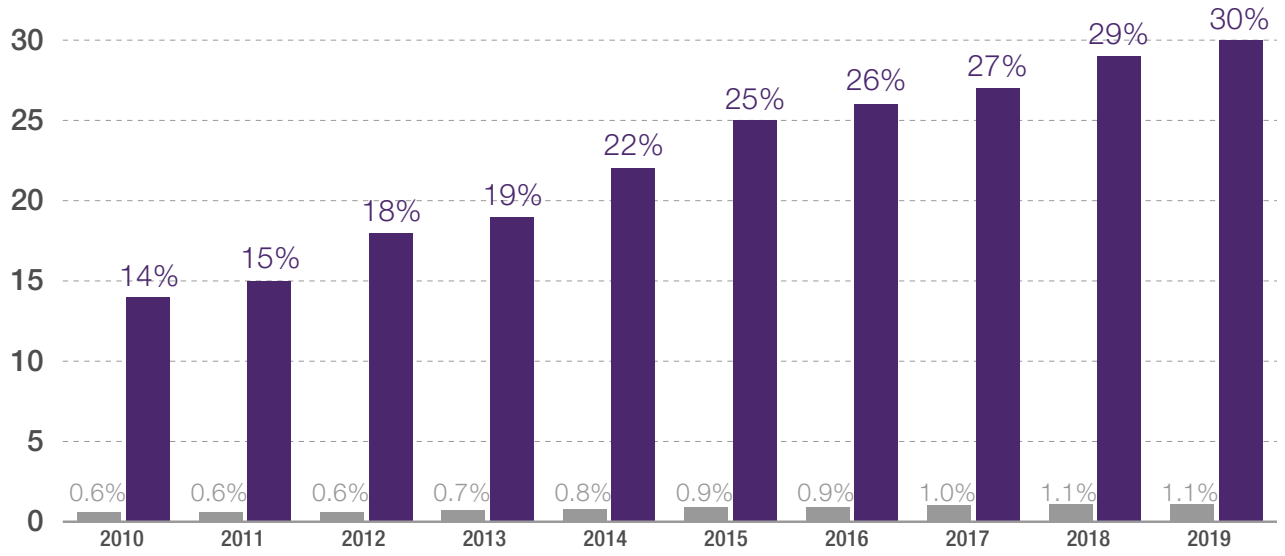


CHART 21 | Specialty drugs' share of eligible costs, 2019, by region

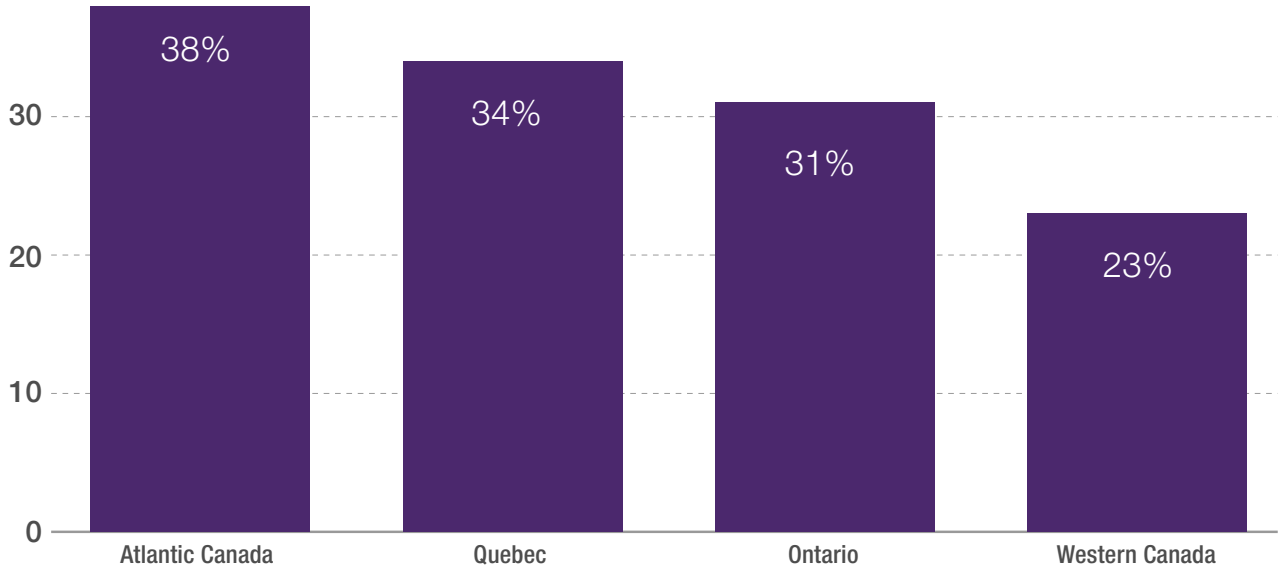


CHART 22 | Breakdown of eligible costs between specialty and traditional drugs by therapeutic area, 2019

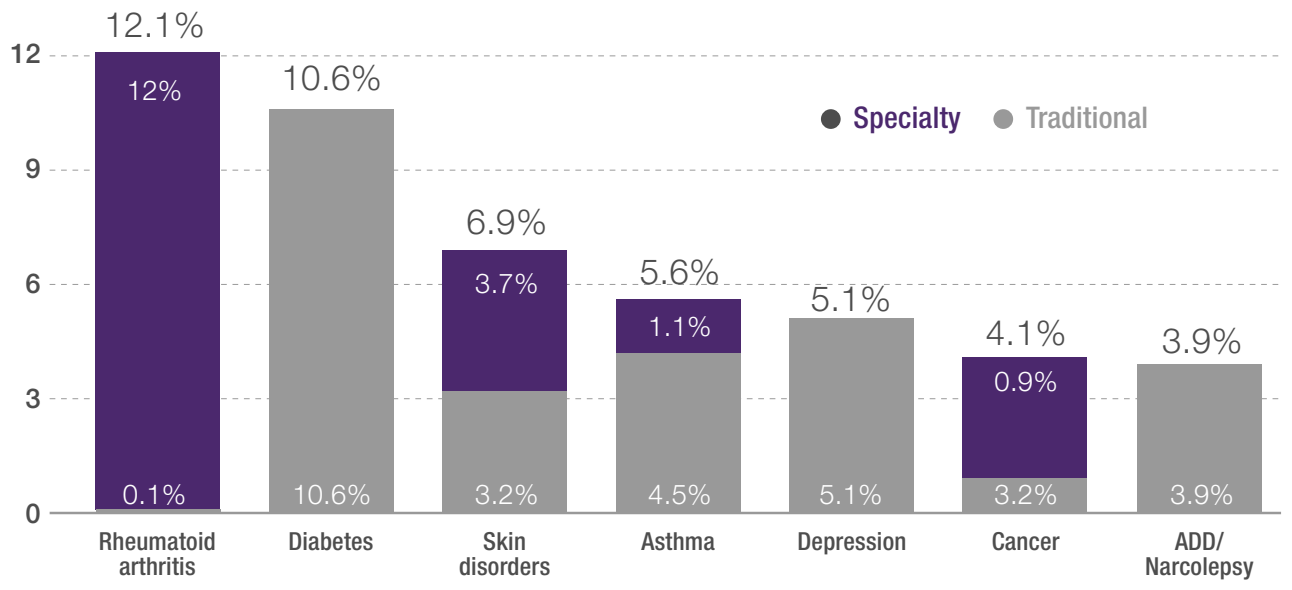
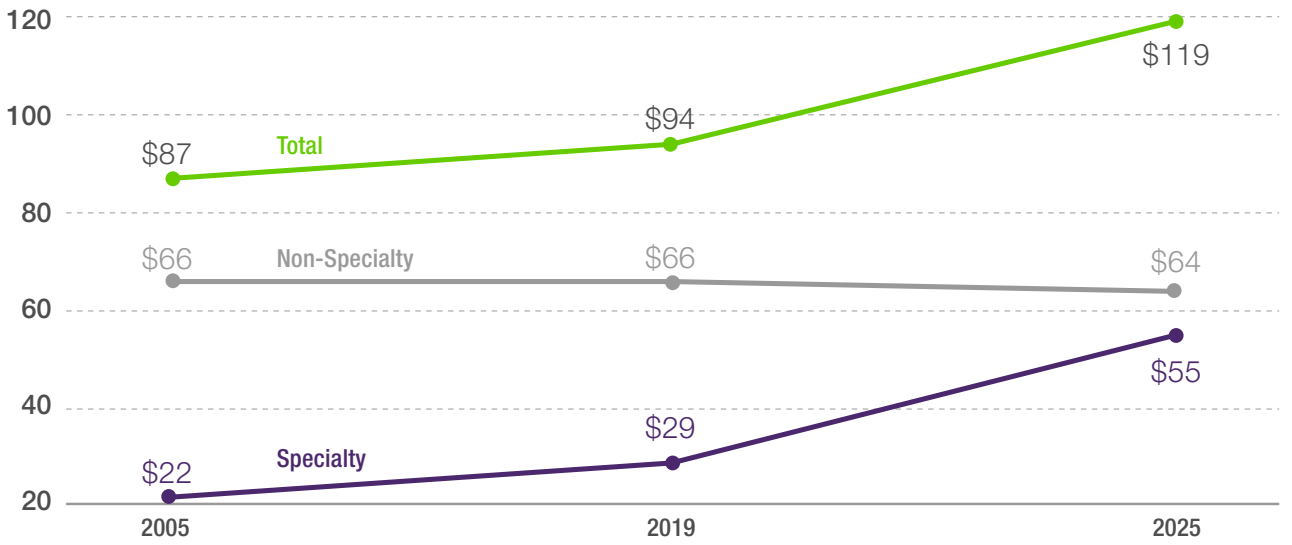


CHART 23 | Monthly cost per certificate by type of drug, 2015 – 2019



Note: numbers may not add up due to rounding

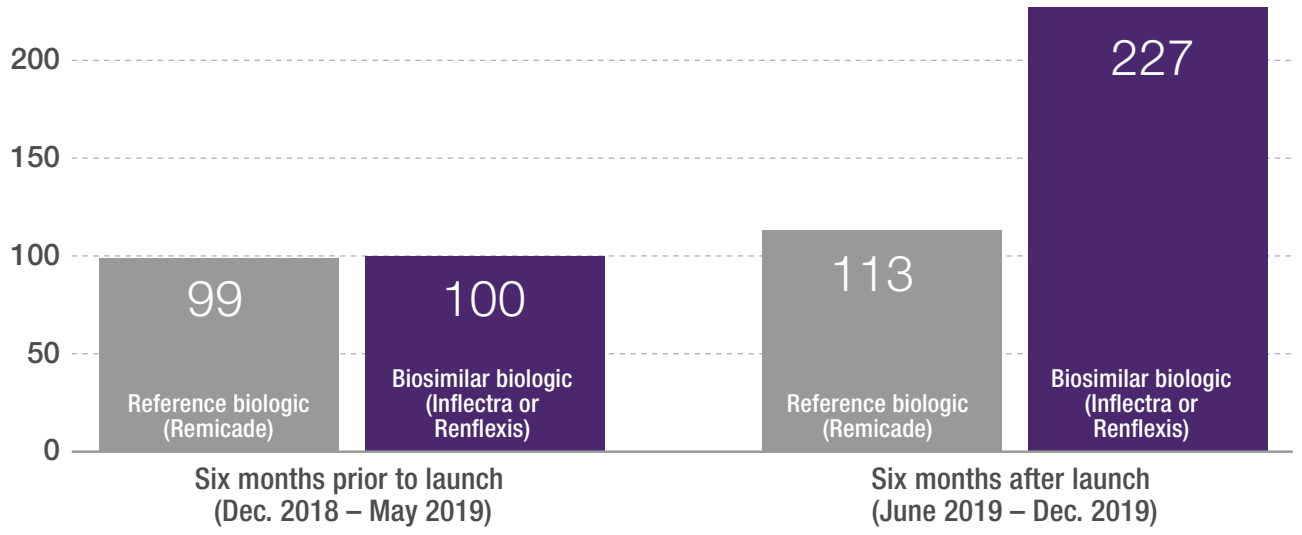
Biosimilar biologics

In 2019, B.C. became the first public payer to implement a mandatory switching policy for certain biologic drugs. Beneficiaries had to switch to a biosimilar in order to continue receiving coverage from the public plan. Alberta and Ontario announced they would implement a similar switching policy in 2020, before COVID-19 prompted an emergency lockdown and postponed the release of these initiatives.

Will these provincial switching policies affect uptake of biosimilar for private drug plans? Based on early data from B.C., "yes" appears to be the answer.

B.C. launched phase 1 of its switching program in late May 2019. During the six-month period prior to launch, private drug plan members who were starting treatment for an inflammatory disease such as rheumatoid arthritis were equally likely to submit a claim for a reference biologic as they were for a biosimilar. Immediately after launch, new patients were twice as likely to submit claims for a biosimilar. "Based on these early results, it appears that the public initiative in B.C. is influencing physician prescribing habits for all patients," notes O'Brien.

CHART 24 | New patients in B.C. using biologics, before and after launch of public switching policy



Summary & recommendations

Just 1.1% of claimants accounted for 30% of total eligible costs in 2019. In pharmacare provinces, specialty drugs' share of private plans' co sts is noticeably lower. If current trends continue, specialty drugs are forecast to account for almost 46% of the average monthly certificate cost by 2025. Lower-priced biosimilars for some of the more frequently prescribed specialty biologics may reduce the growth curve, although uptake needs to increase significantly.

- Plan sponsors can work with their insurance carriers and benefits advisors to develop a long-term strategy for the coverage of specialty drugs, particularly in the event of claims for ultra high-cost drugs for rare diseases. A province-by-province process can be put in place to coordinate with public drug plans that assist with catastrophic drug costs.
- For biologics where biosimilars are available, prior authorization policies and managed formularies can direct new patients to start with a biosimilar.
- Using public drug plans as a model (phase 1 implemented in B.C. at this point), plan sponsors can investigate and consider a mandatory biosimilars switching policy for claimants already taking an originator biologic.

5. **Drugs** by therapeutic class

Snapshot

The top two drug categories—for drugs to treat rheumatoid arthritis and diabetes—remain comfortably in the lead.

- Drugs to treat skin disorders have climbed most rapidly and are now in third position
- High-volume, lower-cost drugs to treat depression, high blood pressure and infection have steadily lost ground to low-volume, higher-cost drugs
- Non-adherence rates are high for four of the top-10 drug categories

Top 10 drug categories

For 10 straight years, drugs to treat rheumatoid arthritis (RA) top the ranking of eligible costs by drug category. The fact that less than half of one percent of claims are behind those costs reflects the high price point of most of these medications (ranging from approximately $20,000 to more than $50,000 annually for a biologic, depending on the drug and patients' needs).

Chart 25 provides a snapshot of whether price, volume or a combination of the two is the main driver of growth behind the top 10 categories.

Drugs for diabetes rank second due to a combination of volume and pricing. The volume is relatively high at 7.0% of claims, yet the gap between share of claims and eligible cost (10.6%) indicates the average price point in this category is climbing.

> "About two-thirds of diabetes costs come from a new class of drugs that are more costly but also much more effective for patients who are not getting results from other therapies. That combined with more long-term utilization, as more people are diagnosed with type 2 diabetes, are driving overall costs, says Kennedy."

Pricing is the biggest factor behind the rankings for drugs to treat:

- Cancer (ranked sixth, with 4.1% of eligible cost and 0.6% claims)
- Multiple sclerosis (eighth, 3.6% and 0.1%, respectively)
- Skin disorders (ranked third, with 6.9% of cost and 4.0% of claims
- Attention deficit hyperactivity disorder (ADHD) and narcolepsy (seventh, 3.9% and 2.6%, respectively)

Three of the categories in the top 10 are there primarily due to volume. Drugs for depression represent the highest share of claims (9.5%); meanwhile, their 5.1% share of costs reflects a relatively low average price point due to the predominance of lower-priced generic drugs. Similar can be said for drugs to treat blood pressure (8.6% of claims, 3.3% of cost) and infection (7.2% and 2.9%, respectively).

Last but not least, the asthma category is ranked fourth overall due almost equally to cost (5.6%) and claims (5.5%). TELUS Health expects that pricing will become the more dominant factor, as more specialty drugs become available in the category (see page 31).

The skin disorders category climbed most in rankings, from seventh position in 2015 to third in 2019. This reflects the growing use of new high-cost specialty drugs for psoriasis, atopic dermatitis and other skin disorders. New high-cost drugs for cancer—which are available in tablet form or are self-injectable and therefore covered by private plans, rather than hospitals—helped propel that category on to the top-10 list in 2017, and its ranking has climbed to sixth. Drugs for ADHD/narcolepsy are also relatively new on the top-10 list and have moved up in the ranking for the third consecutive year.

It's also worth noting that modifiable risk factors, or lifestyle changes (e.g., smoking cessation, weight loss), may be involved in five of the top-10 disease states: diabetes (type 2), asthma, depression, certain cancers and high blood pressure. "Plan sponsors that review their plan data through the lens of determining areas of focus for wellness-related activities can help blunt their cost curve," suggests O'Brien. "A 'pre-claim' focus on these conditions could help lessen the health burden on cost where exposure can be reduced through more targeted wellness activities."

New diabetes monitor makes its mark

One product stands out in the TELUS Health ranking of top products in 2019 by eligible cost: Freestyle Libre, a new glucose monitor that uses a small sensor to automatically and continuously measure blood glucose levels for people with diabetes. It jumped to seventh position, up from 40th in 2018.

"It's very convenient and there's no need for lancets or test strips. The expectation is that it will improve adherence, which will lead to better health outcomes," says Jason Kennedy, Director, Health Business Consulting, TELUS Health.

Freestyle Libre and other continuous glucose monitoring systems are recommended for people with diabetes (type 1 or type 2) who use insulin, who may be having difficulty reaching target blood glucose levels.

CHART 25 | Top 10 drug categories by eligible cost

For treatment of:	Rank	% eligible cost	% claims
Rheumatoid arthritis	1	12.1%	0.4%
Diabetes	2	10.6%	7.0%
Skin disorders	3	6.9%	4.0%
Asthma	4	5.6%	5.5%
Depression	5	5.1%	9.5%
Cancer	6	4.1%	0.6%
ADHD/narcolepsy	7	3.9%	2.6%
Multiple sclerosis	8	3.6%	0.1%
High blood pressure	9	3.3%	8.6%
Infection	10	2.9%	7.2%
% of total eligible costs and claims		**58.1%**	**45.5%**

CHART 26 | Rankings of top 10 drug categories by eligible cost, 2015 – 2019

For treatment of:	2015	2016	2017	2018	2019
Rheumatoid arthritis	1	1	1	1	1
Diabetes	2	2	2	2	2
Skin disorders	7	5	5	3	3
Asthma	4	4	3	4	4
Depression	3	3	4	5	5
Cancer	11	11	9	6	6
ADHD/narcolepsy	10	10	10	9	7
Multiple sclerosis	9	9	8	8	8
High blood pressure	5	6	6	7	9
Infection	6	7	7	10	10

Adherence

A significant number of claimants using medications on the top-10 therapy category list have difficulty taking their medications as prescribed. The rate of non-adherence is by far the highest—65.8%—among those with asthma, a category that accounted for 5.6% of total eligible costs and 5.5% of claims in 2019.

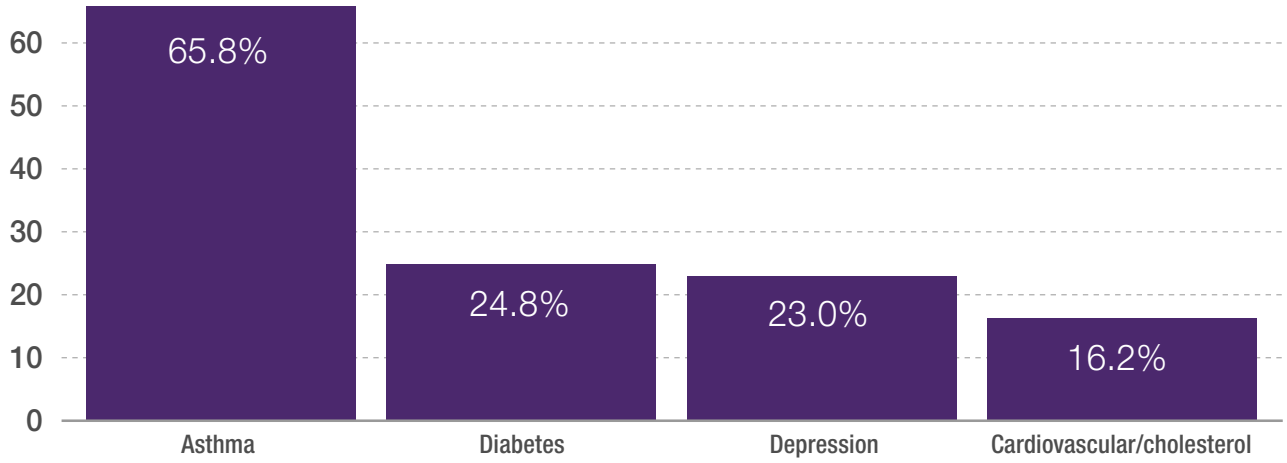
Non-adherence is also high among claimants taking drugs for depression (23.0%), diabetes (24.8%) and cardiovascular conditions (high blood pressure and high cholesterol, 16.2%). These categories represent 28% of total eligible costs.

> Adherence could be improved across several prominent conditions, which could have a positive impact on health outcomes and lower the cost curve going forward, suggests Kennedy.

TELUS Health uses a calculation called the "medication possession ratio (MPR)" to capture rates of non-adherence; put simply, the ratio captures whether claimants are refilling their prescriptions on time. Non-adherence occurs when the MPR is less than 0.8, which suggests that someone did not take their medication as prescribed 20% of the time. When this occurs, a medication for treating a chronic condition is likely not as effective as it could be.

For asthma, the high rate of non-adherence based on MPR also reflects that fact that for many people asthma is seasonal. They fill their prescription for an inhaler in the spring, then find they do not need to refill their prescription until the fall. "Even after factoring in possible seasonality, non-adherence is high among asthma patients due to inadequate inhaler technique, or they are refilling less frequently than the days' supply on the prescription suggests," says Kennedy.

CHART 27 | Rates of non-adherence by therapeutic area, 2019



Canada's drug pipeline

Private drug plans in Canada can expect a relatively quiet year for drug launches in 2020, compared to previous years. Yet a handful of launches will likely have an impact.

For larger patient populations, new medications for diabetes and depression (such as those that suffer from treatment-resistant depression) are indicated for patients who struggle to manage their condition despite efforts to use existing therapies. While both are priced relatively much higher than first-line therapies, their potential to offset other healthcare costs, including absenteeism and lost productivity, is high.

At the other end of the population spectrum, Canada may see its first gene therapy in late 2020 or early 2021. The treatment is for a very rare eye disorder, affecting just 100 to 200 Canadians, and comes at an estimated price of $1 million for both eyes.

Get more details on the current pipeline in the TELUS Health report, The Drug Pipeline: What private plans can expect in 2020.

Categories up close

A number of drug categories have seen an evolution following the launch of breakthrough drugs in recent years. The TELUS Health "Drug Pipeline: Whatever happened to?" report takes a closer look at the impact of breakthrough drugs in five categories: cancer, cholesterol, migraine, hepatitis and weight management. Each category has a different, equally interesting story to tell. Here are a few highlights:

Cancer - While the patient population is low relative to other categories, the number of claims and cost per claimant climb steadily, so much so that category now ranks sixth overall (see page 43). Data for just one of the new, targeted therapies indicate that just a handful of claims could have a major impact on a private drug plan.

Cholesterol – Access to the new biologic medications (PCSK9 inhibitors) appears to be appropriately managed. Perhaps more noteworthy is the steady growth in claimants who are taking traditional cholesterol drugs, which suggests that more can more be done in the areas of prevention and adherence.

Migraine – Even before the new biologics arrived, the number of plan members claiming for migraine drugs has steadily increased. While it's still early days in terms of claims data, the higher-cost biologics—the first preventative therapy for chronic sufferers—may reduce the use of traditional drugs and general additional offsets, such as fewer sick days.

Summary & recommendations

The top 10 list of drug categories is a blend of high-volume, lower-cost drugs and low-volume, higher-cost drugs. In the former group, generic drug options have driven down their share of overall costs. In the latter, new breakthrough therapies provide effective treatment and are generally indicated for targeted groups of patients (including those who are having difficulty managing their conditions). Drugs for diabetes and asthma straddle both camps, with well-established first-line therapies that are heavily genericized, and new targeted therapies with price points that are significantly higher than the first-line therapies.

Private drug plans experienced their biggest increase in overall eligible costs (based on monthly cost per insured) in 2019 compared to the previous four years, after experiencing negative growth in 2018. While much of this can be attributed to the short-lived OHIP+ program in Ontario, which removed insureds under the age 25 from the book of business for a period of 15 months, attention must be paid to other enduring factors.

- It is increasingly important for plan sponsors to work with their benefits advisors to get regular reporting on the top drug categories for their workforce, ranked by costs as well as by volume, in order to identify and address high-priority areas.
- Plan design tools such as mandatory generic substitution and prior authorization lay the foundation for a stable drug plan; a managed formulary can be an important additional measure for sustainability.
- The industry also needs to take a fresh look at measures to improve adherence rates. Technology, such as targeted reminders and app-based medication management programs, can play an important role. Chronic disease management programs would also help increase compliance and overall effectiveness of therapy.
- Plan sponsors can bring in or expand benefits outside the traditional drug plan to support members living with chronic disease; for example, health spending accounts or increased maximums on paramedical services so that plan members can tailor benefits to better meet personal needs.
- Evidence is also building for virtual counselling or health coaching, which can cost-effectively improve success rates for lifestyle changes such as stress management and weight loss.

6. **Conclusion**

On the one hand, specialty drugs continue their steady upward climb, attaining a 30% share of costs due to growth in both utilization and cost per claim. On the other hand, and equally important, traditional drugs appear to be coming out of a long period of low or negative growth. As a result, in 2019 these low-cost, high-volume drugs did not offset or counterbalance the growth in specialty drugs as much as in past years. This “turnaround” in traditional drugs does not necessarily reflect increased drug prices; rather, it reflects the diminished year-after-year impact of patent expiries and legislated reductions in generic drug prices.

Given the increasing complexities within and between specialty and traditional drugs, plan design tools that promote appropriate utilization as well as optimal health outcomes are essential to protect the sustainability of drug plans. Yet of the plan design tools measured in this report, only one (mandatory generic substitution) saw steady gains in the past five years. Looking ahead, new tools show great promise, such as biosimilar-switching strategies, adherence supports and chronic disease management programs for high-cost claimants (the latter two made more feasible with the use of digital technologies).

Last but not least, COVID-19 adds yet another layer of complexity to decision-making. For plan sponsors open to progressive change, the next few years may see a rapid evolution in both drug plan design and their overall role in supporting employee health.

2020

TELUS Health

Drug Data Trends

& National Benchmarks

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