

I N F O Bulletin

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Information Bulletin for Group Insurance Plan Administrators and Benefit Advisors

DRUG SPENDING STILL ON THE RISE IN 2006

Average drug spending per claimant in Canada increased from \$573 in 2005 to \$621 in 2006 according to a recently published report by ESI Canada¹. The 2006 average drug spending figure is double that of 2000.

What are the key factors that drive the ongoing rise in drug spending? In this article, we present a summary of ESI Canada's findings and analysis.

Drivers of Drug Trends

Utilization, ingredient costs and dispensing fees are the three factors that drive drug trends. They each account for a portion of the 2006 increase in drug spending.

- Utilization accounts for 36% of the total increase. Prevalence (more eligible members making claims) and intensity (more scripts per claimant) drive increased utilization.
- Ingredient costs account for 57% of the total increase. The shift to newer, more expensive drugs and treatments largely explains rising ingredient costs.
- Dispensing fees account for the remaining 7% of the total increase. Pharmacists charge dispensing fees when they issue prescription drugs. In 2006, insurance carriers reimbursed an average fee of \$8.14, up from \$7.83 in 2005.

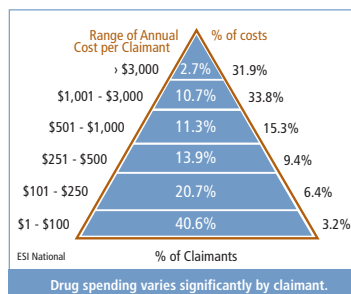
Demographics and Disease Prevalence

Drug spending varies by province, age group, and type of claimant. According to ESI Canada data, Ontario (\$650) and Quebec (\$610) have the highest average spending per claimant in Canada.

Not surprisingly, age is also an important cost factor to consider. The average amount spent in the 56 – 65 age group, at over \$1,200, is double that of the 36 – 45 group.

The pyramid opposite shows a breakdown of claimants according to annual spending on drugs.

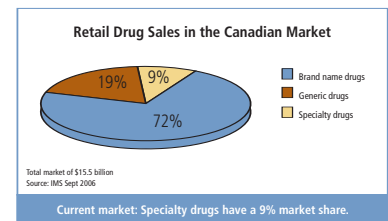
Only 13% of all claimants spend more \$1,000 annually on prescription drugs; yet their claims account for nearly 66% of total costs. It is assumed that the 2.7% of claimants at the top of the pyramid include persons suffering from very serious chronic conditions, such as rheumatoid arthritis, multiple sclerosis and cancer.



Other Factors Affecting Trends

Two other factors must be considered when analyzing drug spending: public policy and specialty drug development.

- Public policy and legislative changes aimed at managing costs in the public sector, often result in shifting costs to the private sector. Recent changes to government reimbursement policies, increased responsibilities for pharmacists, and the opening of an increasing number of private infusion clinics are some of the changes that impact the private sector. This will continue to be the case in the years to come.
- Specialty drugs are currently being developed by pharmaceutical companies to provide treatment options that were not previously available for certain specific conditions. Oral cancer drugs, such as Gleevec and Tarceva, are examples of this new type of specialty drugs. They are unlike any of the previously existing drugs and are much more expensive. Their market share is also growing at a faster rate than the traditional brand name and generic drugs.



Conclusion

Certain measures can be undertaken to help control rising drug costs; each one targets a specific trend driver.

- **Utilization:** Maintaining accurate and up-to-date information on spousal coverage is a good way of obtaining the most efficient utilization. It also ensures that Coordination of Benefits (COB) is applied properly when claims are reimbursed.
- **Ingredient costs:** Integrating incentives for generic drug substitution into the plan design is a good way of reducing spending on the more expensive brand name drugs.
- **Dispensing fees:** They may vary significantly from one pharmacy to another. In some instances, adding a dispensing fee cap can help ensure that the fees remain in the "reasonable" range. Setting a "Usual and Customary" drug price is another way to achieve a similar result.

Plan sponsors wishing to obtain further information on drug cost control may contact their benefits advisor or their Industrial Alliance account executive. Additional information about drugs and drug trends is available through ESI Canada's Web site (www.esi-canada.com).

¹ ESI Canada, ESI Canada 2006 Drug Trend Report, 2007. ESI Canada is Industrial Alliance's partner in providing Pharmacy Benefits Management services. The Drug Trend Report is based on 60 million pharmacy claims from six million Canadians covered by insurance carriers.



INSURANCE FRAUD: A SERIOUS ISSUE

As health and dental claim costs continue to rise, insurance fraud is increasingly becoming a matter of concern for plan sponsors, benefit advisors, and insurance providers.

It is estimated that 5 – 15% of every health insurance dollar spent in North America is lost to fraud. Fraud costs in Canada are over \$12 billion each year.

How to Recognize Insurance Fraud

Fraud occurs when information is deliberately withheld or it is misrepresented so as to ensure the payment of an insurance claim, from which a claimant, a service provider or another party stands to benefit financially. Anyone who knowingly directly or indirectly benefits from such an action (such as by getting a kickback) is party to a fraudulent act.

Categories of Fraud and Abuse

Most cases of insurance fraud fall under the following broad categories:

- **Fraudulent or Abusive Billing Practices**

This category includes health service providers that bill for services not rendered or that bill incorrectly for services rendered. It also includes certain inappropriate billing practices by hospitals, such as billing patients for a stay in a semi-private or private room, when the room had been reserved for them but they never occupied it.

- **Fraudulent or Abusive Prescriptions**

This type of fraud occurs when a prescription is issued for an unnecessary service or medical device, or when a prescription is falsified to allow a medical supplier to receive payment for services or devices that are not medically necessary. Providing hospitalized patients with a private or semi-private room that they did not request, or for which the hospital is obligated to pay for because of the nature of the treatment, also falls under this category.

- **Issuing False Documents and Statements/Withholding Information**

There are generally two types of false documents: false receipts and legitimate receipts that have been altered. Issuing False statements and withholding information are most often associated with disability claim fraud. Here are some examples that fall under this category:

- Misstating restrictions and limitations;
- Failing to report other sources of income;
- Failing to report employment activities (paid or unpaid); and
- Falsifying or altering documents to support the claim.

Industry Driven Initiatives

Insurance carriers consider fraud to be a serious industry-wide problem that negatively impacts their clients' bottom line. Staff training, expansion of audit services, and support of the Canadian Health Care Anti-Fraud Association (CHCAA) are among the initiatives that insurers are taking to help counter fraud.

Industrial Alliance, which has been working on this issue for some time, has established a special task force to monitor the more sensitive areas where fraud can occur and take action when needed. According to Marlene Ivay, Audit Services Co-ordinator at Industrial Alliance, these efforts will intensify in the coming months:

"We intend to focus our efforts on proactive measures, such as promoting better business practices with service providers, and increasing fraud awareness with plan sponsors," says Ivay. "We will also continue to work in partnership with the industry to address this issue. The ultimate objective of all our efforts is to protect our clients' investment with Industrial Alliance, and prevent a minority from benefiting at the expense of the majority."

What can plan sponsors and members do?

Plan sponsors can help detect and prevent fraud. One way is by effectively communicating with employees. Doing so increases employee awareness of insurance fraud, its impact on plan costs, and its legal implications. Another way is by co-operating with the insurer when an employee's claims are being audited.

Plan sponsors and members insured with Industrial Alliance, who suspect that fraudulent activities may be going on within their plan, should call Audit Services at 1-866-789-3938 or send an e-mail to ia_audit_services@inalco.com. This service is totally confidential, and callers may remain anonymous.

About Industrial Alliance

The INFO Bulletin is presented to you by Industrial Alliance.

Industrial Alliance is among the most solid financial institutions in the country and is a leader in insurance and financial services. With offices from coast to coast, Industrial Alliance contributes to the financial well-being of over 3 million Canadians and has \$50 billion in assets under management and under administration, making it the 5th largest life and health insurance provider in Canada.