2022 Drug Data Trends & National Benchmarks

TELUS® Health

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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/certificate holder:	The covered employee (also referred to as the primary cardholder) and his/her/their linked co-beneficiaries (i.e., spouse, children).
Claimant:	An insured individual who has submitted a claim for a medication or medical product that is eligible for coverage under a drug plan.
Eligible amount:	Dollar amount of the drug cost 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.
High-cost claimants:	Claimants with an annual eligible amount of more than $10,000. Within this group, those with an annual eligible amount of more than $100,000 are described as ultra-high-cost claimants.
Insured(s):	Abbreviation for “insured individual(s),” i.e., employee(s), spouse(s) or dependent(s) with insurance coverage, whether or not a claim was made during the reporting period.
Multi-source brand:	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 an “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.

Report foreword

This report is dedicated to healthcare professionals who have continued to care for patients through these incredibly difficult times. We recognize your continued dedication, perseverance and **thank you for all that you do.**

The TELUS Health 2022 Drug Data Trends and National Benchmarks report (TELUS Health report), the third to be released during the pandemic, examines trends in Canada's health insurance and prescription medication space and provides insight into the factors driving those trends.

In light of this past year's intense levels of activity to make vaccines and treatments for COVID-19 available, this report is key for insurers to better understand important changes in the industry as they look forward to life beyond the pandemic. One of the key observations: despite the pandemic-led downward trend on the number of insureds making claims, there is still noticeable growth in the average monthly eligible and claimed amounts. The continued rise in the use of specialty and other higher-cost medications, including ultra high-cost medications for rare diseases, is the main driver of this trend.

The TELUS Health report considers the major trends in private drug plan costs, utilization and plan management in 2021. It also provides indications of shifts in trends as we navigate our rapidly changing world and begin to consider a less COVID-19-cautious Canada.

Through 2021, the number of insurance plan members (insureds) who made a claim decreased. We believe that this is most likely attributed to the pandemic continually restricting access to healthcare, and therefore, fewer diagnoses and prescriptions took place. However, the overall average eligible amount per claim considered by plans rose by 8.9 per cent, which is higher than the past four years and 2.6 times higher than the Consumer Price Index (CPI). This continues to follow trends of previous years and is especially remarkable for 2021, when the CPI was the highest it has been since 1991.

The average monthly eligible amount per insured in 2021 also increased, in large part due to a higher amount per claim. Overall utilization based on the number of claims per insured decreased 3.5 per cent, while the average cost per claim rose 8.9 per cent, which reflects a continued five-year trend. Importantly, despite declines in the number of insureds who submitted claims in the past two years, the upward cost trend still occurred.

Similar to our findings from 2020 and before the pandemic, specialty drugs continue to make a bigger impact on overall utilization trends than traditional drugs. Specialty drugs make up more than one-third of costs for less than two per cent of claimants. In 2021, specialty drugs' growth rate when expressed as an average eligible amount per insured fell just shy of double digits (9.5 per cent), compared to 2.9 per cent for traditional drugs. Assuming current trends continue, TELUS Health forecasts that by the end of 2026, specialty drugs will account for almost half of the average eligible amount per certificate.

Medications for depression climbed to fourth position on the top 10 list of drug categories. While this is in part due to a drop in the asthma category's share of the total eligible amount, it also reflects ongoing mental health challenges that have likely been intensified by the pandemic. Additionally, the diabetes category is steadily gaining on rheumatoid arthritis, which has long held the top position among categories based on eligible amounts, which suggests a correlation between the increase in use of diabetes medications and the rise in obesity rates. However, further research would be needed to determine the causality of this assumption.

Another major piece to consider regarding the leading categories by eligible amount is the fact that four of the top 10 categories are dominated by high-cost, specialty drugs prescribed for small numbers of patients. When the lens is switched from categories to claimants, TELUS Health data reveals that less than two per cent of claimants submit annual eligible amounts that exceed CAD$10,000. These claimants accounted for 40 per cent of the total eligible amount in 2021, up from 33 per cent five years ago. Furthermore, a fraction of claimants, just 0.03 per cent, accounted for close to six per cent of the eligible amount in 2021. These ultra-high-cost claimants are taking drugs to treat rare diseases, which can cost hundreds of thousands of dollars annually.

On the cost-savings front, the impact of biosimilar biologic drugs is promising, based on evidence so far in B.C. Private drug plans in that province saw the share of lower-cost biosimilar drugs soar from seven per cent of the eligible amount for biologics in January 2019 to 65 per cent by the end of 2021.

In terms of savings, by the end of 2021 the relative eligible amount per claimant in B.C. for a biologic was 66 per cent of what it was in January 2019.

The TELUS Health report also makes note of how the pandemic led to delays in diagnosis and treatment for conditions such as depression and cancer across Canada. This resulted in a material reduction in claims or claimants, and the repercussions will likely take years to unfold as provincial healthcare systems catch up on screening, diagnoses and treatments. Unfortunately, studies already show that patients are presenting with more advanced disease.

More is needed to determine whether adoption levels of some plan management tools have indeed plateaued or even started to decline, pandemic notwithstanding. Regardless, pre-pandemic data indicates that growth rates have been modest at best. One of the main factors for plan sponsors and their providers to consider is the increased use of high-cost specialty drugs for fewer claimants.

Those in the health insurance space must continue to look for clues on how much life has changed and how those changes will continue to impact those who use their benefit programs. As we phase into a world less focused on COVID-19 and more on the "new normal," it is increasingly important for policy makers, plan sponsors and employers to drive improvements and innovative practices to maintain a social responsibility to their employees and users of health benefits plans.

TELUS Health hopes the findings and insights on drug trends in Canada in 2021 can further guide important conversations, foster innovation in Canada's health benefits industry, and support our industry peers as we transition into operations beyond the pandemic.

The Canadian healthcare system continues to amaze us with its ability to adapt and move forward in the face of constant adversity. We greatly appreciate your dedication to the advancement and innovation and look forward to continuing to work together in the coming year.

Martin Bélanger
Vice-President, Health Benefits Management
TELUS Health

All data presented in this report is gathered from the 2022 TELUS Health database.

1. Introduction

Year two of the COVID-19 pandemic saw the continuation of much lower rates of prescribing for high-volume drugs such as antibiotics and analgesics. As well, for the second year in a row, more insured individuals (insureds) made no claims at all, reflecting the decreased frequency of medical appointments.

Yet despite these pandemic-driven downward trends, the average monthly eligible amount per insured grew by the same amount in 2021 as it did in 2019, before the pandemic (by 5.0% in both years). As well, the average monthly eligible amount per claim jumped by 8.9% in 2021, well above growth rates for the previous four years.

To put this into a larger context, in the past two years, annual growth rates for the eligible amount per claim significantly outpaced the average annual increases in the Consumer Price Index (CPI). What makes this more remarkable is the fact that the CPI's increase of 3.4% in 2021 was its highest since 1991.

Specialty drugs are the main driver behind the higher amounts submitted for adjudication by private drug plans. Their contribution to the growth rate in the eligible amount per insured fell just short of double digits in 2021.

Trends in the diabetes category also contribute to growing costs for private drug plans. While price points of newer diabetes products fall well below the threshold of what defines a specialty drug, these products are much more expensive than first-line therapies and their utilization is climbing steadily. Indeed, the diabetes category appears set to depose rheumatoid arthritis drugs from their long-held position as the number-one category by eligible amount, in part because public switching policies will increasingly result in more prescriptions for lower-cost biosimilar biologics for rheumatoid arthritis.

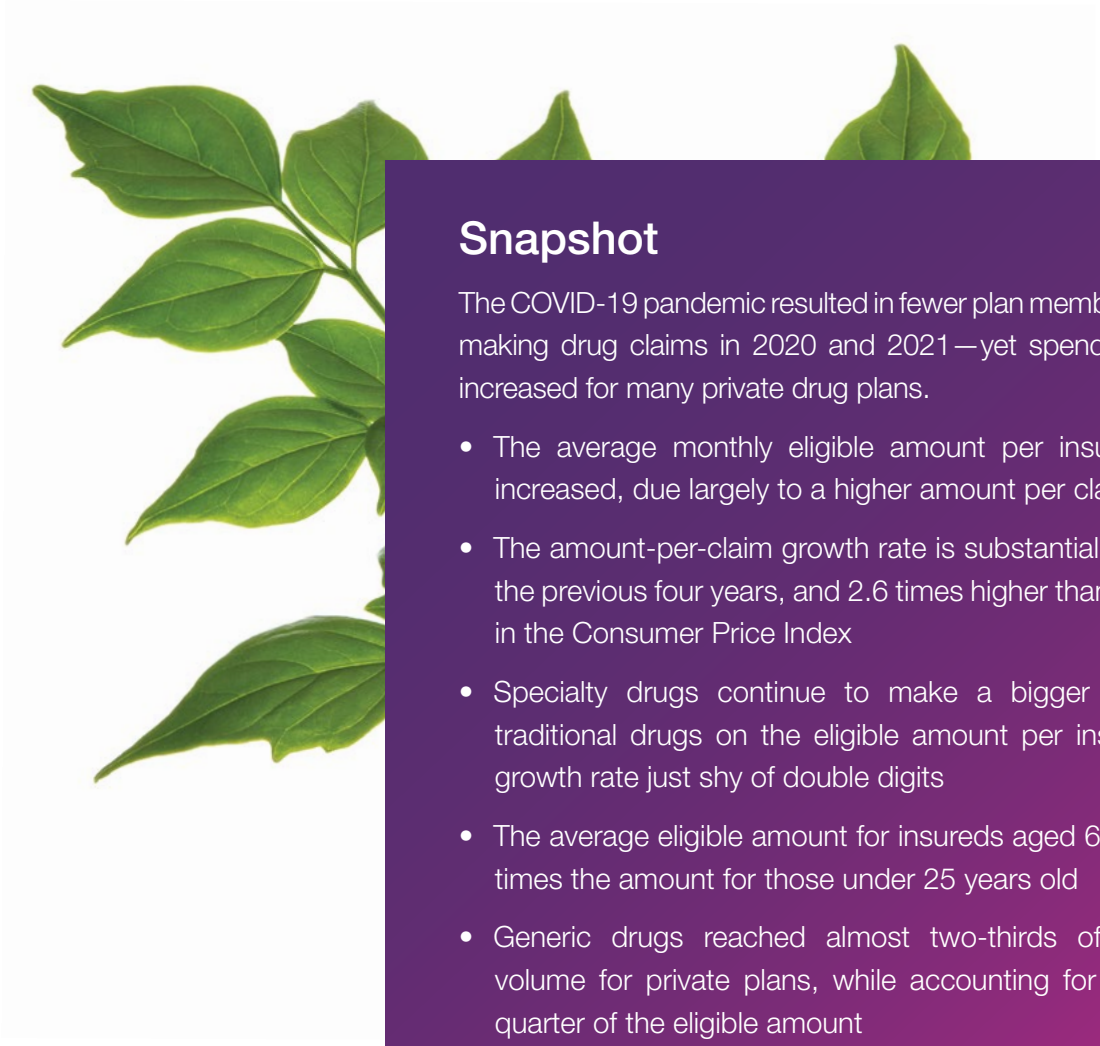
Activity in the depression category must also be noted. While its share of the total eligible amount within TELUS Health's book of business did not increase during the two years of the pandemic, claims volume and the number of claimants did increase. A closer look at the top categories by number of claimants, broken down into age groups, reveals that antidepressants have boosted their ranking from fifth to third position for claimants aged 20 to 39 as well as for those aged 40 to 59.

The TELUS Health 2022 Drug Data Trends & National Benchmarks report captures the claims activities of more than 5.2 million certificate holders in 2021. In addition to claims data trends, this report summarizes adoption rates of plan management tools such as mandatory generic substitution and managed formularies.

> "The growing mix of higher-cost specialty drugs as well as more widespread utilization of drugs for diabetes and mental health are propelling costs upward. Delayed diagnoses and treatments for serious conditions such as cancer will also likely have an impact in future years."

Shawn O'Brien, Principal, Data Enablement and HBM Product, TELUS Health

2. Costs & utilization



Snapshot

The COVID-19 pandemic resulted in fewer plan members (insureds) making drug claims in 2020 and 2021—yet spending has likely increased for many private drug plans.

- The average monthly eligible amount per insured in 2021 increased, due largely to a higher amount per claim
- The amount-per-claim growth rate is substantially higher than the previous four years, and 2.6 times higher than the increase in the Consumer Price Index
- Specialty drugs continue to make a bigger impact than traditional drugs on the eligible amount per insured, with a growth rate just shy of double digits
- The average eligible amount for insureds aged 60 to 64 is 6.6 times the amount for those under 25 years old
- Generic drugs reached almost two-thirds of prescription volume for private plans, while accounting for just under a quarter of the eligible amount

Cost trends

The average monthly eligible amount per insured grew by 5.0% in 2021, compared to a growth rate of 3.6% in 2020 (Chart 1). On the surface, these results continue the growth pattern of the past five years (after setting aside the impact of Ontario's short-lived OHIP+ program in 2018, when the removal of all insureds under the age of 25 caused a negative growth rate).

However, a closer look reveals there is more to this story. The growth rates for 2021 and 2020 occurred despite notable declines in the number of insureds who submitted claims during the first two years of the pandemic. Meanwhile, among those who did submit claims, the number of claims increased appreciably compared to before the pandemic (see "Utilization trends" for more details).

On top of these shifts in utilization, the average monthly eligible amount per insured increased for both traditional and specialty drugs (Chart 2). Specialty drugs are the bigger driver of this increase year after year, with a growth rate of 9.5% in 2021, compared to 8.7% in 2020.

“Growth in the eligible amount for specialty drugs continues to far surpass growth in traditional drugs, at 9.5% compared to just 2.9%,” says O’Brien. “As more novel therapies come to market that treat previously untreated or undertreated diseases, we will very likely continue to see increased utilization of these breakthrough, higher-cost products.”

Regionally for specialty drugs, Quebec saw the highest increase, at 11.3%, followed by Ontario (10.2%) and Atlantic Canada (9.1%). The relatively low rate of 6.7% in Western Canada reflects the Pharmacare/universal drug plans in B.C., Manitoba and Saskatchewan.

The 2.9% increase in monthly eligible amount per insured for traditional drugs compares to 1.3% in 2020. It was relatively consistent across all regions, with a slightly lower result in Atlantic Canada (2.4%).

For both drug types combined, Quebec saw the biggest increase in average monthly eligible amount among all insureds, at 6.0%, followed by Ontario (5.3%) and Atlantic Canada (5.1%) (Chart 3).

When the lens is switched to look at actual claims, Ontario saw the biggest increase (11.2%) in the average eligible amount per claim, followed by Atlantic Canada (10.1%) and (at some distance) by Western Canada (7.8%) and Quebec (6.6%) (Chart 4).

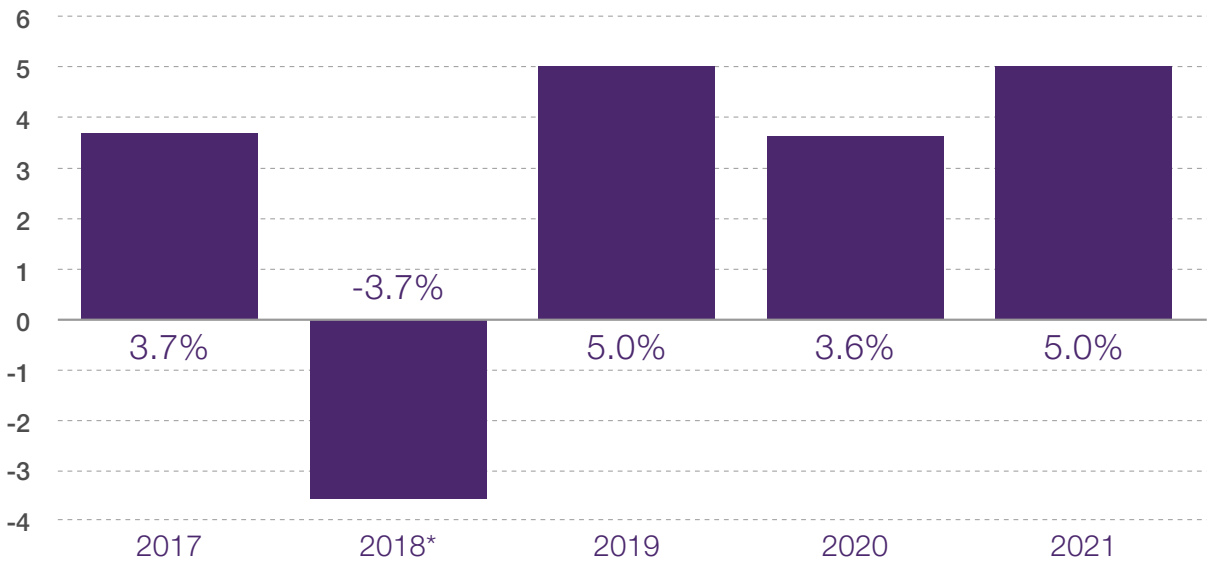
"The large increases in 2021 partly reflect the fact that the cost per claim in 2020 was artificially lower than usual because of the period of time in that year when maintenance claims were limited to 30-day supplies rather than 90 days," notes O'Brien. "As well, the use of specialty drugs and drugs to treat rare disease is on the rise."

When results are considered by age (Chart 5), the biggest increase in 2021 occurred among insureds aged 30 to 39 (6.9%), followed by those under 25 (6.2%). This is a departure from 2020, when the result for insureds aged 30 to 39 (1.5%) was the lowest among all age groups. In 2021, the lowest result was among insureds aged 60 to 64, at 3.4% compared to the overall average of 5.1%.

Having said that, the average monthly eligible amount per insured aged 60 to 64 is much higher than all other age groups, at $104.44 compared to just $15.76 for insureds under 25 (Chart 6). Results for 2021 mark the second year of a triple-digit average monthly eligible amount for those aged 60 to 64 (it was $100.97 in 2020).

> "Monthly eligible amounts for 60- to 64-year-olds is almost seven times that of people under 25 years old. Younger people typically claim for more acute therapies that are lower cost, but as we age, the chronic conditions emerge, says O'Brien."

CHART 1 | Change in average monthly eligible amount per insured, 2017 – 2021



*Results from 2018 reflect the impact of OHIP+ in Ontario, which affected private drug plans from January 1, 2018 until April 1, 2019.

CHART 2 | Change in average monthly eligible amount per insured by type of drug, 2020 – 2021

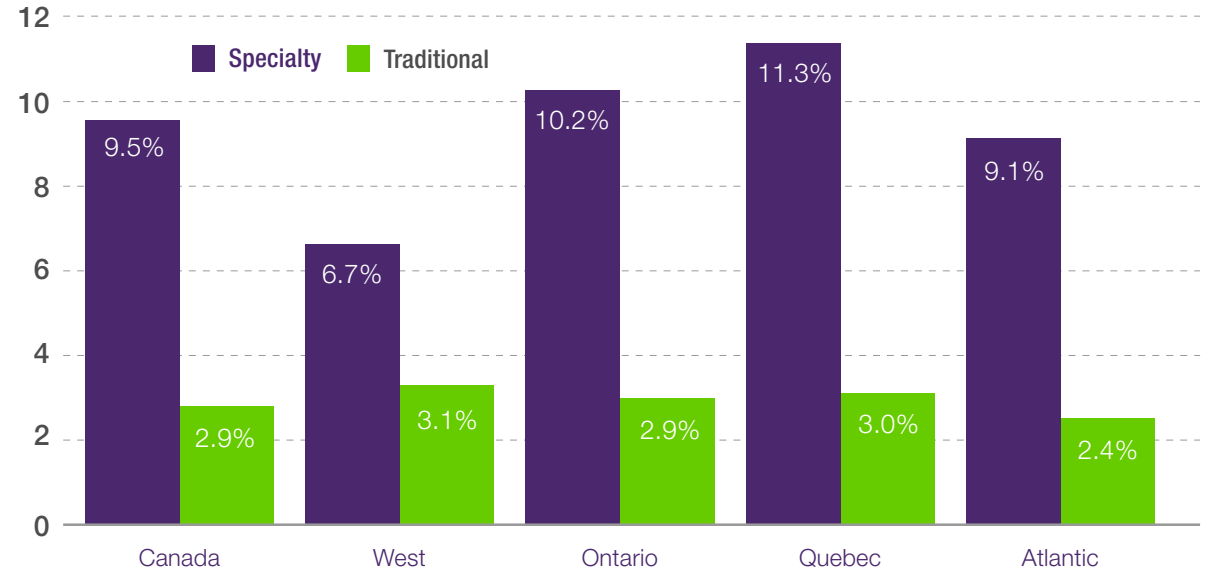


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CHART 3 | Change in average monthly eligible amount per insured by region, 2020 – 2021

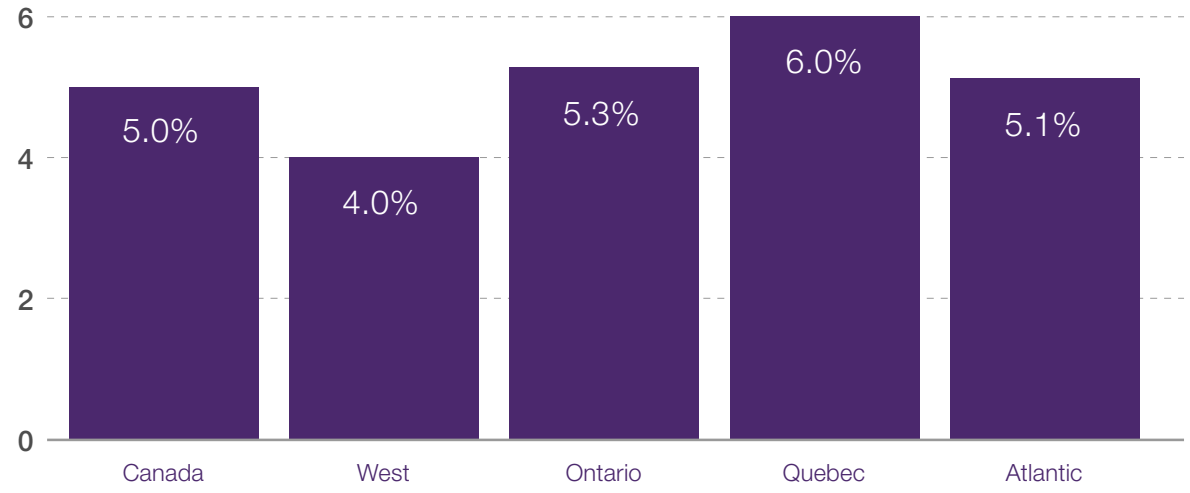


CHART 4 | Change in average eligible amount per claim by region, 2020 – 2021

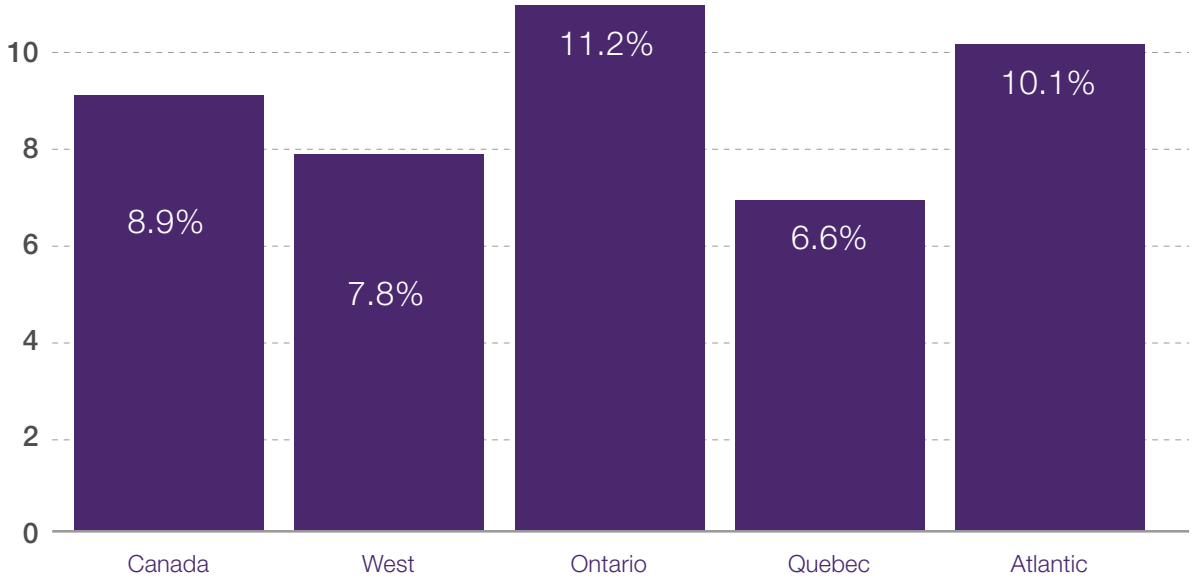


CHART 5 | Change in average monthly eligible amount per insured by age, 2020 – 2021

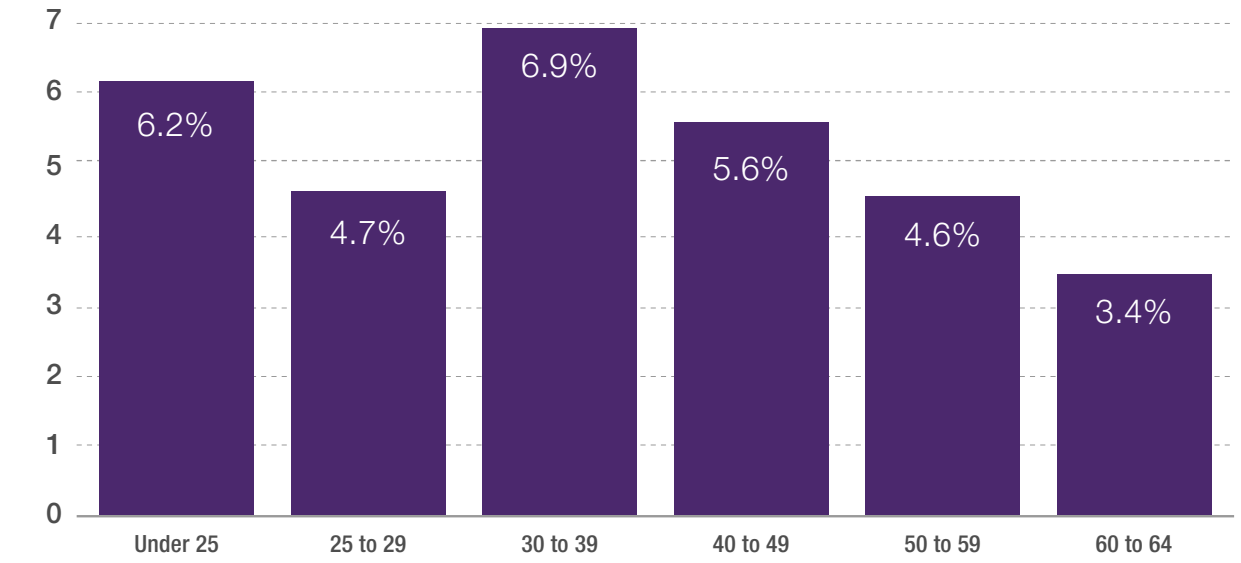
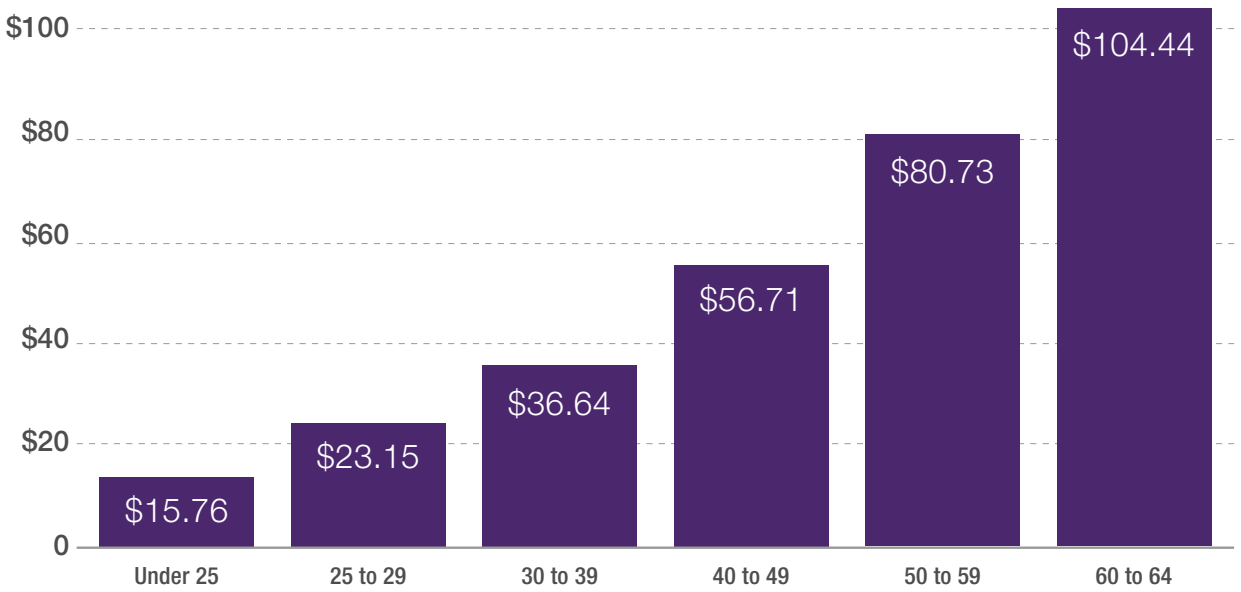


CHART 6 | Average monthly eligible amount per insured by age, 2021



Utilization trends

Monthly utilization of the prescription drug plan, when spread out across all insureds, declined in 2021 across all regions, led by Ontario (-5.3%) and Atlantic Canada (-4.6%) (Chart 7). The national decline of 3.5% in 2021 contrasts with gains of 1.4% in 2020 and 3.8% in 2019.

Expressed another way, fewer insureds made claims in the past two years: 56.3% and 56.8% did so in 2021 and 2020, respectively, compared to rates consistently higher than 60.0% before the pandemic (Chart 8). These results strongly suggest that insureds saw physicians less often in the past two years, resulting in fewer of them getting prescriptions.

On the other hand, the number of claims per distinct claimant is higher than before the pandemic (Chart 9). In 2021, claimants submitted an average of 11.1 claims, down slightly from 11.4 during the first year of the pandemic but up quite a bit from prior years, when the result was at or close to 10 claims per claimant. The result of 11.4 claims per claimant for 2020 partly reflects more frequent refills of chronic medications due to drug-supply policies in most provinces during the early months of the pandemic (i.e., refill amounts were limited to 30-day supplies instead of the usual 90 days).

The average eligible amount per claim also increased substantially compared to previous years (Chart 10). By the end of 2021 it was $83.45, which is 8.9% more than the average for 2020 ($76.63). During the three previous years, growth rates ranged from 1.3% to 3.1%.

The 2021 increase of 8.9% is more than 2.6 times the rise in the average annual Consumer Price Index (CPI) of 3.4%. This echoes what happened in 2020, when the 2.4% increase in the eligible amount per private drug-plan claim was more than three times that of the CPI (0.7%). In the three years prior to the pandemic, increases in the average eligible amount per claim were 1.6 to 1.9 times the gains recorded for the CPI (Chart 11).

What makes the results for 2021 more remarkable is the fact that the CPI's increase of 3.4% was its highest since 1991.

When all claims are added up for the year, the average annual eligible amount per claimant was $928.30 for 2021, 6.0% higher than in 2020 ($876.11) (Chart 12). While this is a moderately high gain within the most recent five-year period, it's substantially less than the 13.9% jump recorded for 2020.

Chart 13 presents a regional overview of costs and utilization in 2021.

CHART 7 | Change in monthly utilization per insured by region, 2020 – 2021

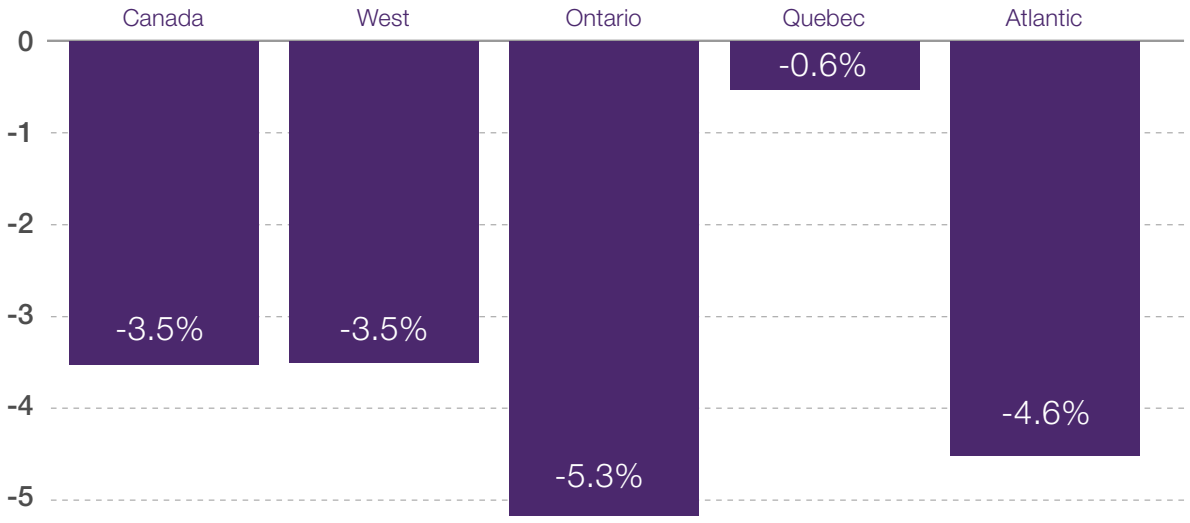


CHART 8 | Number of insureds who made a claim, 2017 – 2021

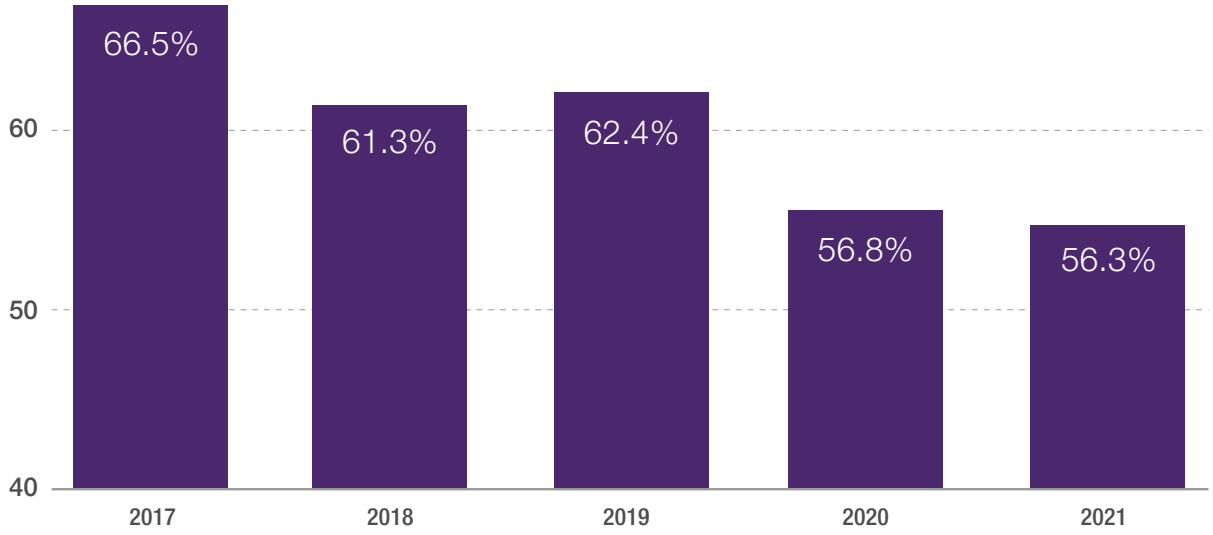


CHART 9 | Number of claims per distinct claimant, 2017 – 2021

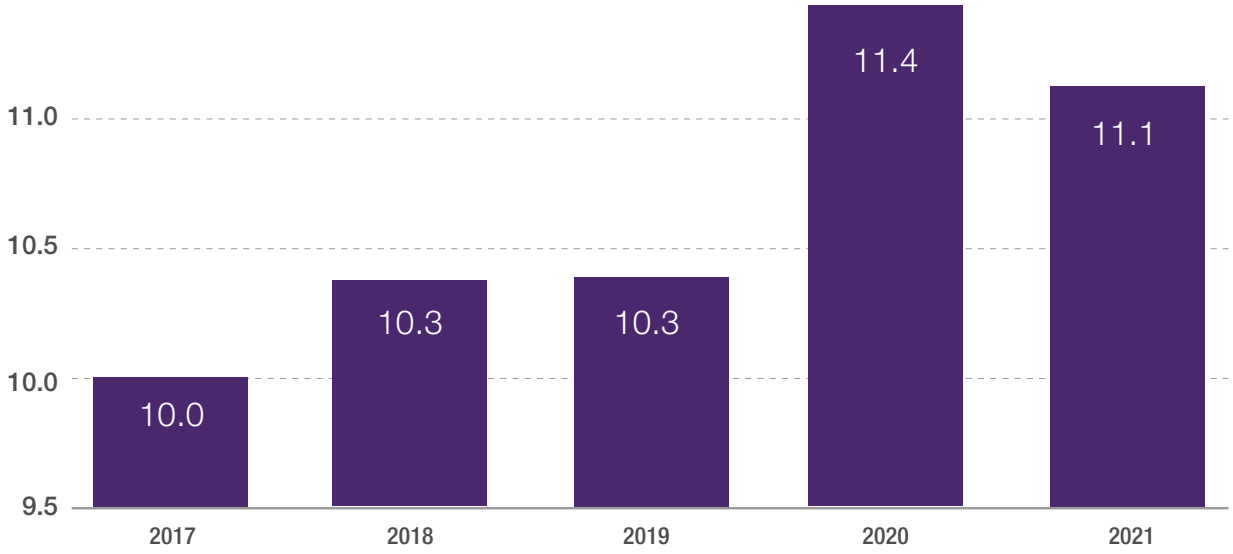


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CHART 10 | Average eligible amount per claim, 2017 – 2021

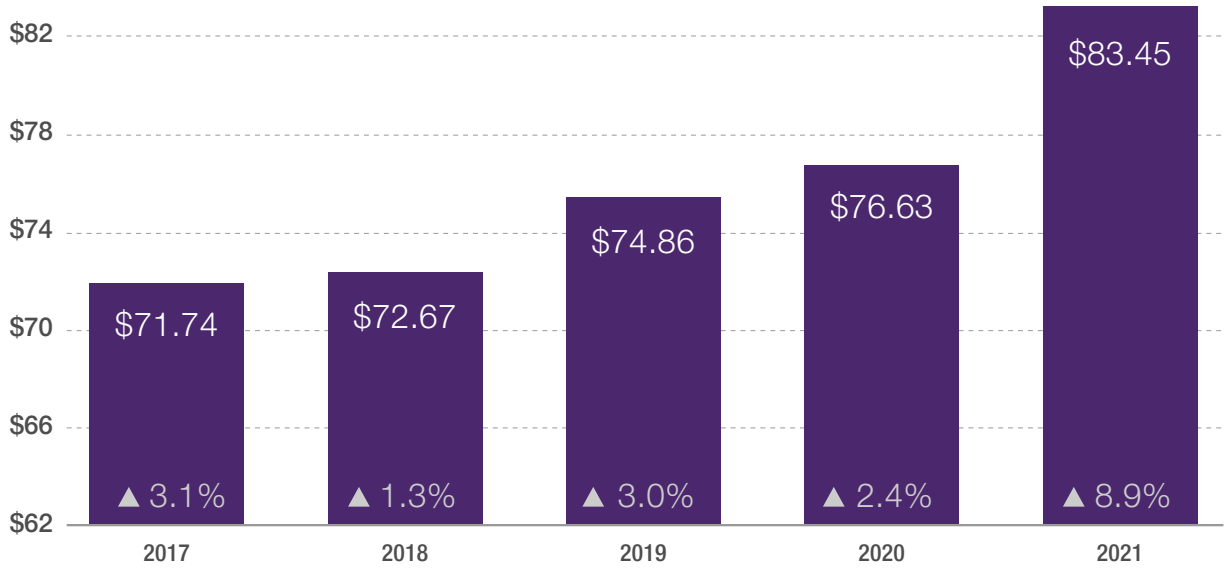

CHART 11 | Change in average eligible amount per claim compared to the Consumer Price Index, 2017 – 2021

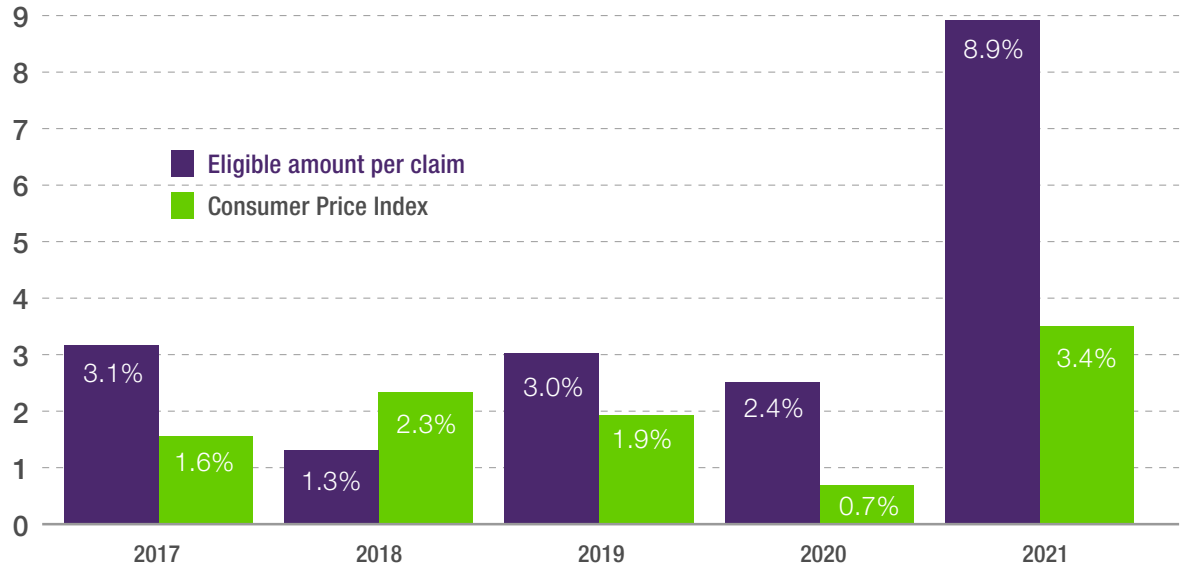

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CHART 12 | Average annual eligible amount per distinct claimant, 2017 – 2021

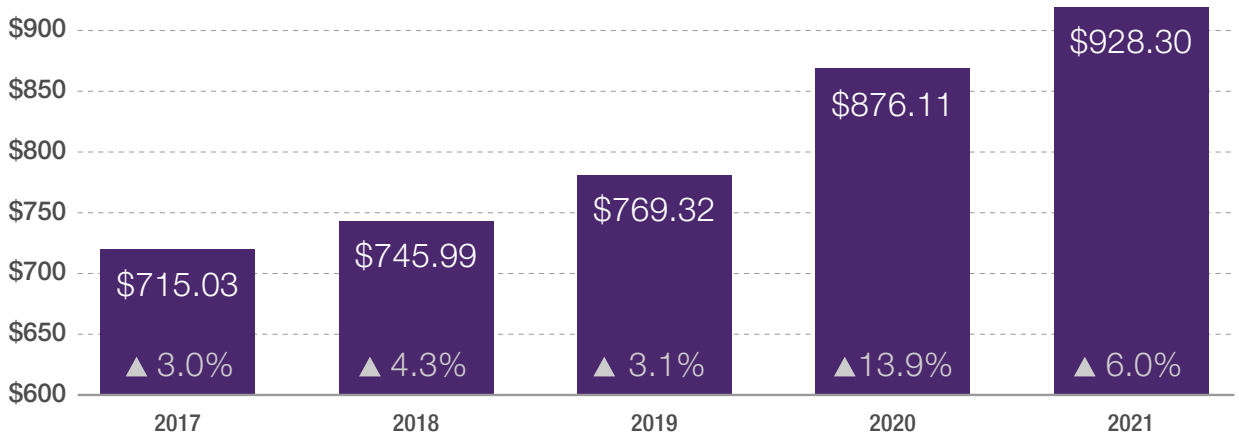


CHART 13 | Overview of costs & utilization by region, 2021

	Canada	West	Ontario	Quebec	Atlantic
Monthly eligible amount per insured	$43.56	$31.92[1]	$44.93	$61.04	$55.62
Monthly utilization per insured	0.52	0.42	0.47	0.88[2]	0.58
Insureds who made a claim	56.3%	53.9%	54.7%	64.0%	64.3%
Average eligible amount per claim	$83.45	$76.87	$96.46	$69.35[2]	$95.52
Average claims per claimant	11.1	9.3	10.2	16.5[2]	10.9
Average age of employee/cardholder	41.8	41.0	41.9	42.4	43.4

1 Western Canada has the lowest monthly eligible amount per insured because provincial Pharmacare/universal drug plans in B.C., Manitoba and Saskatchewan automatically become the 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 amount per claim and the highest average number of 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 prescription drugs continue to account for a greater share of claims covered by private drug plans, reaching 66% of claims in 2021 compared to 64% in 2020 and 61% five years ago, in 2017 (Chart 14). Looking further back, to 2013, 56% of claims were for generic drugs. Mandatory substitution policies are the main drivers of this upward trend (page 47).

Regionally, utilization of generics ranges from a high of 72% in Atlantic Canada (compared to 71% in 2020 and 69% in 2017) to a low of 63% in Ontario (62% in 2020 and 59% in 2017). Quebec continues to post the highest rate of growth, from 60% in 2017 to 66% in 2021.

> “Quebec has steadily grown its generic fill rate since its government introduced the ‘Do not substitute’ guideline for prescribers in 2015. Prior to that, Quebec historically had the lowest generic fill rates, notes O’Brien.”

Of the remaining 34% of prescription drugs covered by private drug plans, 27% are single-source brand-name drugs (for which no generic options are available), down from 30% in 2020 and 32% five years ago (Chart 15). Another 7% are multi-source drugs (for which generics are available), compared to 6% in 2020 and 7% in 2017. In 2013, 10% of drugs covered by private plans were multi-source.

Multi-source drugs’ share can never drop to zero for two reasons: a small percentage of patients have adverse reactions after switching to a generic and must go back to the brand drug; and mandatory dispensing policies allow for the dispensing of a multi-source drug when the patient pays the difference in price between the brand and the generic.

With that in mind, how low can the use of multi-source drugs go? Atlantic Canada may be a good indicator of that, as multi-source drugs accounted for only 4% of prescriptions covered in 2021, compared to a high of 9% in Quebec. “However, it’s tricky to compare provinces because a drug considered multi-source in one province may not be multi-source in another. Each province determines interchangeability,” says O’Brien.

The pan-Canadian Pharmaceutical Alliance’s (pCPA’s) Generic Tiered Pricing Framework dictates pricing for generic drugs. Prices can be as low as 10% of the brand reference price, in the case of high-volume drugs with many generic options, or up to 85% of the brand price if only one generic option is available. With that in mind, generic drugs’ 66% share of prescription volume for private drug plans translates into a 24% share of the eligible amount for coverage, unchanged from 2020 (Chart 16). In 2013, generic drugs accounted for 26% of the eligible amount. Their declining share, despite steady growth in volume, speaks to the impact of pCPA’s pricing framework, which began rolling out in 2014.

CHART 14 | Utilization of generic drugs by region, 2017 – 2021

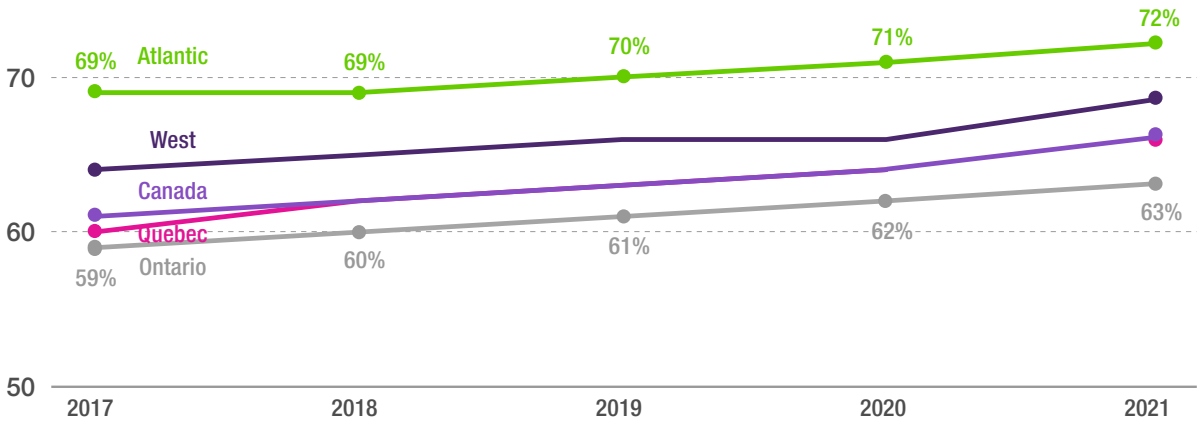


CHART 15 | Utilization by type of drug, 2017 versus 2021

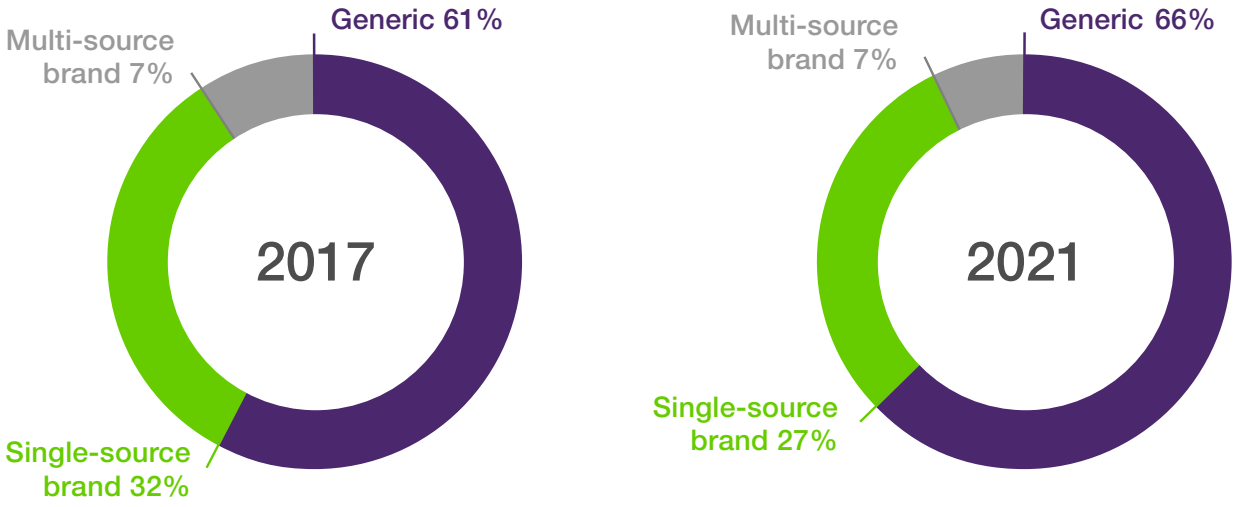
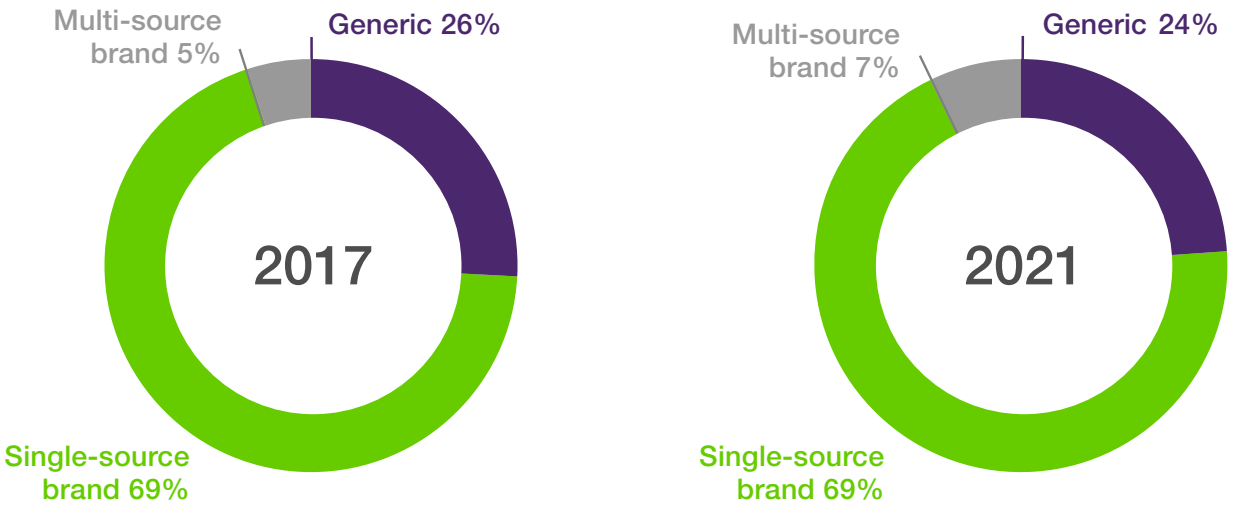


CHART 16 | Eligible amount by type of drug, 2017 versus 2021



High-cost claimants

Two per cent of all claimants submitted eligible amounts totalling more than $10,000 in 2021. These high-cost claimants accounted for 40% of the total eligible amount for all claimants, up from 33% in 2017 (Chart 17).

“Even more compelling is the fact that 0.03% of claimants accounted for close to 6% of the total eligible amount by the end of 2021. These claimants are taking ultra-high-cost drugs for very rare diseases, which can cost hundreds of thousands of dollars annually,” says O’Brien.

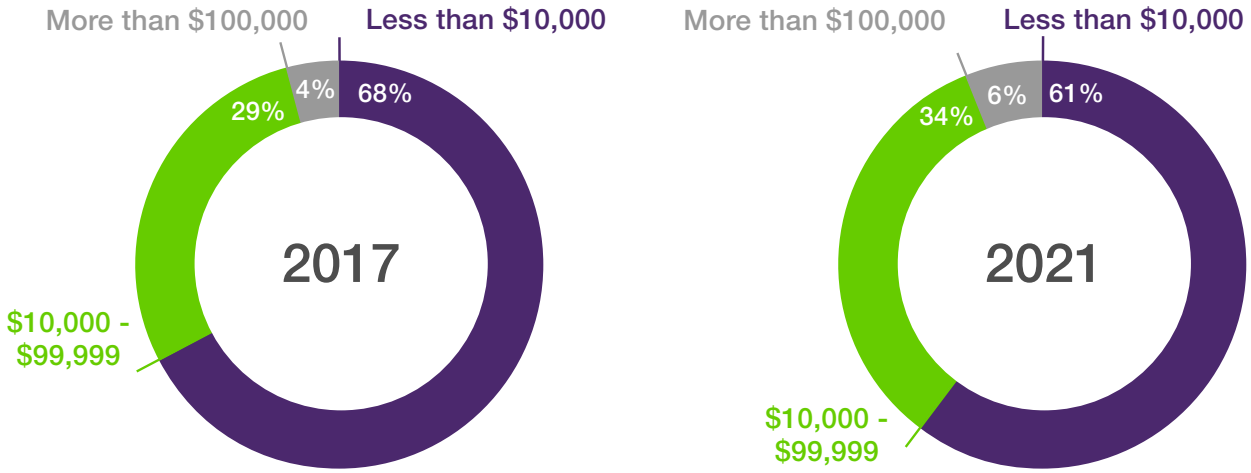
A closer look reveals that among ultra-high-cost claimants (i.e., those with an annual eligible amount of more than $100,000), about half were at that level in 2020 and again in 2021. As well, half of high-cost claimants (i.e., those with an annual eligible amount above $10,000) in 2020 moved into the ultra-high-cost zone in 2021.

“And if we dig down even deeper, 20% of claimants new to the ultra-high-cost category had costs below $10,000 in 2020. In just one year, likely as a result of the progression of disease, the eligible amounts for their treatments increased more than 10-fold,” emphasizes O’Brien.

Among claimants with a total eligible amount exceeding $100,000, drugs to treat cancer, rheumatoid arthritis and cystic fibrosis accounted for the largest proportion of the amount, followed at some distance by treatments for skin disorders and gastrointestinal conditions.

> “Comorbidities are also a factor. High-cost and ultra-high-cost claimants live with an average of six health conditions,” adds O’Brien.

CHART 17 | Breakdown of total eligible amount by annual amount per claimant, 2017 versus 2021*



Summary

Growth rates for the eligible amount per claim significantly outpaced growth rates for the CPI in the past two years. This is especially remarkable for 2021, given that the rise in the CPI was its highest since 1991. This translates into a higher eligible amount spread out across all insureds, despite the fact that fewer insureds made claims. Specialty drugs and other higher-cost drugs (namely for diabetes, page 36) are the main factors behind the escalation in eligible amount per insured. High-cost claimants, with annual eligible amounts exceeding $10,000, account for 40% of the total, up from 33% in 2017.

*Totals do not add up to 100% due to rounding.

3. Specialty drugs

Snapshot

Specialty drugs' share of the eligible amount reached a third of the total eligible amount, even though fewer than 2% of claimants submitted claims for these drugs.

- Assuming current trends continue, TELUS Health forecasts that by the end of 2026, specialty drugs will account for almost half of the average eligible amount per certificate
- Private plans in Atlantic Canada continue to experience the highest share of specialty claims based on eligible amount, though all regions saw small increases in 2021
- Specialty drugs dominate treatments for rheumatoid arthritis, skin disorders and cancer
- B.C.'s switching policy for biosimilar biologics has had a profound impact on private plans in that province

Share of costs & claimants

For the third year in a row, specialty drugs' share of the eligible amount increased by two percentage points, from 30% in 2019 to 32% in 2020 and 34% in 2021 (Chart 18). Specialty drugs' share has tripled since 2008 (11%), when TELUS Health began publicly reporting these numbers.

"The introduction of new high-cost drugs indicated for rare diseases, as well as the expanded utilization of existing specialty drugs, are driving exposure," says O'Brien.

Specialty drugs' share of claimants has also inched forward for three years in a row, from 1.1% in 2019 to 1.3% in 2020 and 1.4% in 2021. While these increases would be considered inconsequential in other categories, they are noteworthy here given the much higher price points of specialty drugs. "The growth in percentage of claimants is becoming a significant factor driving overall costs. In the last five years, the compound annual growth rate [CAGR] of percentage of claimants has been growing higher than the CAGR of specialty costs: it was 8.8% for claimants compared to 5.9% for costs," explains O'Brien.

As in past years, private plans in Atlantic Canada experience the highest volume of specialty claims—accounting for 41% of the eligible amount in 2021, compared to 40% in 2020 (Chart 19). The main reason can be traced to disease epidemiology, as the prevalence of certain genetic, rare diseases is higher in Atlantic Canada. “We are seeing a disproportionate amount of claimants for drugs for rare diseases, with an annual treatment cost of over $100,000, in Atlantic Canada,” confirms O’Brien.

Remaining regions also saw slight gains in specialty drugs’ share of the eligible amount in 2021: from 36% in 2020 to 38% in Quebec, from 33% to 34% in Ontario, and from 24% to 25% in Western Canada. The historically lower share in Western Canada is due to the Pharmacare/universal drug plans in B.C., Saskatchewan and Manitoba, which mitigate the impact of specialty drugs on private plans in that region since public coverage kicks in once plan members have paid an income-based deductible.

Specialty drugs dominate in three of the top-ranking drug categories based on eligible amount (Chart 20):

- For rheumatoid arthritis, where 99% of the eligible amount (or 12.5 out of its 12.6 share points) was for specialty drugs in 2021, leading to its number-one rank among all drug categories
- For skin disorders such as psoriasis, where specialty drugs accounted for 73% of the eligible amount, up from 62% in 2020 and 54% in 2019
- For cancer, where specialty drugs represented 81% of the eligible amount

How does all of this translate for private drug plans in terms of the monthly eligible amount per certificate? In 2021, the total average eligible amount per certificate was $100 per month, up from $97 in 2020 (Chart 21). The breakdown was $34 for specialty and $66 for non-specialty (traditional) drugs, or 34% and 66% of the eligible amount, respectively. This compares to $31 and $66 (32% and 68%), respectively, in 2020; and $26 and $68 (28% and 72%) five years ago. Long story short, specialty drugs are solely responsible for the higher average monthly eligible amount per certificate year after year.

"Over 13 years, the CAGR for cost per certificate for specialty drugs has increased on average by nearly 9.9% each year. This compares to an average annual decrease of 1.5% per year for non-specialty drugs," says O'Brien.

TELUS Health forecasts that, should current trends continue, specialty drugs could represent almost half of the average eligible amount per certificate by 2026, or $55 out of a total certificate amount of $111.

Pricing and an expanding pipeline are the main reasons why specialty drugs steadily grow their share of the eligible amount per certificate. An inverse trend for traditional drugs is also a factor: their average monthly amount per certificate has either not changed or has declined in the past 10 years. It was $68 in both 2012 and 2017, and $66 in 2021. By 2026, the forecasted average eligible amount per certificate for traditional drugs will be $56.

"The expanding pipeline for specialty drugs will continue to put upward pressure on plan costs," says O'Brien. "In coming years, private plans will feel the impact of new specialty drugs marketed for Alzheimer's disease, macular degeneration and atopic dermatitis, for example."

CHART 18 | Specialty drugs by share of claimants and eligible amount, 2012 – 2021

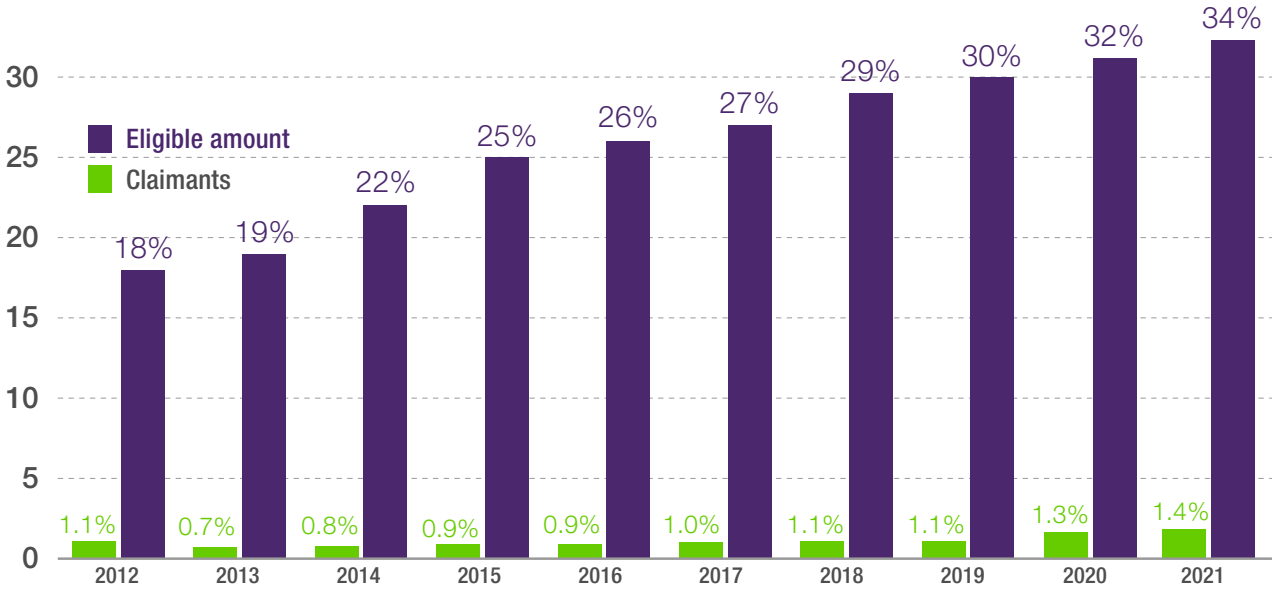


CHART 19 | Specialty drugs' share of eligible amount by region, 2021

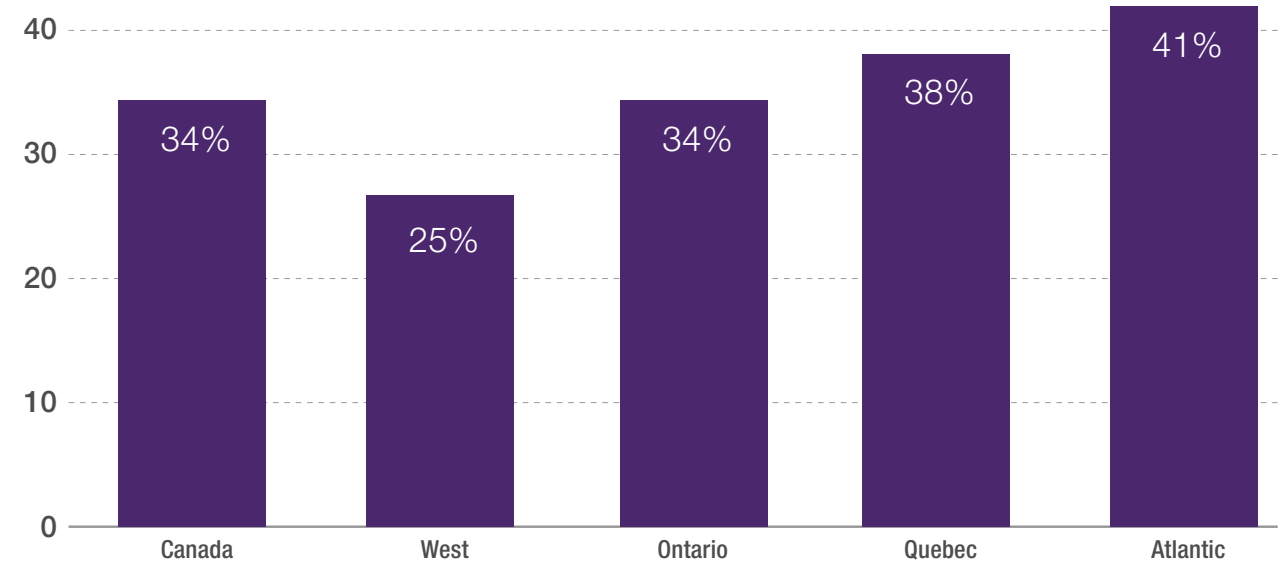


CHART 20 | Breakdown of shares of eligible amount between specialty and traditional drugs for top-ranking drug categories in 2021

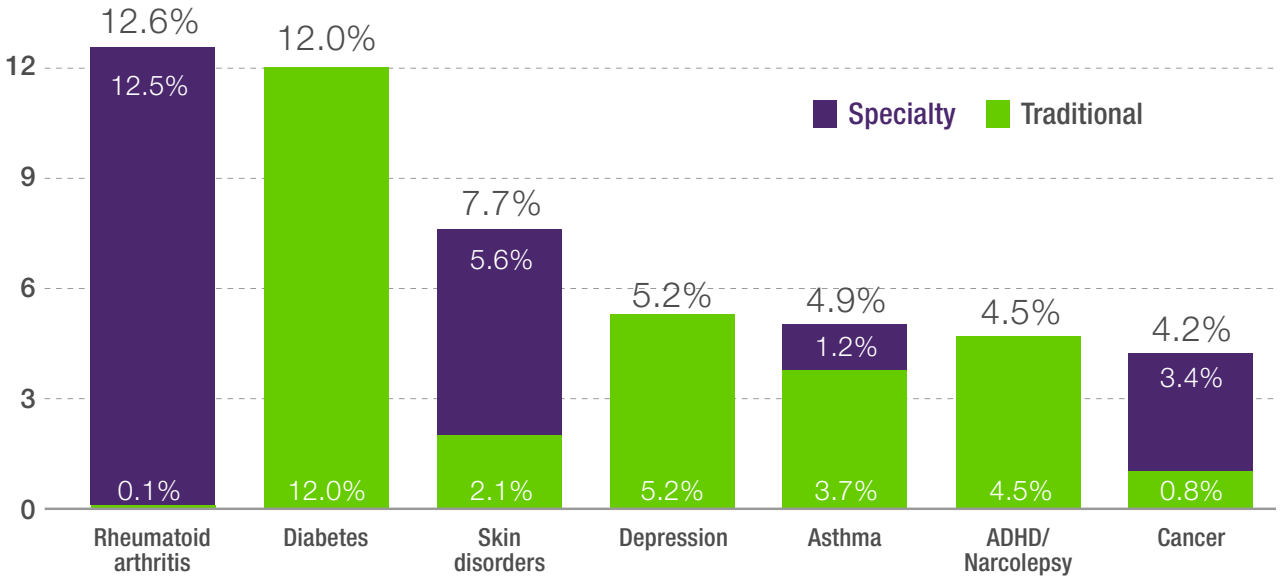
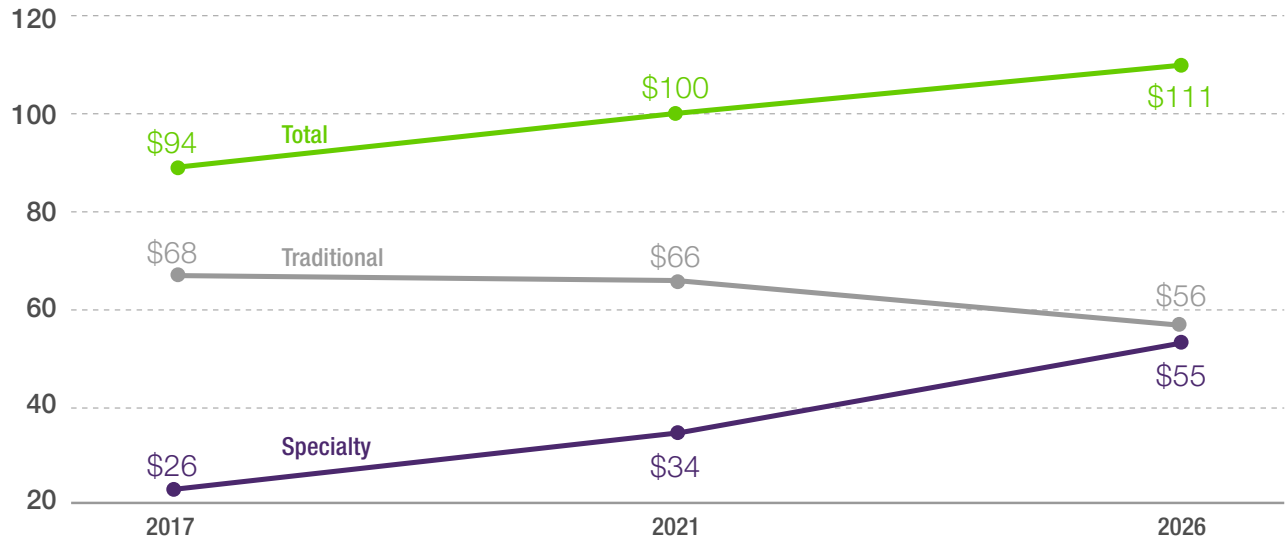


CHART 21 | Average monthly amount per certificate by type of drug, 2017 – 2026 (forecast)



Biosimilar biologics

Private drug plans in B.C. saw biosimilar drugs' share of the eligible amount for biologics with biosimilar options soar from 7% in January 2019 to 65% by the end of 2021 (Chart 22). This level of cost distribution toward biosimilars is more than five times that of the rest of Canada (12%).

Two factors are behind the dramatic turnaround: first and foremost, B.C.'s Biosimilars Initiative took effect in November 2019. The switching policy currently encompasses nine originator biologics for which biosimilars are available. Second, B.C.'s universal PharmaCare drug plan spurred private plans to mimic the government's switching policy in order to avoid taking on the full cost of originator biologics for plan members who choose not to switch and instead turn to their private plan for coverage.

In January 2019, TELUS Health's claims data for private drug plans in B.C. showed that biosimilar biologics represented 7% of eligible costs for biologics that had biosimilar options. By the end of 2019, just two months after the B.C. biosimilar switching policy began to roll out, that share had climbed to 20%. Growth was steady in 2020, finishing at 33% in December, then accelerated sharply in 2021 to reach 65%.

As expected, savings were immediate. By the end of 2021, the relative eligible amount per claimant in B.C. for a biologic was two-thirds (66%) what it had been in January 2019 (Chart 23).

In contrast, biosimilars' share of the eligible amount in the rest of Canada was just 12% at the end of 2021—less than a fifth of B.C.'s share. And the relative eligible amount per claimant has increased by 10% since January 2019.

Uptake of biosimilars in the rest of Canada is expected to accelerate as more provinces enact their own switching policies, prompting some private plans to follow suit. Alberta's policy took effect in January 2021, and New Brunswick, Nova Scotia and the Northwest Territories also launched programs in 2021. Quebec's switching policy began in April 2022.

"Private plans across Canada have also already begun to benefit from what we call the 'halo effect.' Physicians are gradually changing their prescribing habits for all patients who require biologic drugs to treat their conditions, so that more new patients are starting on a biosimilar rather than an originator biologic," says O'Brien.

CHART 22 | Biosimilars' share of the total eligible amount for biologics with biosimilar options, B.C. versus rest of Canada, January 2019 – December 2021

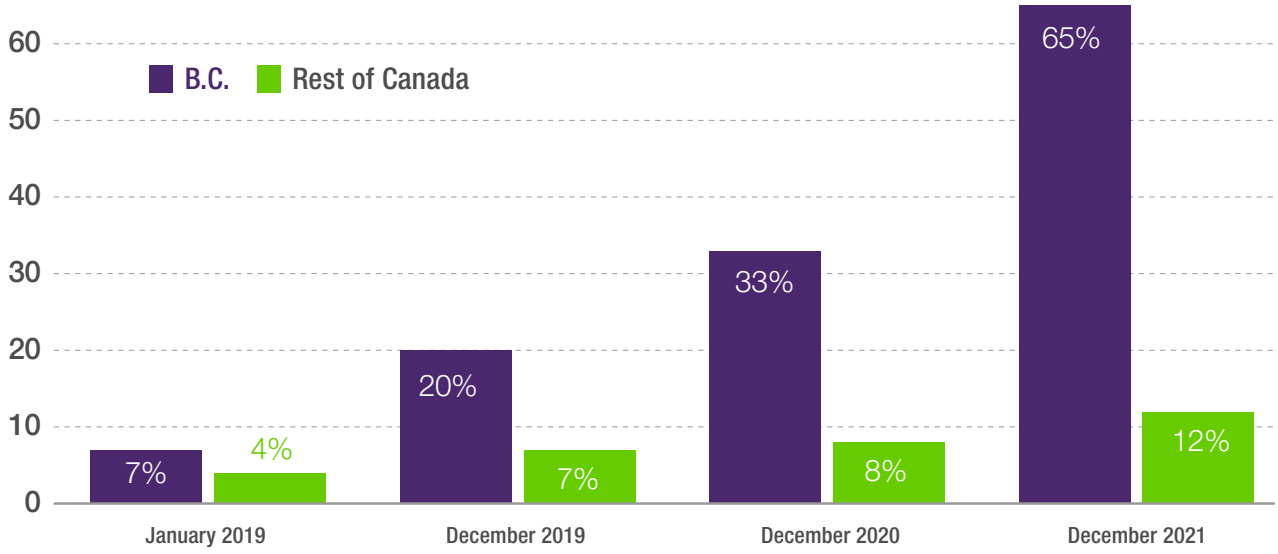
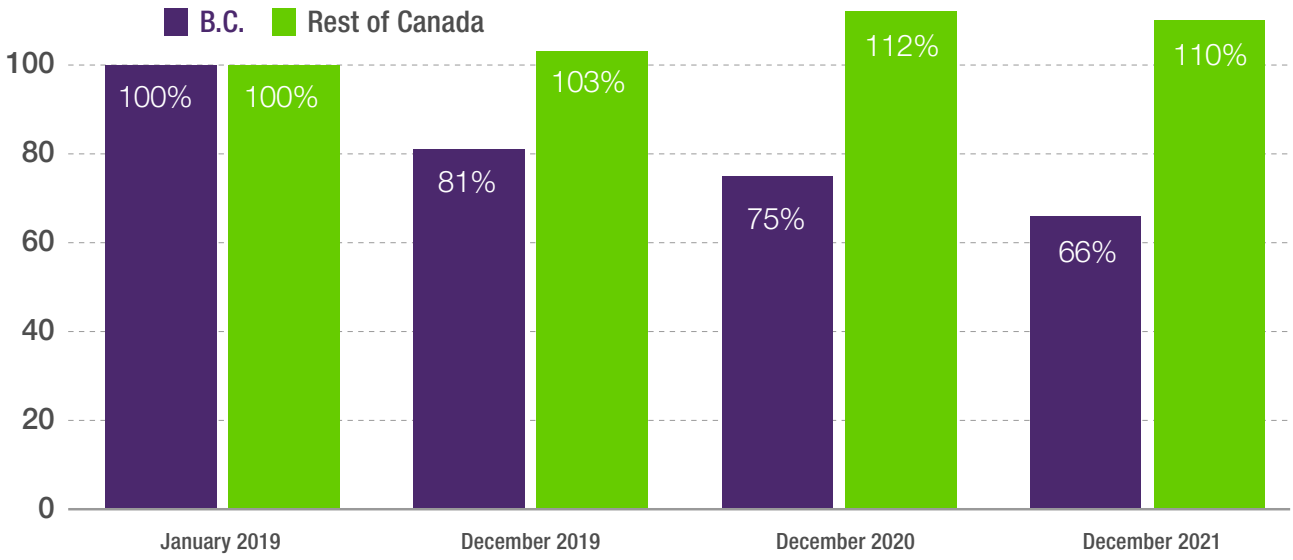


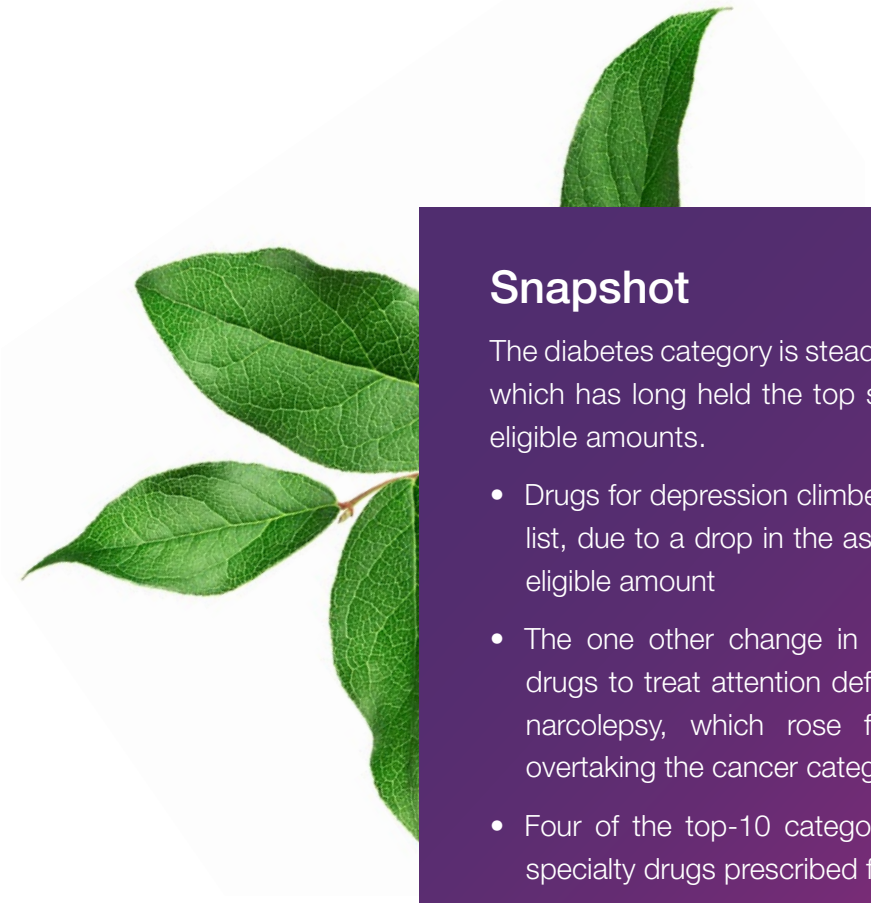
CHART 23 | Relative eligible amount per claimant for biosimilar biologics in B.C. versus rest of Canada, January 2019 – December 2021



Summary

Specialty drugs command a third of the total eligible amount considered for coverage by drug plans, despite a relatively miniscule number of insureds taking these drugs. Their share of private drug plans' average monthly eligible amount per certificate is expected to reach almost half by 2026. B.C.'s policy of switching patients on originator biologics to lower-cost biosimilars has had a huge impact on private plans, which saw almost a 10-fold increase in biosimilars' share of the eligible amount for biologics with biosimilar options (from 7% prior to the policy to 65% by the end of 2021).

4. Drugs by therapeutic class



Snapshot

The diabetes category is steadily gaining on rheumatoid arthritis, which has long held the top spot among categories based on eligible amounts.

- Drugs for depression climbed to fourth position on the top-10 list, due to a drop in the asthma category's share of the total eligible amount
- The one other change in ranking goes to the category of drugs to treat attention deficit hyperactivity disorder (ADHD)/ narcolepsy, which rose from seventh to sixth position, overtaking the cancer category
- Four of the top-10 categories are dominated by high-cost, specialty drugs prescribed for small numbers of patients

Top 10 by eligible amount

The top three categories based on eligible amount—rheumatoid arthritis, diabetes and skin disorders—maintained their rankings, although diabetes drugs and devices appear primed to take over the number-one position in the not-too-distant future (Charts 24 and 25).

Results for the past five years show that diabetes drugs have steadily grown their share of the total eligible amount, from 9.2% in 2017 to 12.0% in 2021. Their share of claims has climbed consistently as well, from 6.6% in 2017 to 7.7% in 2021.

An analysis of 20 years of surveillance data (from 1999 to 2019) collected by the Public Health Agency of Canada found that the prevalence rate of diabetes in Canada increased by an average of 3.3% per year.[1] In 2019, 8.8% of Canadians lived with type 1 or type 2 diabetes.

1. LeBlanc AG, Gao YJ, McRae L, et al. At-a-glance – Twenty years of diabetes surveillance using the Canadian Chronic Disease Surveillance System. Health Promot Chronic Dis Prev Can. 2019 Nov;39(11):306-309.

Higher-cost therapies are also a driver of growth in the diabetes category:

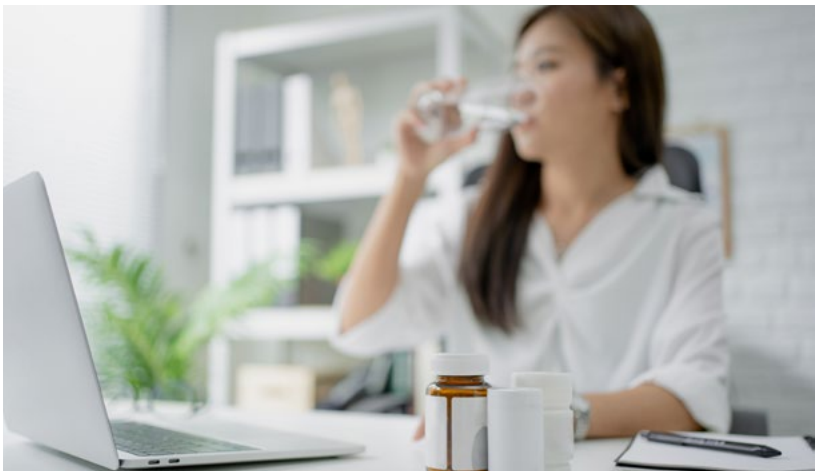
- Several classes of second-line therapies for type 2 diabetes have seen strong uptake in the past decade. More than half of patients are unable to manage their diabetes despite taking medications and trying to make lifestyle changes, and second-line therapies are indicated for this group of people.[2]
- The average annual eligible amount for these second-line therapies is more than $1,100, compared to about $120 annually for metformin, the first line of therapy for type 2 diabetes. Two of these second-line medications (Ozempic and Jardiance) are on TELUS Health's top-10 list of products by eligible amount.
- Freestyle Libre is a next-generation blood glucose monitor that uses a small sensor to automatically and continuously measure blood glucose levels, removing the need for lancets and test strips. The average annual eligible amount for this device is about $1,600, compared to about $730 for first-generation monitors. Freestyle Libre ranks sixth on the top-10 list of products by eligible amount.

Meanwhile, the number-one category of rheumatoid arthritis (RA), comprised almost entirely of higher-cost biologic drugs, has seen its share of the total eligible amount inch forward from 12.0% in 2017 to 12.6% in 2021. Its annual share of claims has remained unchanged at 0.4% since 2018. These results suggest that private drug plans have yet to experience many claims for lower-priced biosimilar biologics for RA, even though these drugs first entered the Canadian market in 2015. While recent public-plan switching policies in B.C. and Alberta—requiring patients on originator RA biologics to switch to a biosimilar—have had an impact on private drug plans in those provinces, biosimilars' impact in the rest of Canada is not yet appreciable (page 32).

The number-three category of drugs, to treat skin disorders such as psoriasis, has grown its share of the total eligible amount from 4.4% in 2017 to 6.9% in 2020, and to 7.7% in 2021. Its share of claims declined slightly, from 3.4% to 3.2%, which indicates that price points are the main driver of growth. Indeed, 73.0% of the eligible amount is for higher-cost specialty drugs (page 29).

2. Khunti K, Ceriello A, Cos X, et al. Achievement of guideline targets for blood pressure, lipid, and glycaemic control in type 2 diabetes: A meta-analysis. Diabetes Res Clin Pract. 2018 Mar;137:137-148.

In all, four of the top-10 categories are dominated by specialty drugs for small numbers of patients. The two other categories (in addition to those for RA and skin disorders) are for cancer, which ranks seventh with 4.2% of the total eligible amount (compared to 4.3% in 2020) and 0.6% of claims; and for multiple sclerosis, which ranks eighth with 3.4% of the total eligible amount (3.5% in 2020) and 0.1% of claims.



The depression category rose in the rankings to fourth position, although its share of the total eligible amount was unchanged at 5.2%. Its shift in status is mainly due to the asthma category's drop in share, from 5.6% in 2020 to 4.9% in 2021. Having said that, claims volume for antidepressants climbed slightly in 2021, to 11.0% from 10.4%, and their share of claimants increased (page 40). In other words, more insureds are taking antidepressants. However, since the category is highly genericized (resulting in a downward trend for pricing), the impact of these increases on the total eligible amount is negligible.

The rise of the category for drugs to treat ADHD/narcolepsy is also worth noting. Five years ago, the category ranked 10th with 3.3% of the total eligible amount and 2.2% of claims; in 2021, it ranked sixth (overtaking cancer), with 4.5% of the total eligible amount and 3.3% of claims. The relatively consistent growth rates for both eligible amount and claims indicate a growing patient population for these medications.

"Online schooling may be a factor behind the increased diagnosis of ADHD, for children who found it even more difficult to focus in front of a screen," notes Caroline Le Pottier, Consultant Pharmacist, TELUS Health, adding that two ADHD drugs (Vyvanse and Concerta) are on TELUS Health's top 10 list of products by eligible amount.

Unfortunately for patients, the cancer category may reclaim its higher ranking before too long, adds O'Brien. "There have been cancelled or delayed mammograms, Pap tests and colonoscopies during the pandemic and now we are seeing a backlog of these screenings, which may result in increased numbers of new claimants in 2022 and beyond. And studies have begun to show that patients are presenting with more advanced disease."

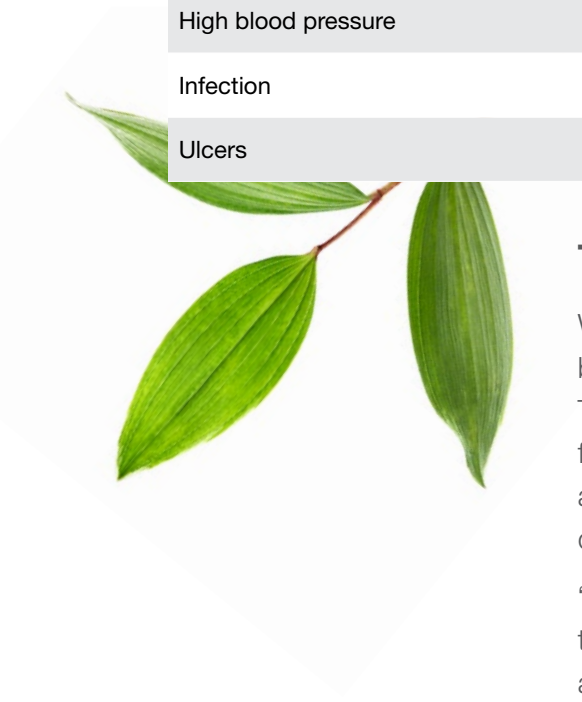
Rounding out the top-10 list by category are two high-volume, low-cost categories: for high blood pressure (hypertension) and ulcers. The former saw its share of the total eligible amount decline from 4.4% in 2017 to 2.8% in 2021, and the latter's share declined from 3.3% to 2.6%. Meanwhile, their shares of total claims remained consistent (8.6% in 2017 and 8.7% in 2021 for high blood pressure, and 4.6% in 2017 and 4.8% in 2021 for ulcers), which likely reflects reduced price points in these highly genericized categories.

CHART 24 | Top 10 drug categories by eligible amount, 2021

For treatment of:	Rank	% of total eligible amount	% of total claims
Rheumatoid arthritis	1	12.6%	0.4%
Diabetes	2	12.0%	7.7%
Skin disorders	3	7.7%	3.2%
Depression	4	5.2%	11.0%
Asthma	5	4.9%	4.8%
ADHD/narcolepsy	6	4.5%	3.3%
Cancer	7	4.2%	0.6%
Multiple sclerosis	8	3.4%	0.1%
High blood pressure	9	2.8%	8.7%
Ulcers	10	2.6%	4.8%
% of total eligible amount and claims		**59.9%**	**44.6%**

CHART 25 | Rankings of top 10 drug categories by eligible amount, 2017 – 2021

For treatment of:	2017	2018	2019	2020	2021
Rheumatoid arthritis	1	1	1	1	1
Diabetes	2	2	2	2	2
Skin disorders	5	3	3	3	3
Depression	4	5	5	5	4
Asthma	3	4	4	4	5
ADHD/narcolepsy	10	9	7	7	6
Cancer	9	6	6	6	7
Multiple sclerosis	8	8	8	8	8
High blood pressure	6	7	9	9	9
Infection	7	10	10	-	-
Ulcers	-	-	-	10	10



Top 5 by claimants

What happens when the lens is switched to the top five categories by number of claimants? As expected, results vary based on age. The antibiotics/anti-infectives category is the only one in the top five for all three age groups of insureds, and it consistently ranks at the top of the list. However, the category's share of claimants dropped significantly in 2021 compared to five years ago.

"The results for antibiotics and anti-infectives clearly reflect the impact of the pandemic due to delayed surgeries, fewer appointments with prescribers, including dentists, and lower rates of infection due to public-health measures such as wearing masks," says Le Pottier.

In all three age groups, rankings shifted for the top five categories by number of claimants—perhaps most notably for antidepressants, which climbed to third position for claimants aged 20 to 39 as well as for those aged 40 to 59.

Up to 19 years old

- While antibiotics/anti-infectives reign as the number-one category, the number of claimants dropped from 52.9% of the total in 2017 to 31.7% in 2021
- Drugs for skin disorders overtook asthma therapies for the number-two spot, with 21.6% and 17.9% of claimants, respectively
- Allergy treatments maintain their fourth position, with 17.5% of claimants
- Drugs for ADHD climbed the rankings by three levels in four years, from eighth position in 2017 to fifth in 2021. Almost one in eight (13.3%) claimants took these medications in 2021

20 to 39 years old

- In the top-ranked antibiotics/anti-infectives category, the number of claimants aged 20 to 39 who used these drugs decreased from 43.7% in 2017 to 31.8% in 2021, comparable to these drugs' use among those aged up to 19 years (31.7%)
- Birth control pills ranked second (22.5%), followed closely by drugs for depression (22.1%)
- The number of claimants taking antidepressants increased from 15.8% in 2017 to 22.1% in 2021, enough to boost this category's ranking from fifth to third position
- Drugs for skin disorders (17.6%) and anti-inflammatories/analgesics (16.0%) round out the top five

40 to 59 years old

- Antibiotics/anti-infectives do not have quite as much of a lead in this age group, accounting for 29.3% of claimants. Drugs in the number-two category, for blood pressure, are used by 23.8% of claimants
- Antidepressants rose two levels to third position, with their share of claimants rising from 19.1% in 2017 to 22.7% in 2021
- Ulcer drugs also improved their ranking by two, from sixth position in 2017 (19.0%) to fourth in 2021 (20.2%)
- Anti-inflammatories/analgesics dropped from third in 2017 (21.3%) to fifth in 2021 (19.3%)

Adherence

During the first year of the pandemic, plan members taking medications in one of four high-volume categories—to treat diabetes, depression, cardiovascular/cholesterol issues (specifically, high blood pressure or high cholesterol) or gastrointestinal problems (specifically, ulcers)—were less likely to take these medications as prescribed compared to before the pandemic. These four categories represent 27.2% of the total eligible amount.

> "It appears there was a small spike in non-adherence in 2020, perhaps due to disruptions caused by the pandemic," says Le Pottier.

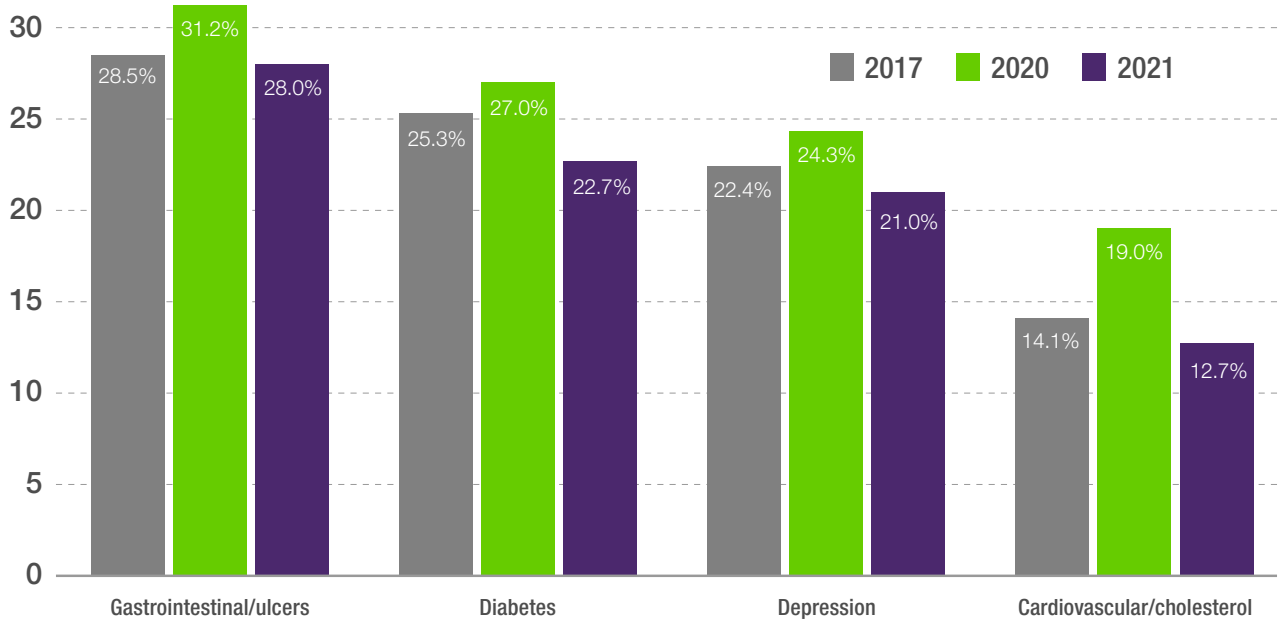
The good news: in 2021, non-adherence not only returned to pre-pandemic levels, but it appears to have abated somewhat in three of the four categories (Chart 26):

- For diabetes drugs, non-adherence fell to 22.7% in 2021 from 25.3% in 2017
- For antidepressants, 21.0% of claimants were non-adherent in 2021, down from 22.4% in 2017
- For drugs to treat cardiovascular/cholesterol issues, non-adherence declined to 12.7% in 2021 from 14.1% in 2017

Time will tell if this is the start of a long-term positive trend; in any case, improved adherence is always a worthy pursuit for plan sponsors. "Programs and policies are available that successfully support adherence, so that medications can deliver their full value to both patients and plan sponsors," emphasizes Le Pottier, adding that "there is no single solution for non-adherence. It can be a matter of affordability for one person, and a lack of motivation for another."

TELUS Health uses a calculation called the “medication possession ratio (MPR)” to track rates of non-adherence. The ratio captures whether claimants are refilling their prescriptions on time. Non-adherence occurs when the MPR is less than 0.8. For example, if a person had a prescription dispensed for a 90 days’ supply but filled the next prescription after 115 days had passed, they would have an adherence rate of about 0.78 (i.e., they had a 90 days’ supply in their possession for 115 days before the next fill). Anything below 0.8 is considered non-adherent. When this occurs, a medication for treating a chronic condition is likely not as effective as it could be.

CHART 26 | Rates of non-adherence by drug category



Drug pipeline

The drug pipeline for 2022 could be described as relatively quiet for private drug plans. Out of four categories singled out as potentially having an impact on private drug plans, two of them—for multiple sclerosis (MS) and macular degeneration—are expected to generate cost savings, thanks to a slew of new generics for MS and several biosimilar options for macular degeneration.

Two new drugs for atopic dermatitis (eczema) failed to get recommendations from the Canadian Agency for Drugs and Technologies in Health for coverage by public payers. As well, one of the new drugs for this condition, and a fourth still under review by Health Canada, may cause potentially serious adverse cardiovascular events.

A drug for Alzheimer's disease, approved in the U.S. amid considerable controversy, is now under review by Health Canada. If it is approved, private plans could see some claims since the drug is indicated for those with mild to moderate symptoms, who could still be part of the working-age population.

The pandemic has also triggered the entry of vaccines and treatments for COVID-19. Health Canada has approved six vaccines so far, with another two under review. Six biologics, generally administered intravenously in a hospital, are currently available for treatment. At this point, all of these vaccines and treatments are publicly funded.

Get the details in the TELUS Health's report, The drug pipeline: What private plans can expect in 2022.

Categories up close

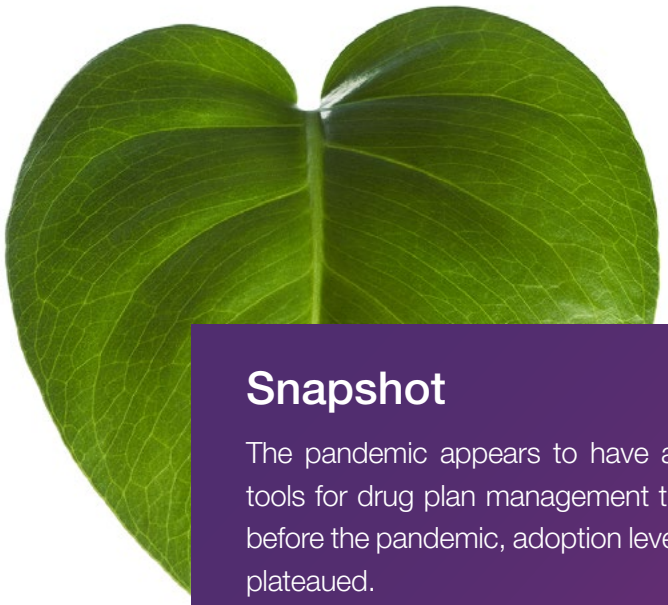
In the 2022 Category watch: Impact of the pandemic report, TELUS Health takes a closer look at drug categories that one might have suspected would be more susceptible to changes in utilization due to the pandemic: namely, the categories for depression, pain (including the use of opioids), substance use disorder and obesity.

In fact, while the first year of the pandemic did have some impact, changes in claims activity for all four categories were already well underway before the public health crisis. These pre-existing trends reasserted themselves during the second year of the pandemic. In three of the four categories, this meant a return to strong rates of growth. Changes in the remaining category, narcotic analgesics (including opioids), have been negative or flat for the past five years.

Summary

The diabetes category appears primed to take over the number-one spot for spending by private drug plans, due to the growing utilization of higher-cost therapies and a medical device that improves patients' ability to manage the disease. Adherence to diabetes drugs also appears to be improving. The four categories dominated by specialty drugs (for RA, skin disorders, cancer and multiple sclerosis) saw virtually no changes in their shares of the total eligible amount. While the depression category's share also did not change, claims volume and the number of claimants rose for these low-cost medications.

5. Plan management



Snapshot

The pandemic appears to have arrested the adoption of most of the six tools for drug plan management tracked by TELUS Health. However, even before the pandemic, adoption levels of several of the tools may already have plateaued.

- Generic substitution policies, prior authorization and coinsurance are by far the most popular tools
- Certificates with annual drug-plan maximums increased slightly

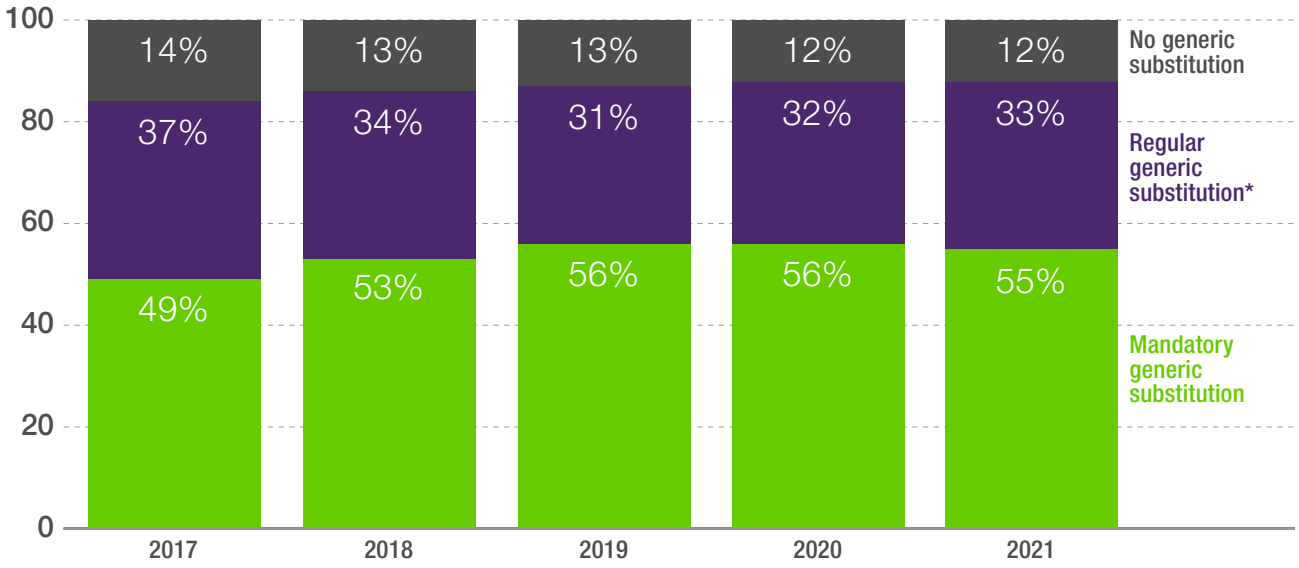
Generic substitution policy

The number of private drug plans with mandatory generic substitution policies appears to have plateaued; in fact, at the group plan level, the presence of these policies appears to have declined somewhat in 2021.

Fifty-five per cent of certificate holders had plans with mandatory generic substitution policies, virtually unchanged from 2020 and 2019 (both 56%) (Chart 27). Five years ago, 49% of certificates had plans with mandatory substitution policies.

Outside of mandatory substitution, 33% of certificates have plans with regular generic substitution policies, comparable to 2020 (32%). A total of 88% of certificates have either a mandatory or regular generic substitution policy, compared to 86% five years ago, in 2017. That leaves 12% with no measures for generic substitution in 2021.

CHART 27 | Certificates with plans that include generic substitution policies, 2017 – 2021



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

Coinsurance & deductible

Seven out of 10 certificates (70%) have a drug plan that includes coinsurance, unchanged from last year (70%) and slightly up from 69% in 2017 (Chart 28).

Among those with coinsurance, the most common breakdown continues to be 80% paid by the employer and 20% paid by the plan member. Sixty-five per cent of certificate holders had plans with this breakdown in 2021, unchanged from five years ago. Among remaining certificate holders, 22% had plans where employers paid anywhere from 85% to 95% of the cost, and 13% had plans where employers paid 75% or less of the costs.

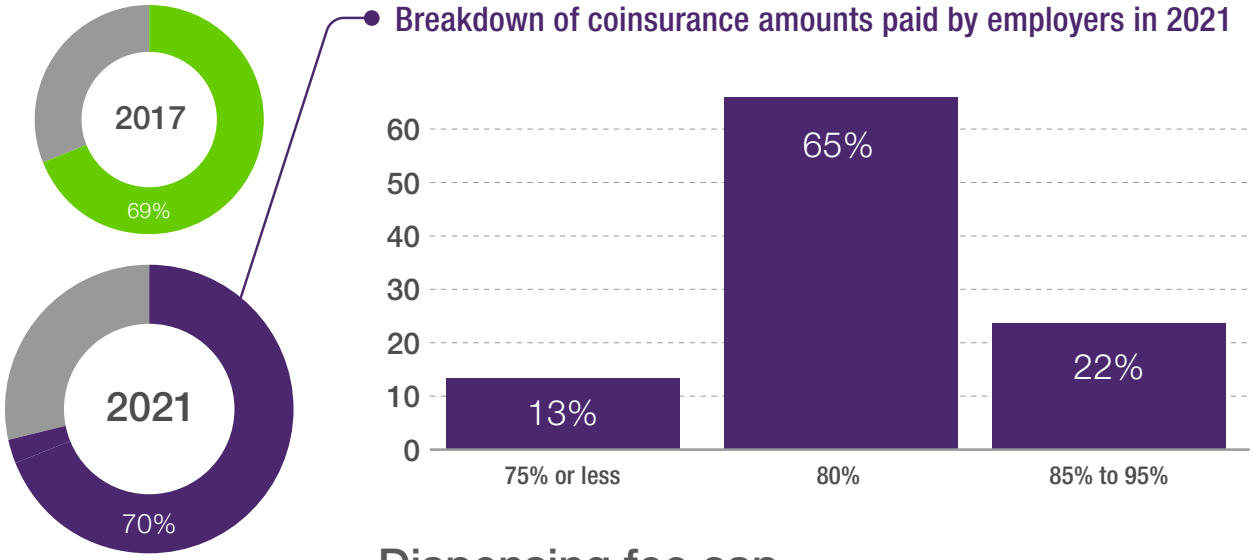
"A 20% out-of-pocket payment by the claimant has come to be seen as a reasonable amount for cost-sharing and to promote a better understanding of the value of the benefit program," notes O'Brien. "Often the claimant's coverage can be made whole either through coordination of benefits with a spouse's plan or through a healthcare spending account if that's available."

Deductibles are much less common: only 10% of certificates had plans that require an annual deductible (unchanged from 2020), and only 12% had plans requiring a deductible per claim (compared to 13% in 2020).

These results are virtually unchanged from five years ago (10% and 14%, respectively). The most common annual deductible is between $50 and $100 (for 39% of certificates), followed by more than $100 (32%) and less than $50 (28%). The most likely per-claim deductible is between $4.00 and $5.99 (39%), followed by $2.00 to $3.99 (27%) and $10 or more (19%).

“Deductible amounts are historically quite low and eroding as drug costs continue to climb. They do not make a meaningful impact on containing or sharing costs. We have seen more of a trend toward percentage-based coinsurance, which moves with inflation,” says O’Brien.

CHART 28 | Certificates with plans that include coinsurance, 2017 versus 2021



Dispensing fee cap

Twenty-eight per cent of certificates had drug plans with dispensing fee caps in 2021, virtually unchanged from five years ago (29%) (Chart 29). Of those certificates, 39% saw their coverage for the dispensing fee capped at an amount of up to $7.99, followed by 22% with a cap of $8.00 to $8.99. For 13% of certificate holders, the cap did not kick in until $11.00 (among these holders, 4% paid between $15 and $16 toward the dispensing fee).

“Often dispensing fees are overlooked as a cost contributor, but they can make up a meaningful amount of the eligible amount per claim. Based on the average dispensing fee submitted in 2021 and our average eligible amount per claim, dispensing fees account for nearly 15% of the total,” says O’Brien.

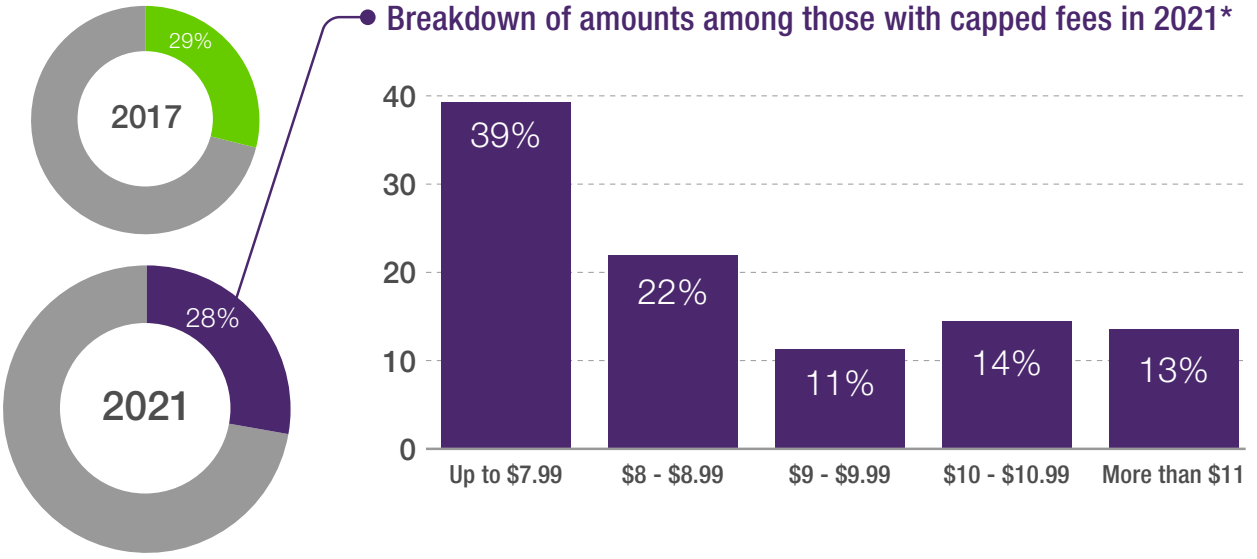
The average dispensing fee in Canada was $11.76 in 2021, an increase of 52 cents compared to 2017 ($11.24). Pharmacies in Quebec had the highest average dispensing fee, at $13.35, compared to a low of $11.02 in the Atlantic provinces and $11.07 in Western Canada. The remaining region, Ontario, had an average dispensing fee of $11.19.

It should be noted that pharmacies in Quebec are not required to separate out the dispensing fee when billing to drug plans. TELUS Health calculated the dispensing fee for Quebec by adding a reasonable markup to the ingredient cost, which leaves the remaining amount as the dispensing fee.

By store format, pharmacies that are part of banners or chains have the highest average dispensing fee, at $11.82. These pharmacies also dispense the most claims by far: 84.7%, compared to 15.1% dispensed by independently owned pharmacies (where the average dispensing fee is $11.47). Virtual or mail-order pharmacies have the lowest fee, at $8.64; however, they represent less than half of one per cent of claims (0.2%).

“The average cap of about $8 means that about $3 of the dispensing fee is shifted over to the plan member, although members who use a virtual pharmacy may not be impacted at all by the cap,” notes O’Brien.

CHART 29 | Certificates with plans that include capped dispensing fees, 2017 versus 2021



*Total does not add up to 100% due to rounding

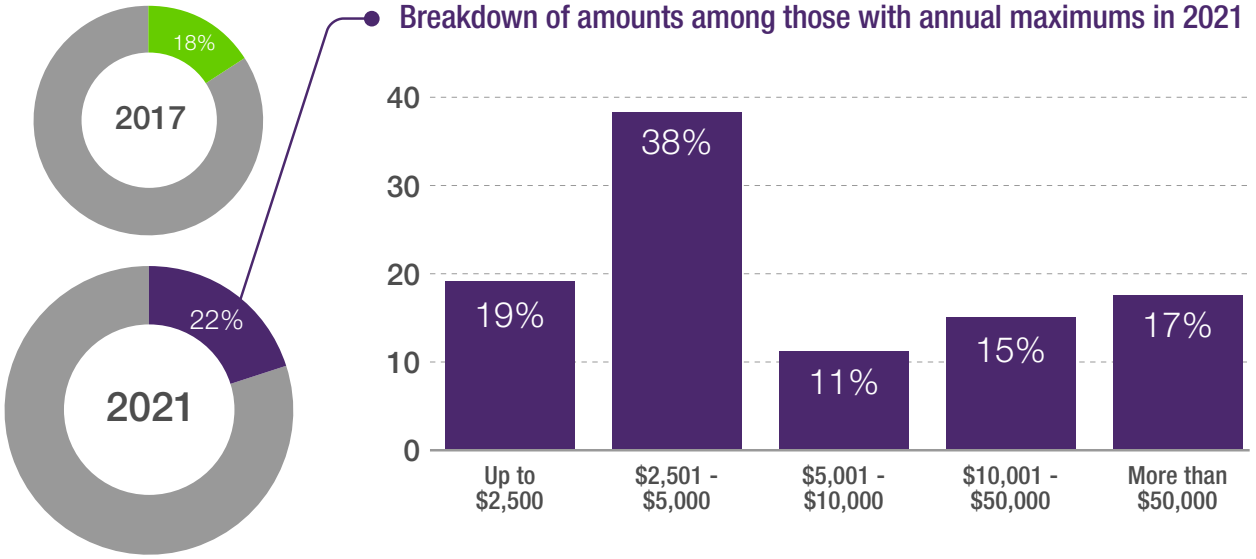
Annual maximum

Twenty-two per cent of certificate holders had drug plans with annual maximums in 2021, unchanged from 2020 and up from 18% in 2017 (Chart 30).

The largest proportion of these certificates (38%) had maximums of between $2,501 and $5,000, followed by 19% of certificates with maximums of up to $2,500. Eleven per cent had annual maximums of between $5,001 and $10,000, leaving 32% with maximums exceeding $10,000.

"The most common maximum—between $2,500 and $5,000—is actually quite low. These tend to be in smaller employer plans, given how significant the impact of one or two high-cost claimants could be. Some plans that do implement lower annual maximums such as these may also direct funds into a healthcare spending account where the contribution is defined," says O'Brien.

CHART 30 | Certificates with plans that include annual drug plan maximums, 2017 versus 2021



Prior authorization

More than eight out of 10 certificate holders (84%) had drug plans that include a prior authorization (PA) process, virtually unchanged from 2020 (85%) and compared to 86% in 2017 (Chart 31).

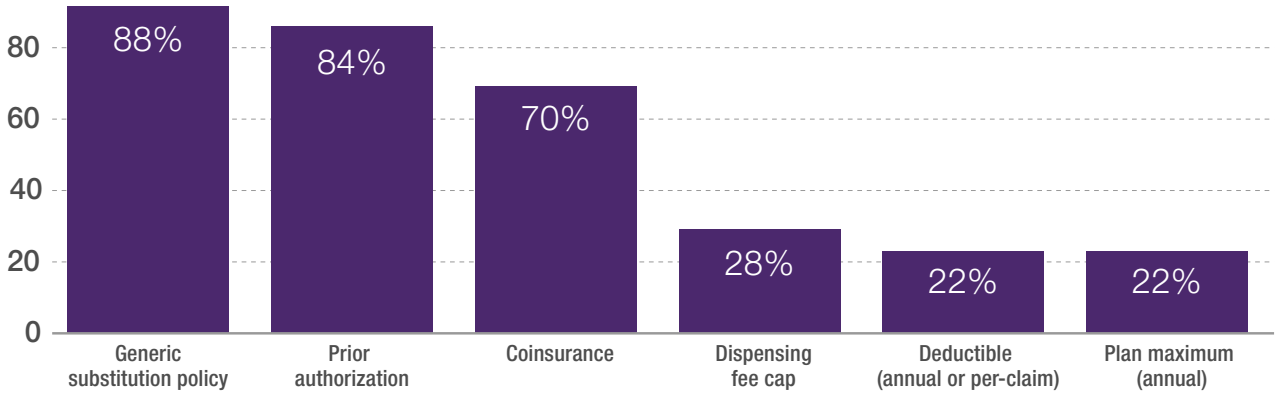
"Prior authorization is an effective tool to help make sure the right drug is taken at the right time, particularly given the evolution of therapies in some classes of drugs, such as the diabetes category. The new therapies may be more effective, but they often come at a higher cost," notes O'Brien.

CHART 31 | Certificates with plans that include prior authorization, 2017 versus 2021

Summary

More time needs to pass to determine whether adoption levels of some plan management tools have plateaued or even started to decline, pandemic notwithstanding. Regardless, pre-pandemic data indicates that growth rates have been modest at best.

CHART 32 | Summary of certificates with plans that include the following tools for drug plan management



6. Conclusion

The pandemic further complicates an already complex, changing landscape for private drug plans.

Year after year, high-cost claimants take a larger share of the total eligible amount submitted to private drug plans. This increase is fuelled on the one hand by the growing utilization of specialty drugs to treat a wider range of serious conditions, and on the other hand by the emergence of novel, ultra-high-cost drugs for very rare diseases.

As a result, the average eligible amount across all insureds climbed in 2021, despite the fact that, for the second year in a row, fewer insureds made a single claim (a reflection of reduced medical visits during the pandemic). The increase in the average eligible amount per claim is well above growth rates for the previous four years, and almost triple the average increase in the Consumer Price Index in 2021.

It may be years before the claims data reveal the full impact of the pandemic. The proportion of claimants among insureds will likely rebound to pre-pandemic levels—and perhaps surpass them, as more new claimants may come forward in response to the healthcare system catching up on delayed diagnoses and/or treatments for chronic conditions, including cancer. Unfortunately, some of these claimants will require more treatment than they would have had the pandemic not occurred, due to a worsening of their condition that might have been preventable had they been able to receive treatment earlier.

Comprehensive, nuanced reporting on the key drivers of growth in cost and utilization, as well as the impact of cost containment measures, is increasingly important for plan sponsors, their providers and advisors. TELUS Health is committed and prepared to continue to deliver such actionable information and analysis to its clients and to the industry at large.

2022 Drug Data Trends & National Benchmarks

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