2023 Drug Data Trends & National Benchmarks

TELUS® Health

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Glossary

Adjudicated amount:	The amount paid by the plan after the application of any plan design fiscal parameters.
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.
Eligible amount:	Dollar amount of the drug cost found eligible for coverage by TELUS Health, before the application of any plan design fiscal parameters (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 “insurance plan member(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 equivalents exist.
Reference biologic:	First-on-market, large-molecule 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.

Foreword

As we emerge from the COVID-19 pandemic, the 2023 Drug Data Trends & National Benchmarks Report (Drug Trends Report) provides us with a compelling and thorough snapshot of the impact that the last few years have had on Canada's health insurance and prescription medication space.

The 2023 edition offers all stakeholders in the space important perspectives into the driving forces triggering these changes.

The end of the pandemic saw a slow shift toward normalcy in 2022, but with much progress still being required. Many findings from this year's report suggest that 2022, and perhaps 2023, might be the calm before the storm, as private drug plans have yet to experience the full impact of the return to normalcy post COVID-19. While certain trends indicate a return to pre-pandemic levels, we note that people across Canada are trying to catch up with medical appointments that were skipped or delayed due to the pandemic and are now facing significant wait times due to an overall backlog in the public health system. It may take several more years before those plan members are able to catch up on delayed medical appointments, diagnostic tests and surgeries.

On the other hand, those who have been able to book medical appointments may contribute to a higher claims count and higher cost per claim due to deferred care and presenting with a later-stage diagnosis, since serious illnesses may have remained undetected or worsened in pandemic years. As a comparison, from 2014 to 2019, the number of claims per person consistently hovered around 10 claims annually. By the end of 2020, that had jumped to 11.4 claims on average, largely because of provincial policies mandating a shorter day supply in efforts to curb drug shortages, and remained noticeably ahead of pre-pandemic numbers with 10.8 claims in 2022.

There has also been a shift in eligible amounts by age group, with younger adults moving ahead of those in older demographics. When analyzing claims data by age, we find that the growth rate in eligible amount for plan members under the age of 25, at 14.2%, is more than double that of plan members aged 60 to 64 (6.2%) and 50 to 59 (5.4%).

The report also outlines the growing impact of biosimilar switching policies on cost trends in 2022, and found that savings are mostly being offset by growth in the use of higher-cost, second- and third-line therapies for chronic diseases such as diabetes. The result is moderate growth in spending by private drug plans for the third year in a row, with a slight decline in 2022.

B.C. was the first province to launch a switching policy (in 2019), and saw biosimilars' share of claims to private plans in the biologics category climb from 5.5% at the start of 2019 to 20.4% by end of that year. As of December 2022, biosimilars accounted for 64.7% of claims for all biologics. Similarly dramatic results occurred in Quebec, where the share grew to 38% by the end of April 2022. By the end of 2022, in lockstep with B.C., their share reached 64.8%. These policies have had a ripple effect on private drug plans, particularly in B.C. and Quebec, where sponsors have followed the lead of public payors in biosimilar switching. Nationally, that has translated to significant growth of biosimilars' share of claims in the biologics category from just 4.2% in January 2019 to 32% in December 2022. That will likely accelerate in 2023 and 2024, as remaining provinces and territories complete their transition periods.

The impact of biosimilar switching was only one factor in the shifting proportion of plan costs in 2022. For the first time in more than 10 years, the growth rate for specialty drugs fell behind that of traditional. While the number of claimants increased for specialty drugs—with the largest single-year increase since TELUS Health's reporting began—the share of eligible amounts declined for the first time since 2008 compared to traditional drugs. In contrast, the utilization and related costs of traditional drugs have also surged in 2022, with use rebounding since the start of the pandemic.

The increase in claims for high-cost traditional drugs in two of the top-10 medication categories—diabetes and attention deficit hyperactivity disorder (ADHD)—has also led to a proportional shift away from specialty drugs as main cost drivers. In fact, after 10 years, the rheumatoid arthritis category conceded its number-one ranking to diabetes, buoyed by real-world evidence of the clinical benefits of certain higher-cost therapies for both diabetes management and weight loss.

The data trends regarding the link between COVID-19 and declining mental health have become clearer after three years of available statistics, especially for young adults. Claims for antidepressants remain elevated compared to pre-pandemic years and the highest growth in utilization occurred among plan members below 19 years old. The growth is even more apparent when we consider the proportion of claimants from this age group, which climbed from 15.9% of all claims for antidepressants in 2018 to 19.3% in 2022.

It is our hope that insights like these, and others provided in the pages ahead, will continue to help private insurers and benefits advisors adjust and improve benefits plans. TELUS Health remains committed to delivering actionable information to plan sponsors, providers and advisors on key drivers of change in cost and utilization, as well as the impact of cost-management measures, maintaining that valuable close collaboration that helps support employees in their pursuit of better health and wellbeing.

This report has been published annually since 2015, and we continue to work tirelessly to break down data silos by stimulating efficiency through collaboration and digitizing the value chain in this highly critical sector. By continuing to deliver important insights such as those contained in the Drug Trends Report, we look to stay true to our commitment to power a healthier future by helping Canadians live healthier and happier lives.

Martin Bélanger
Managing Director, Payor Solutions

2023 Drug Data Trends & National Benchmarks

1. Introduction

Growth in spending by private drug plans was moderate for the third year in a row; in fact, it was down slightly in 2022 compared to the previous two years.

The biggest factor: specialty drugs. While still a major driver of growth in spending for private drug plans, they loosened their grip in 2022. The implementation of biosimilar switching policies is the reason why—so much so that the category of drugs for rheumatoid arthritis, dominated by biologics for which lower-cost biosimilars are now available, has dropped to second position on the top-10 list after more than a decade in the number-one spot. For the first time in more than 10 years, specialty drugs' share of the total eligible amount also declined ever so slightly, despite the largest single-year increase in the number of claimants.

On the other hand, the increased utilization of certain drugs to treat diabetes played a role in shifting the balance between specialty and traditional drugs. Indeed, the diabetes category is now the number-one category by eligible amount, after years of steady growth.

Overall, monthly utilization of private drug plans changed very little in 2022. After the pandemic, the number of insurance plan members (insureds) submitting a claim remained lower than usual while the number of claims per claimant remained higher than usual. Both trends, however, appear to be returning to pre-pandemic levels.

A closer look at claims and claimants reveals three main findings: an upsurge in claims for plan members under nine years of age, likely for antibiotics to treat respiratory infections; more claimants and claims for antidepressants, especially for plan members under 19 years old; and more adult claimants for drugs to treat attention deficit hyperactivity disorder.

The 2023 Drug Data Trends & National Benchmarks Report captured claims data for more than 4.6 million primary cardholders in 2022. In addition to analyzing claims data trends, this report serves as a reference for the adoption of plan management tools, including mandatory generic substitution policies.

2. Costs and utilization

Snapshot

- Growth in the average monthly eligible amount per certificate was moderate and slightly down from the past two years
- Younger plan members bucked the trend, with double-digit increases in eligible amounts among those aged up to nine years old
- The growth rate in the average eligible amount per claim returned to usual levels after a large increase in 2021
- The increase in eligible amount per claim was significantly below the change in the Consumer Price Index in 2022, which is a reversal of results from 2021 and 2020
- Overall, monthly utilization of drug plans did not change in 2022; regionally, however, there was modest growth in Western Canada and a modest decline in Quebec
- Compared to before the pandemic, the number of insureds who submitted a claim remained lower than usual while the number of claims per claimant remained higher, although both appear to be reverting to pre-pandemic levels
- Generic drugs' share of claims climbed steadily, albeit at a slower pace in 2022

Cost trends

Growth in spending by private drug plans remains moderate for the third year in a year; in fact, it declined somewhat in 2022, likely due to new policies for biosimilar medications.

Specifically, when we look at the average monthly amount of drug costs eligible for coverage spread out across all certificates (i.e., primary-cardholder employees), the growth rate was 2.6% in 2022 compared to 3.2% in 2021 and 2.8% in 2020 (chart 1). In dollar terms, the average monthly eligible amount per certificate was $103.30 by the end of 2022 compared to $100.73 in 2021 and $97.58 in 2020 (chart 2).

Regionally, Quebec played the biggest role in flattening the growth curve: its average monthly eligible amount per certificate declined by 1.4% (chart 3).

“Quebec’s policy for biosimilar drugs took effect early in 2022. We saw rapid adoption of the policy by private plans as well, which explains the slower growth in drug spending in that province,” says Lavina Viegas, Director, Adjudication Best Practices and Data Enablement, TELUS Health. For more on the impact of biosimilar switching policies, see page 30.

As well, Quebec reported lower utilization overall of private drug plans in 2022. That would also have contributed to the drop in average monthly eligible amount (page 17).

When we look at claims data by age, the growth rate in eligible amount for plan members under the age of 25, at 14.2%, is more than double that of plan members aged 60 to 64 (6.2%) and 50 to 59 (5.4%) (chart 4). Most of this growth, by far, came from the youngest of plan members, where the eligible amount jumped by 33.6% for those under five years of age, and by 26.5% for those aged five to nine years.

“Very young children avoided exposure to a number of infections such as flu, RSV and strep throat during the first two years of COVID-19, which means that respiratory infections came back with a vengeance when public health measures were lifted,” explains Viegas. She adds that higher-cost therapies are also a factor. “Their indications are expanding to include younger age groups.”

The growth was enough to shift shares of the total eligible amount, with the share for the under-25 age group increasing to 13.1% from 12.4% in 2021 while that for the oldest age group, from 45 to 64 years, declined to 56.7% from 57.9% (chart 5).

However, the impact on total eligible amount in 2022 was negligible given the older age group's dominance and the large difference in average annual eligible amounts per claimant: $490.58 per claimant under the age of 25 in 2022, compared to more than $1,000 for claimants 45 and older. At the two extremes, the average annual eligible amount was $1,533.98 for claimants aged 60 to 64 and just $197.48 for claimants up to four years of age.

When the lens is switched to claims, across all ages, the average eligible amount per claim was $85.39 in 2022, 2.3% more than the average of $83.44 in 2021 (chart 6). This follows an unusually high growth rate of 8.9% in 2021. For the three years prior to that, growth rates in the eligible amount per claim ranged from 1.3% to 3.0%.

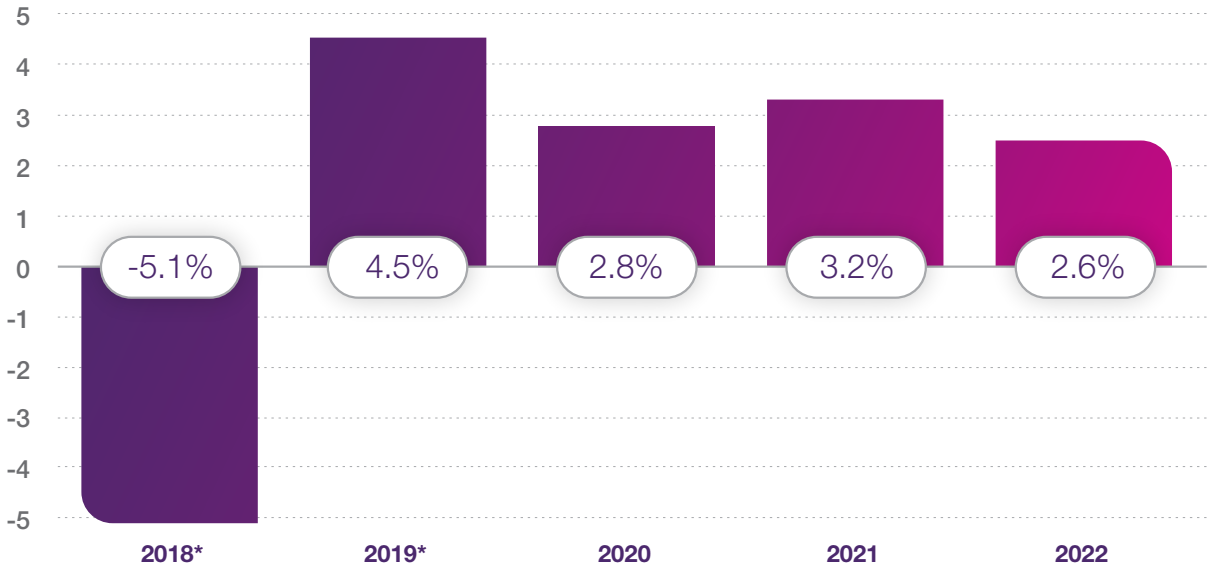
"Prescriptions reverted to 90-day fills in 2021 after dropping to 30 days in 2020 to help protect the drug supply. That's likely a major reason for the jump in cost per claim in 2021," says Viegas.

Regional rates in Western Canada (2.3%) and Ontario (3.0%) fell in line with the national growth rate of 2.3% in the average eligible amount per claim, while Atlantic Canada (-0.4%) and Quebec (1.1%) were below the national average (chart 7). See chart 14 for more on the differences between regions.

Additional analysis by TELUS Health found that plans with managed formularies benefit from lower growth rates and lower average eligible amounts per claim. In 2022, the average eligible amount per claim grew by 2.4% for plans without managed formularies compared to 1.7% for plans with managed formularies. In dollar terms, the average eligible amount per claim for plans with non-managed formularies was $88.53 compared to $75.05 for plans with managed formularies. In 2018, the respective amounts were $74.85 and $67.05.

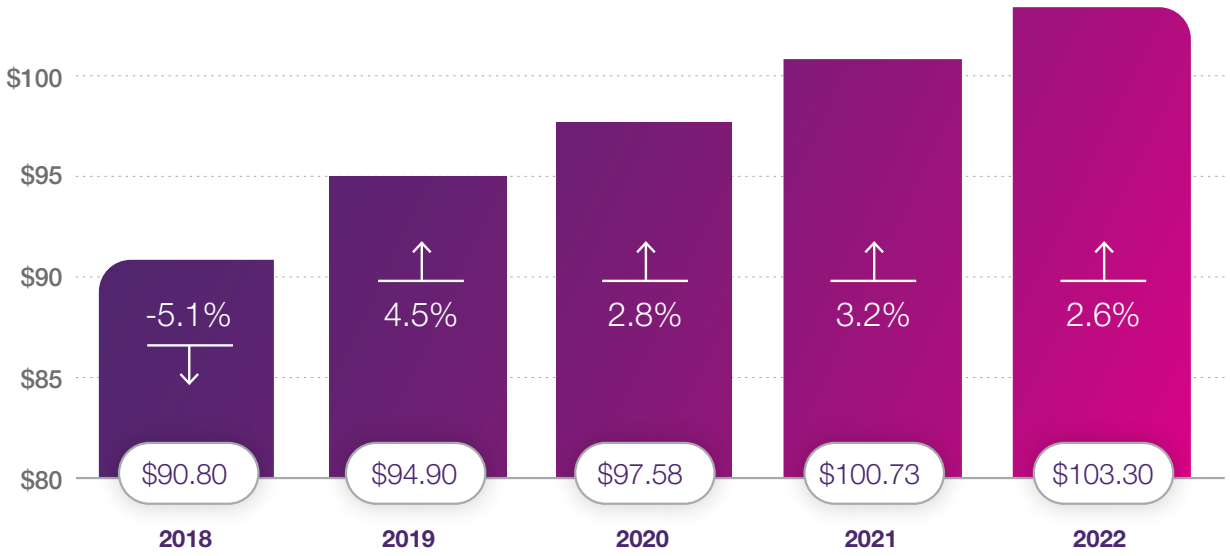
How does the cost per claim compare with the Consumer Price Index (CPI)? During the first two years of the COVID-19 pandemic, growth rates in the average eligible amount per claim significantly outpaced changes in the CPI. Last year saw a reversal of this trend. The change in CPI was 6.8% in 2022, the largest increase since 1982 (10.9%) and almost three times the growth rate of 2.3% for the eligible amount per drug claim (chart 8).

CHART 1 | Change in average monthly eligible amount per certificate, 2018 – 2022



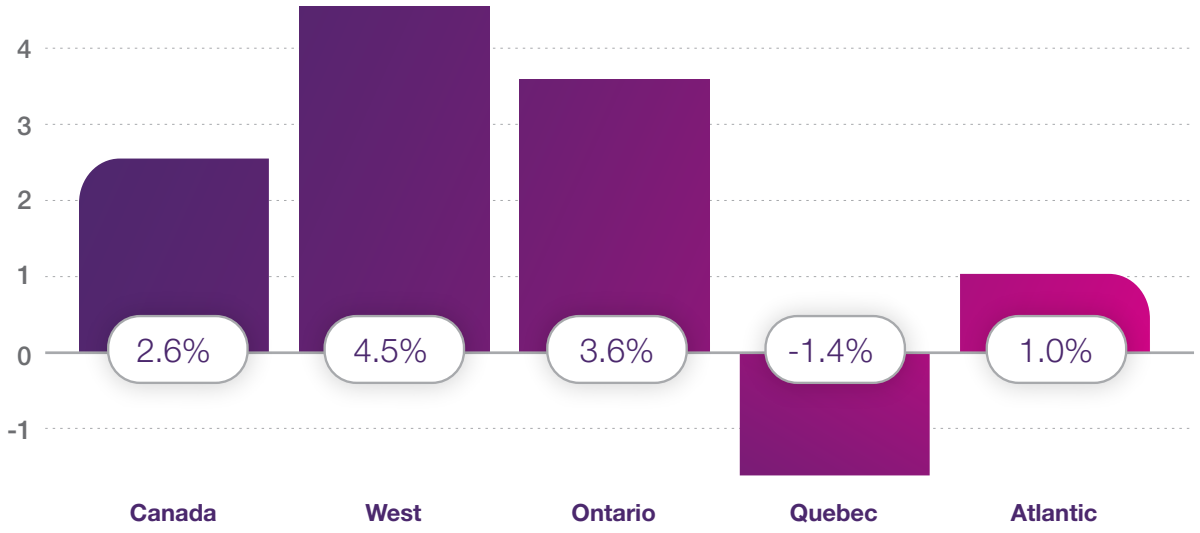
*Results from 2018 and 2019 reflect the impact of OHIP+ in Ontario, which affected private drug plans from January 1, 2018, until April 1, 2019. Source: TELUS Interactive Reporting (TIR) database.

CHART 2 | Average monthly eligible amount per certificate, 2018 – 2022



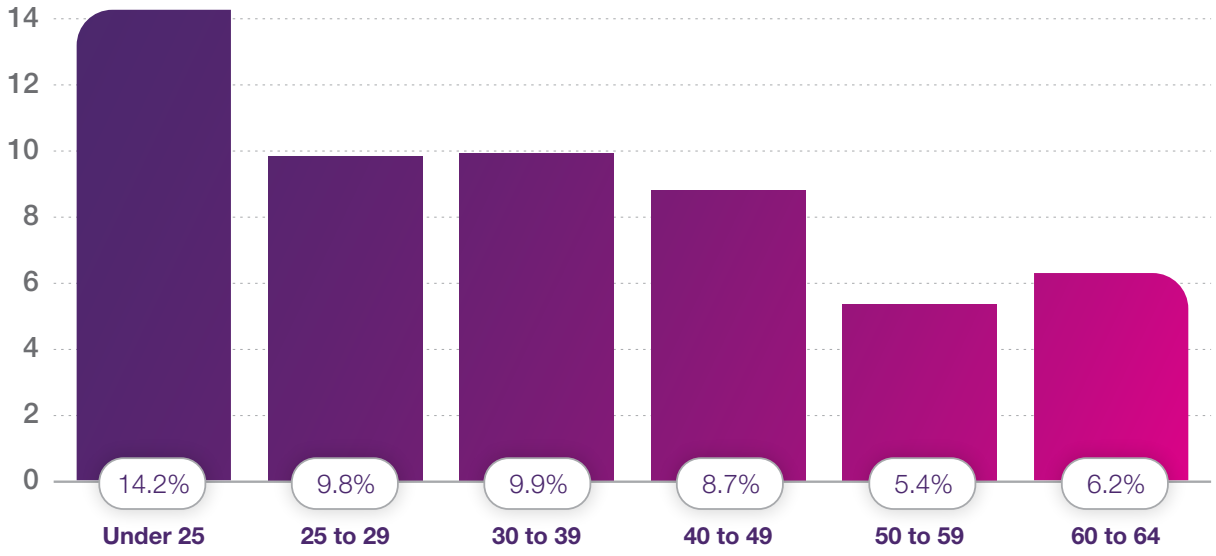
Source: TELUS Interactive Reporting (TIR) database.

CHART 3 | Change in average monthly eligible amount per certificate by region, 2021 – 2022



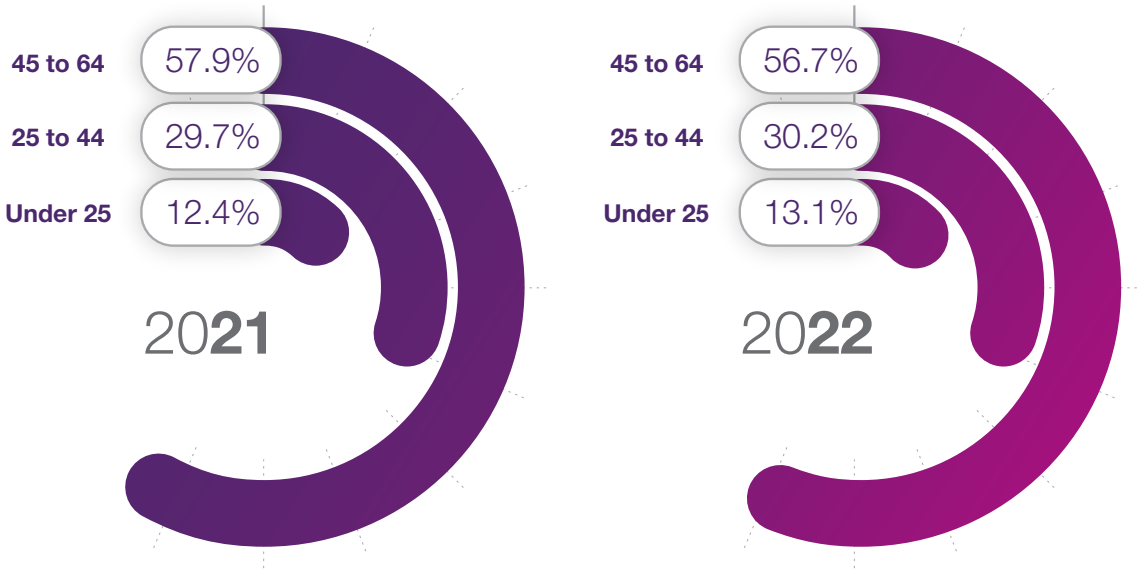
Source: TELUS Interactive Reporting (TIR) database.

CHART 4 | Change in total eligible amount by age, 2021 – 2022



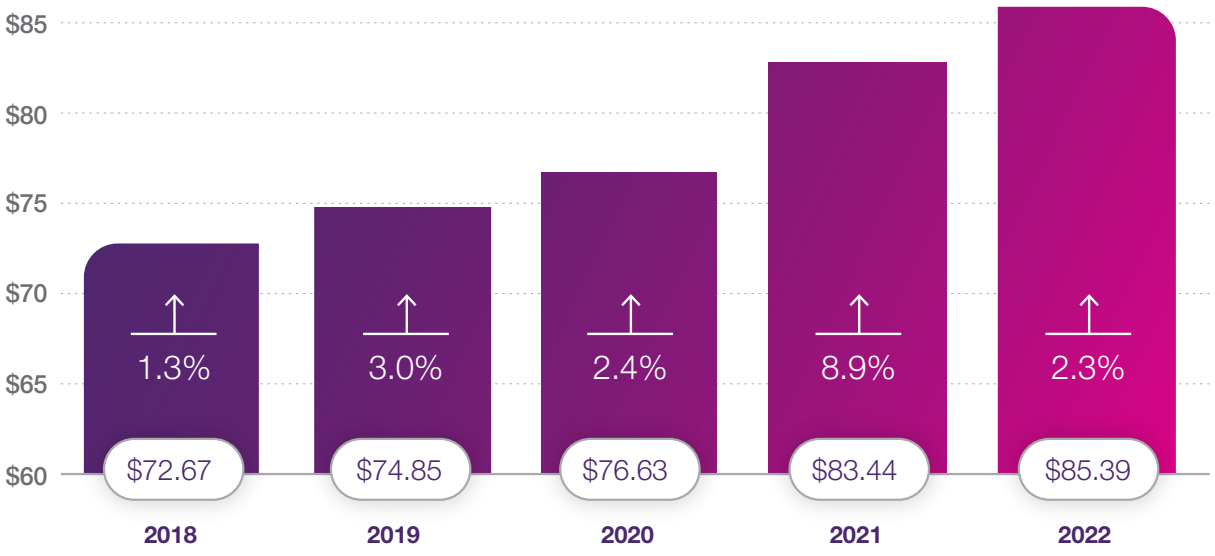
Source: TELUS Interactive Reporting (TIR) database.

CHART 5 | Share of total eligible amount by age, 2021 versus 2022



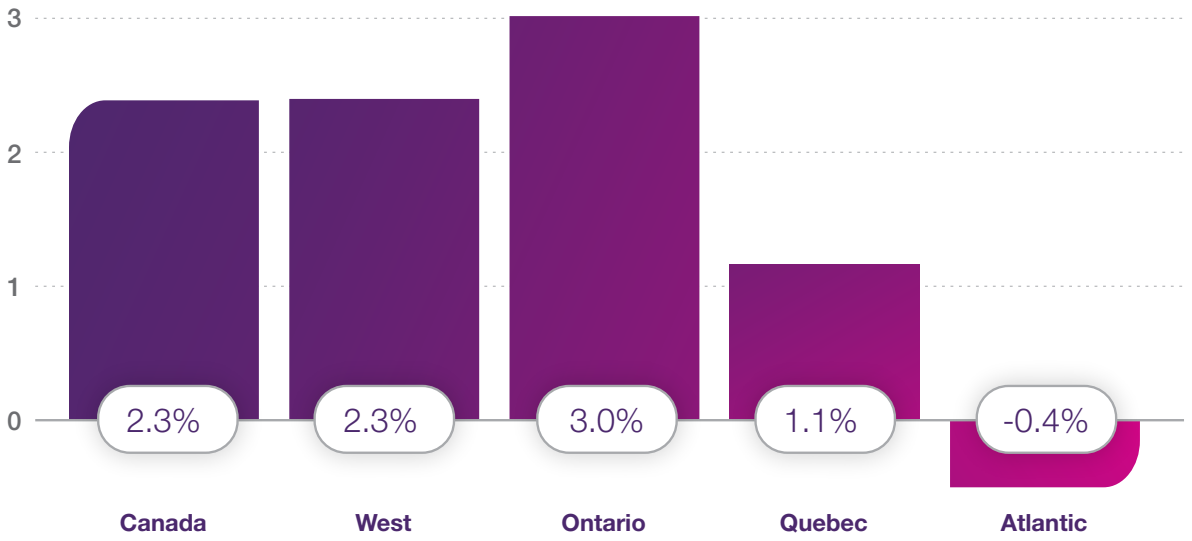
Source: TELUS Interactive Reporting (TIR) database.

CHART 6 | Average eligible amount per claim, 2018 – 2022



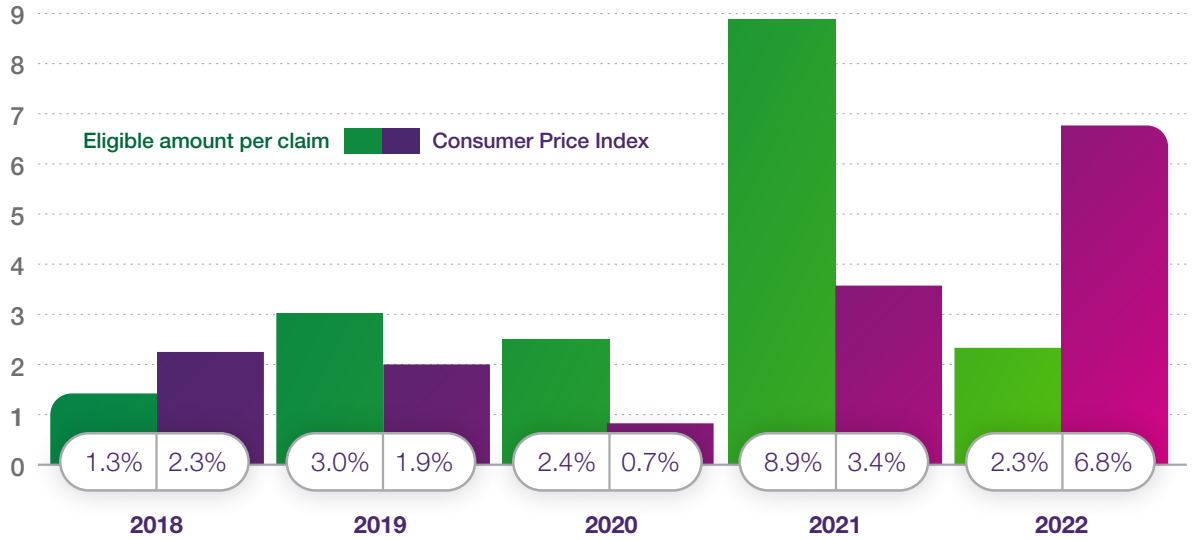
Source: TELUS Interactive Reporting (TIR) database.

CHART 7 | Change in average eligible amount per claim by region, 2021 – 2022



Source: TELUS Interactive Reporting (TIR) database.

CHART 8 | Change in average eligible amount per claim compared to the Consumer Price Index, 2018 – 2022



Source: TELUS Interactive Reporting (TIR) database.

Utilization trends

Monthly utilization of prescription drug plans, when spread out across all certificates, held steady in 2022 with a barely discernible growth rate of 0.2% (chart 9). This follows a decline of 5.2% in 2021.

As with the average eligible amount (page 11), the Quebec region was the biggest factor behind the lack of growth. Average monthly utilization per insured dropped by 2.5% in that province, compared to small gains of 2.2% in Western Canada, 1.3% in Atlantic Canada and 0.6% in Ontario (chart 10).

These results reflect the fact that, since the start of the pandemic, fewer insureds have submitted claims. By the end of 2020, the first year of the pandemic, 60.8% of insureds had made a claim, down from 67.3% in 2019 (chart 11). The number declined even further in 2021, to 59.2%. While the result of 61.1% in 2022 suggests utilization is rebounding, it is still well below pre-pandemic levels.

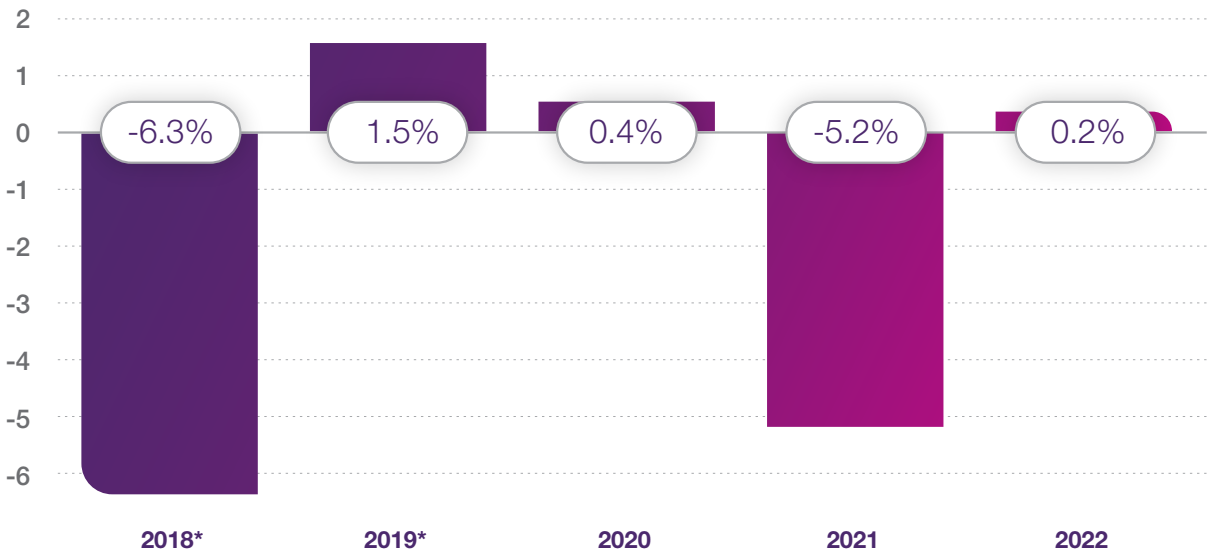
The number of claims per claimant tells a different story. Before the pandemic, the number of claims per claimant consistently hovered just below or just above 10 claims annually, according to TELUS Health data from 2014 to 2019. By the end of 2020, that had jumped by 11.2% to 11.4 claims on average (chart 12). While levels have subsided somewhat since then, to 11.1 claims in 2021 and 10.8 in 2022, they are still noticeably ahead of pre-pandemic numbers.

> “Canadians are trying to catch up with medical appointments that were skipped or delayed due to the pandemic but now they’re caught waiting because of the huge backlog in the healthcare system, says Viegas. And those who are able to catch up may contribute to a higher claims count and higher cost per claim due to deferred care and presenting with a later-stage diagnosis.”

The average annual eligible amount per claimant was $922.64 in 2022, a small decline (-0.6%) after two years of unusually high growth rates during the first two years of the pandemic (13.9% in 2020 and 6.0% in 2021). Five years ago, by the end of 2018, the average annual eligible amount per claimant was $744.65 (chart 13). As noted previously, this varies significantly by age, from $197.48 for claimants up to four years of age to $1,533.98 for claimants aged 60 to 64 (page 12).

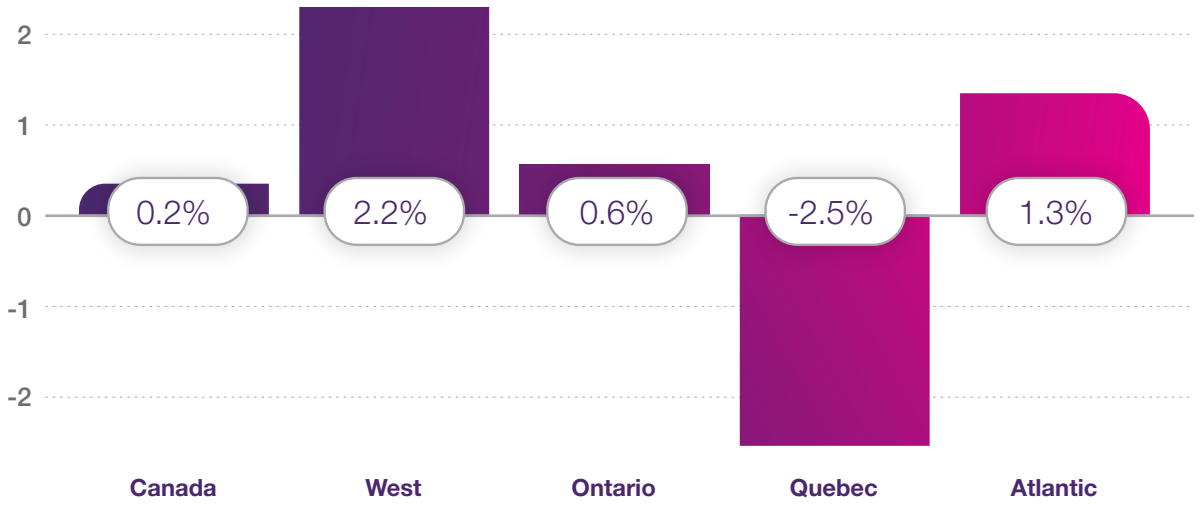
Chart 14 presents national and regional overviews of costs and utilization in 2022.

CHART 9 | Change in monthly utilization per certificate, 2018 – 2022



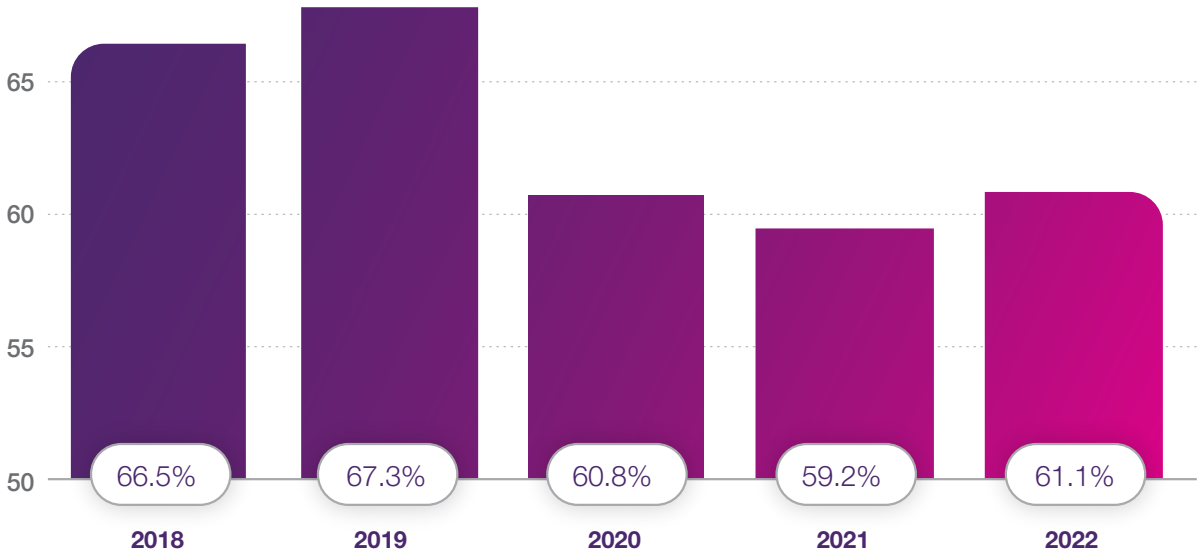
*Results from 2018 and 2019 reflect the impact of OHIP+ in Ontario, which affected private drug plans from January 1, 2018, until April 1, 2019. Source: TELUS Interactive Reporting (TIR) database.

CHART 10 | Change in monthly utilization per certificate by region, 2021 – 2022



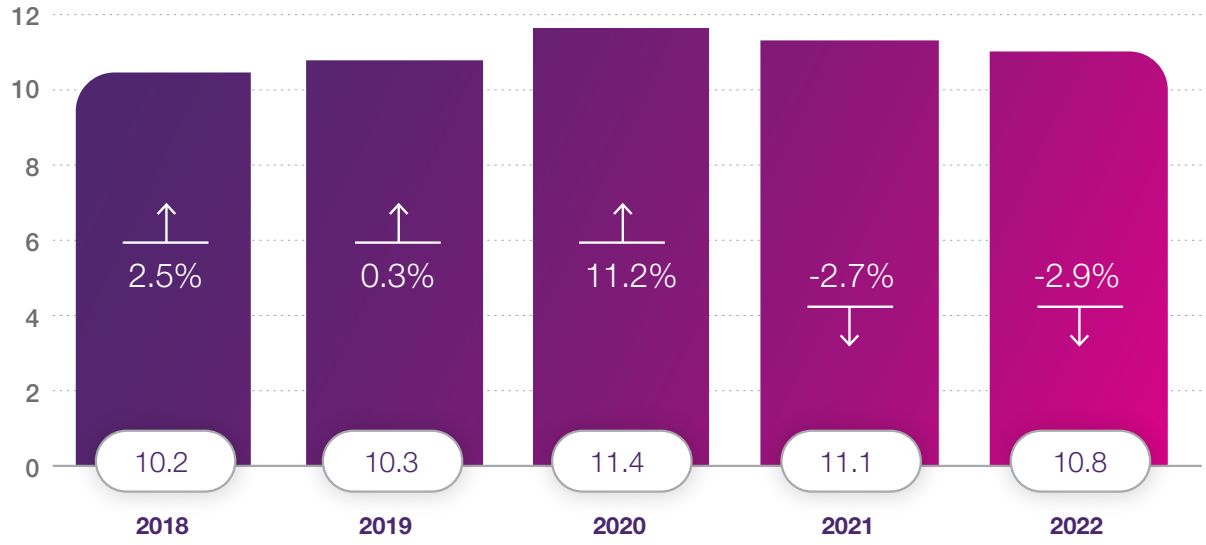
Source: TELUS Interactive Reporting (TIR) database.

CHART 11 | Number of insureds who made a claim, 2018 – 2022*



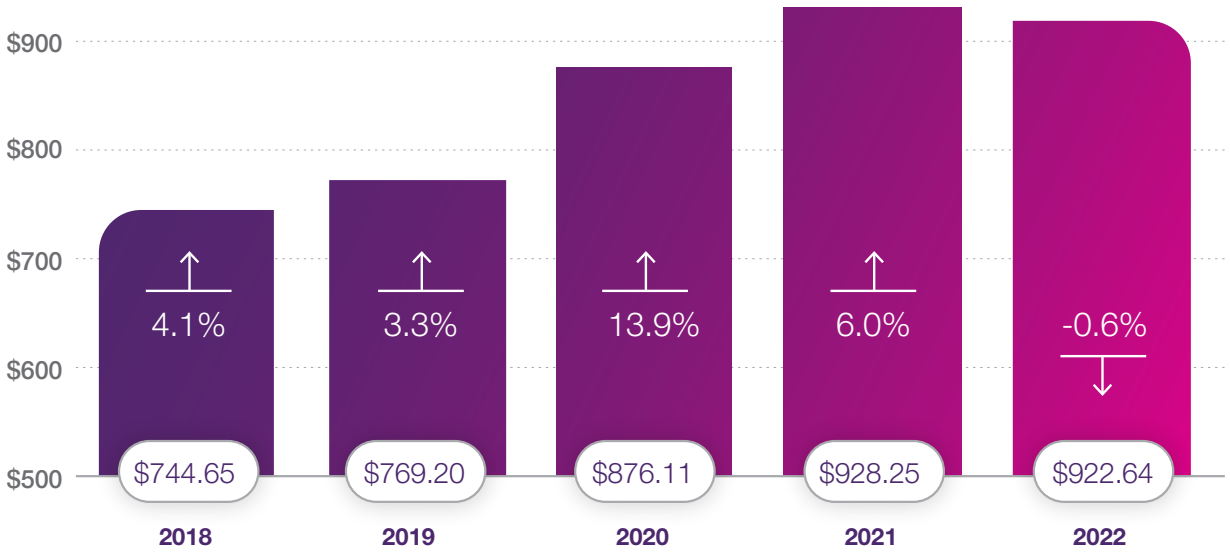
*Calculated based on an average of 2.2 insureds per certificate. Source: TELUS Interactive Reporting (TIR) database.

CHART 12 | Number of claims per claimant, 2018 – 2022



Source: TELUS Interactive Reporting (TIR) database.

CHART 13 | Average annual eligible amount per claimant, 2018 – 2022



Source: TELUS Interactive Reporting (TIR) database.

CHART 14 | Overview of costs and utilization nationally and by region, 2022

	Canada	West	Ontario	Quebec	Atlantic
Monthly eligible amount per certificate	$103.30	$78.46[1]	$109.99	$128.76	$125.64
Monthly utilization per certificate	1.2	1.0	1.1	1.8[2]	1.3
Average eligible amount per claim	$85.39	$78.59	$99.33	$70.10[2]	$95.17
Average number of claims per claimant	10.8	9.0	9.8	16.5[2]	10.6
Average age of certificate/primary cardholder	41.5	40.9	41.6	41.8	43.2

1 Western Canada has the lowest monthly eligible amount per certificate because provincial Pharmacare/universal drug plans in B.C., Manitoba and Saskatchewan automatically become the primary payor 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 60- to 90-day supplies.

Source: TELUS Interactive Reporting (TIR) database.

Utilization of generic drugs

Generic drugs' share of claims covered by private drug plans increased marginally, from 65.6% in 2021 to 66.2% in 2022 (chart 15). While the rate of growth may be slowing, generics' share of claims has been climbing steadily for at least 10 years. Five years ago, in 2018, they accounted for 62.4% of claims, and five years prior to that, in 2014, their share was 56.9%.

Mandatory substitution policies are the biggest factor behind this upward trend (page 41). While these plans still allow for claimants to access a brand-name drug, coverage is cut back to the price of the generic drug and the difference between that and the brand-name price may be picked up directly by the claimant or by the brand-name manufacturer's patient assistance program.

Regionally, Atlantic Canada continues to lead with a generic fill rate of 72.0%, virtually unchanged from 2021 (71.9%), followed by Western Canada (68.3%), Quebec (66.5%) and finally Ontario (63.8%). Over a five-year period, Quebec is the leader, growing by 4.6 percentage points over 2018 (61.9%) compared to a national gain of 3.8 points.

For the remaining 33.8% of claims, 26.9% are for single-source brand-name drugs for which no generic options are available, virtually unchanged from 2021 (27.1%), and 6.9% are for multi-source brand-name drugs for which generics are available (chart 16). The latter result is down slightly from 2021 (7.2%). Ten years ago, in 2014, multi-source drugs accounted for 10.3% of claims.

As expected, given its number-one ranking for generic fill rate, Atlantic Canada boasts the lowest share of claims for multi-source brand-name drugs (4.2%). Meanwhile, the shares in Quebec and Ontario, which trail somewhat in generic penetration, are highest at 8.2% and 6.3%, respectively.

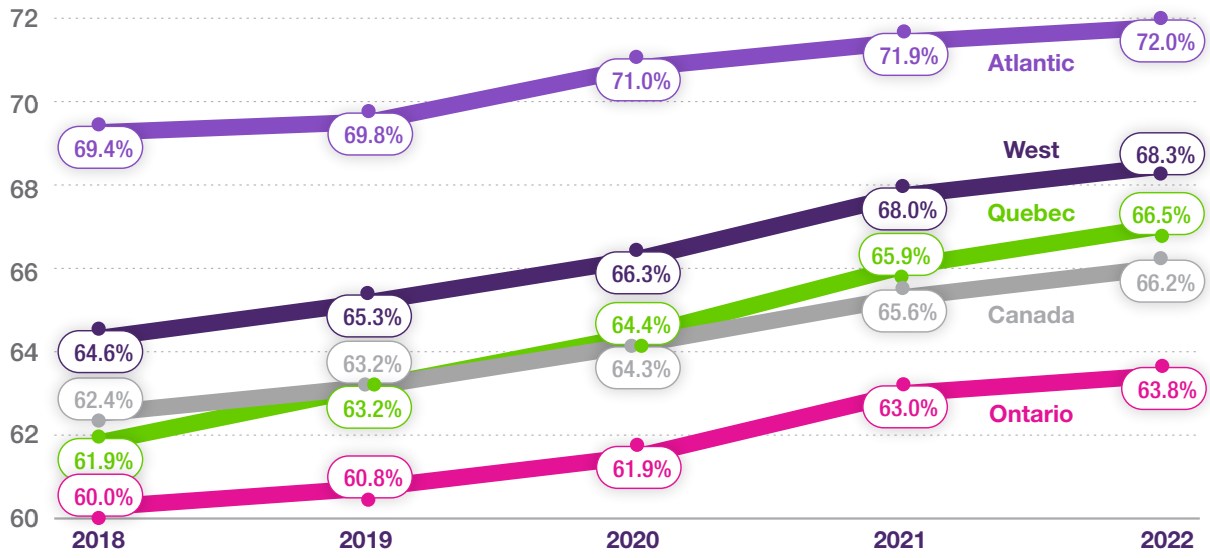
"The higher levels for multi-source brands in Quebec and Ontario are potentially due to physician-driven behaviours that mandate no substitution for certain therapeutic classes of drugs, for example for ADHD. Or there could be greater adoption of manufacturer-sponsored patient assistance programs in central Canada," notes Viegas.

When the lens is switched to eligible amounts, the breakdown flips due to the much lower cost of generic drugs. Indeed, the generic drugs' 66.2% share of claims translated into a 24.7% share of the eligible amount in 2022, leaving 75.3% of the eligible amount for single- and multi-source brand-name drugs (chart 17).

It's worth noting that generics' 24.7% share of the eligible amount in 2022 is less than their share of 25.4% in 2018, even though their portion of claims grew from 62.4% to 66.2% during that five-year period.

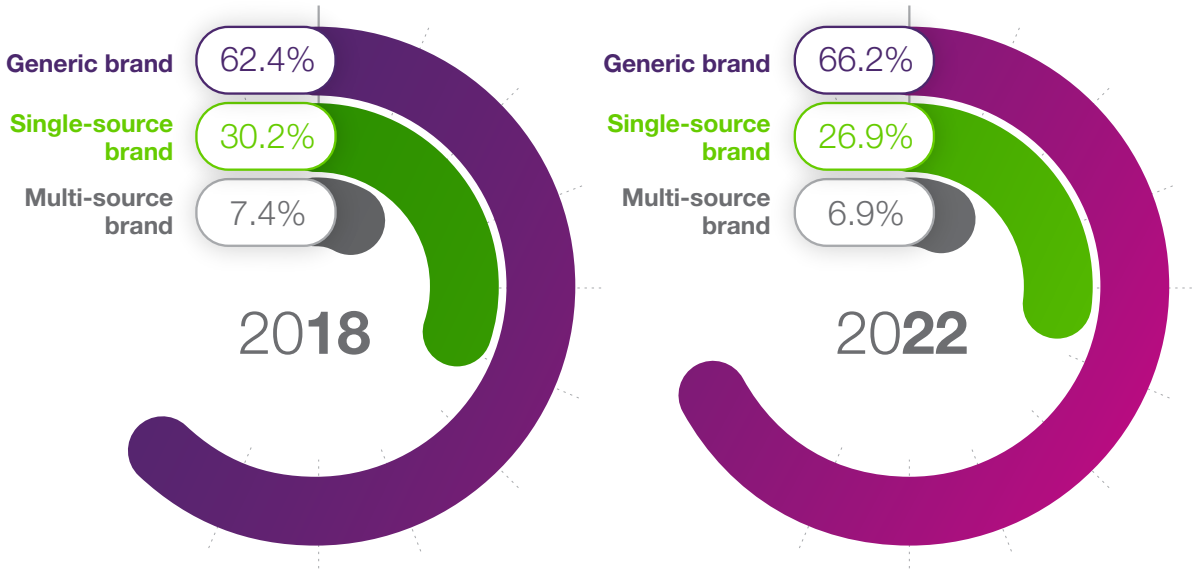
> "This speaks to the impact of the Canadian Pharmaceutical Alliance's Generic Tiered Pricing Framework, which mandates that the pricing of generics can be as low as 15% of the brand-name price for high-volume drugs with many generic options, says Viegas."

CHART 15 | Utilization of generic drugs nationally and by region, 2018 – 2022



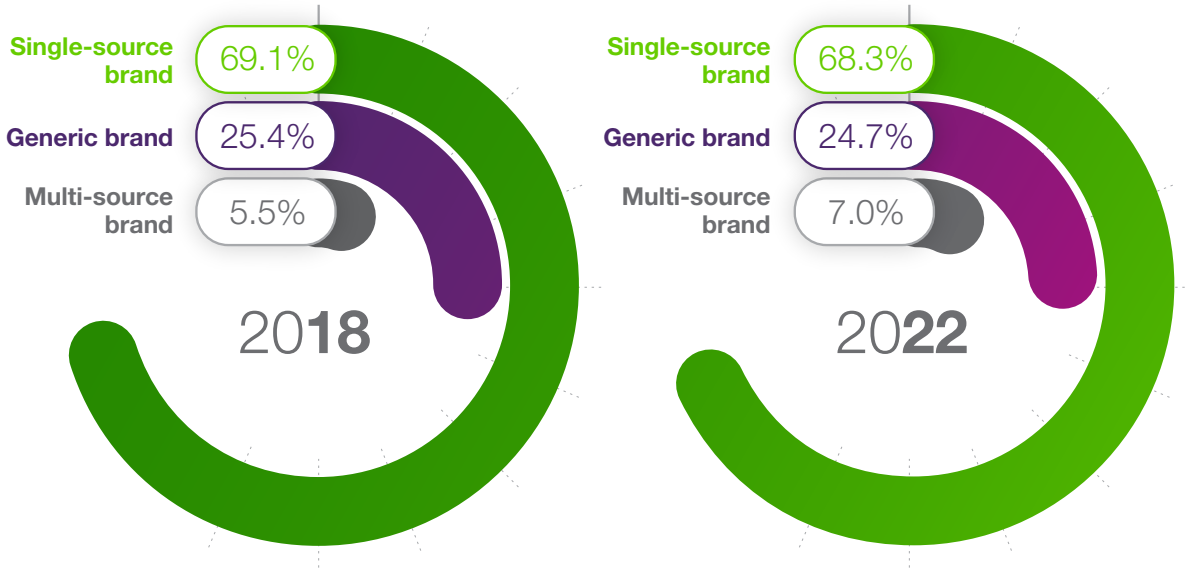
Source: TELUS Interactive Reporting (TIR) database.

CHART 16 | Utilization by type of drug, 2018 versus 2022



Source: TELUS Interactive Reporting (TIR) database.

CHART 17 | Eligible amount by type of drug, 2018 versus 2022



Source: TELUS Interactive Reporting (TIR) database.

Summary

Biosimilar switching policies influenced cost trends in 2022, contributing to a relatively low increase in the average eligible amount per certificate. This marks the third year of reasonable rates of growth in drug plan spend. The use of a managed formulary brings down the rate of growth even further. Overall monthly utilization changed very little, tempered in part by two opposing trends: the proportion of insureds making a claim remained lower than usual while the number of claims per claimant remained higher than usual. Both trends, however, appear to be returning to pre-pandemic, usual levels.

3. Specialty drugs

Snapshot

- For the first time in more than 10 years, the eligible amount for specialty drugs grew at a slower pace than for traditional drugs
- While specialty drugs maintained their share of one third of the total eligible amount, their share did decline slightly—and for the first time since reporting began in 2008
- Meanwhile, the number of claimants increased for specialty drugs
- Regionally, specialty drugs' share of the total eligible amount continued to be disproportionately higher in Atlantic Canada, and noticeably lower in Western Canada
- Provincial biosimilar-adoption policies have had a ripple effect on private drug plans, particularly in B.C. and Quebec

Share of costs and claimants

While growth continues for specialty drugs, the upward trajectory is not as steep as in previous years. And for the first time in more than 10 years, the growth rate for specialty drugs fell behind that of traditional drugs.

The total eligible amount for specialty drugs grew by 6.5% in 2022, down from 8.6% in 2021 and 10.6% in 2020 (chart 18). Meanwhile, the eligible amount for traditional drugs increased by 8.9%, up from 2.1% in 2021 and 1.8% in 2020.

"A combination of factors contributes to the surge in spend for traditional drugs," says Viegas. "Utilization is gradually rebounding since the start of the pandemic, and two of the top-10 categories, diabetes and ADHD, are seeing very strong growth for drugs that are relatively high-cost compared to other traditional drugs."

When the eligible amounts are combined, specialty drugs hold a 33.1% share, down from 33.6% in 2021 (chart 19). While a 0.5 percentage point decrease could be described as marginal, it is the first decline since TELUS Health began reporting on claims data for specialty drugs in 2008.

A final point worth noting: specialty drugs' apparent deceleration occurred even though the number of claimants grew from 1.4% to 1.7% of all claimants. Again, while the 0.3 percentage point increase could be described as unremarkable, on the other hand, it is the largest single-year increase since 2008 and represents tens of thousands of new patients taking specialty drugs.

Despite the increase in claimants for specialty drugs, the slower growth rate of eligible amounts appears to have mitigated the category's escalating burden on private drug plans. Specifically, when eligible amounts for specialty drugs are spread out across all certificates, or primary cardholders, the average monthly eligible amount per certificate inched forward by just 0.9% in 2022 to reach $34.14, following increases of 7.7% in 2021 and 8.8% in 2020 (chart 20).

> "This is very likely due to the increased utilization of biosimilars and the resulting cost savings. Public switching programs have increased over the last couple of years and a number of private payors have followed suit," says Viegas.

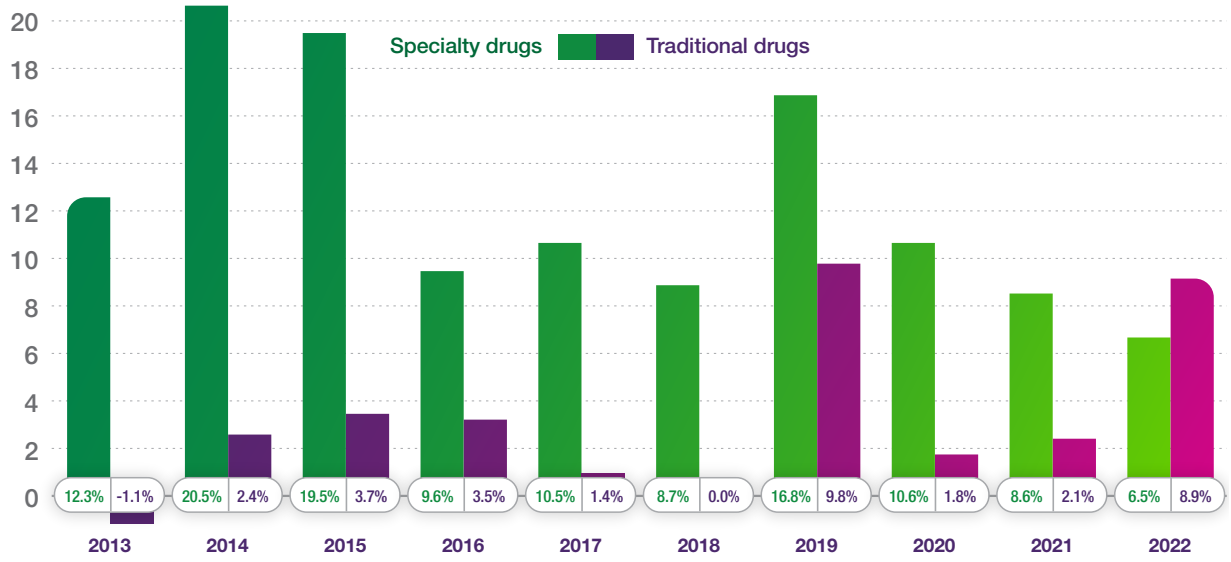
For more on the impact of provincial biosimilar-adoption policies, see page 30.

For traditional drugs, the average monthly eligible amount per certificate increased by 3.2% to $69.06 in 2022, compared to a gain of 1.2% in 2021 and virtually no change in 2020 (0.1%). For traditional and specialty drugs combined, the average amount per certificate was $103.20 in 2022 compared to $100.73 in 2021, an increase of 2.5% following increases of 3.3% in 2021 and 2.7% in 2020.

Regionally for specialty drugs, Atlantic Canada continues to track well ahead in terms of share of the total eligible amount, accounting for 39.6% in 2022, compared to 33.1% nationally (chart 21). The higher prevalence of certain genetic, rare diseases in Atlantic Canada is the main factor behind this regional variation.

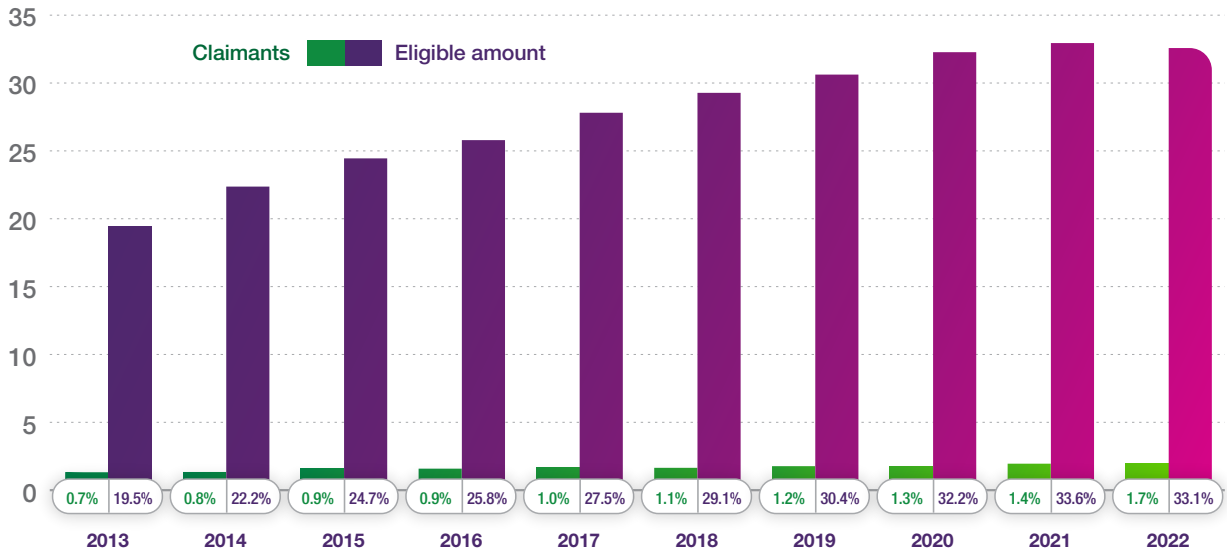
At the other extreme is Western Canada, where specialty drugs account for 26.1% of the total eligible amount. This region's historically lower share is due to the universal drug plans in B.C., Saskatchewan and Manitoba, where public coverage automatically kicks in once plan members have paid an income-based deductible.

CHART 18 | Change in total eligible amount for specialty and traditional drugs, 2013 – 2022



Source: TELUS Interactive Reporting (TIR) database.

CHART 19 | Specialty drugs by share of claimants and eligible amount, 2013 – 2022

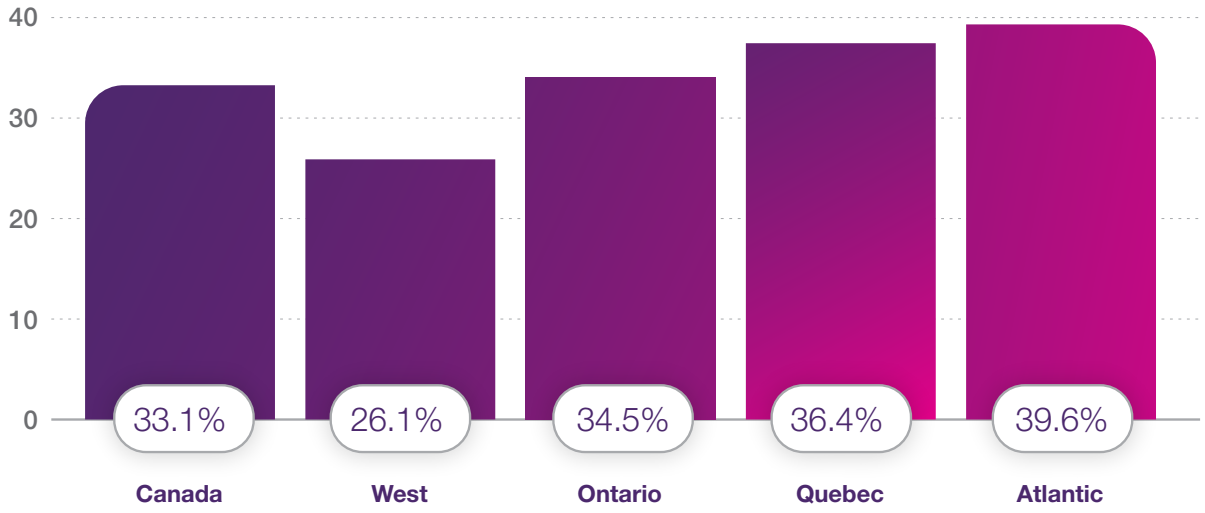


Source: TELUS Interactive Reporting (TIR) database.

CHART 20 | Average monthly eligible amount per certificate for traditional and specialty drugs, 2018 – 2022

Source: TELUS Interactive Reporting (TIR) database.

CHART 21 | Specialty drugs' share of eligible amount by region, 2022



Source: TELUS Interactive Reporting (TIR) database.

Biosimilar biologics

As of April 2023, eight provinces and two territories have implemented or announced policies to move or switch public plans' coverage of originator biologics to biosimilar biologics. Private plans are following suit, as evidenced by TELUS Health claims data—though uptake very much depends on the jurisdiction.

B.C. was the first to launch a switching policy, in 2019. The province's PharmaCare drug plan was a key driver behind the decision of many private plan insurers to adopt a switching policy as well, to avoid taking on the full cost of originator biologics for plan members who could no longer get coverage from PharmaCare. As a result, private plans saw biosimilars' share of the claims for all biologics with biosimilar options climb from 5.5% at the start of 2019 to 20.4% by the end of that year. By December 2022, biosimilars accounted for 64.7% of claims for all biologics with biosimilar options (chart 22).

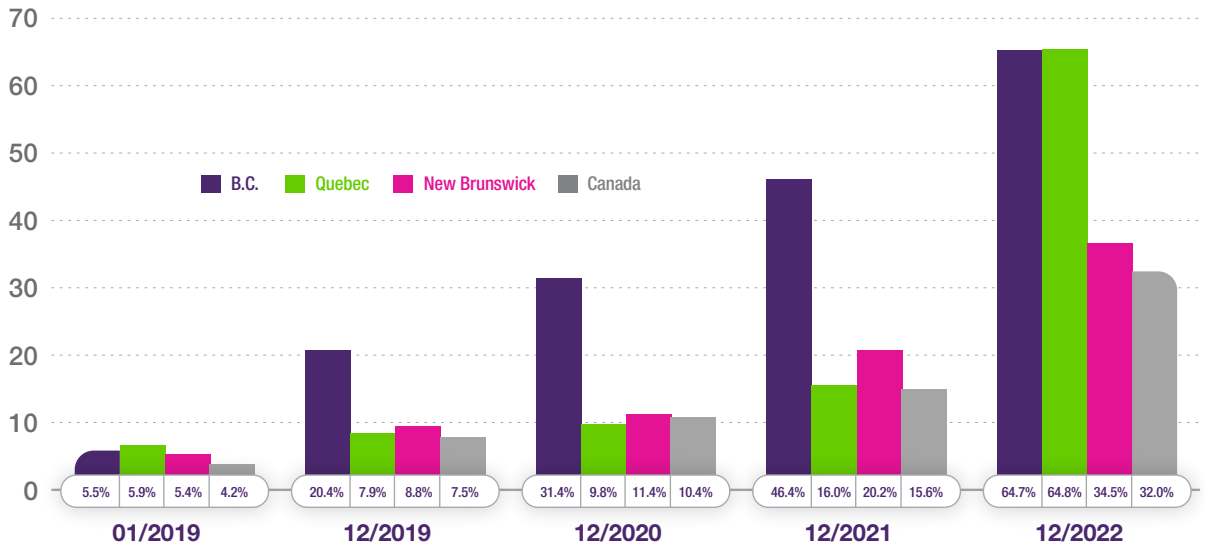
Similarly dramatic results occurred in Quebec, which also has a universal drug plan. Biosimilars' share of all biologic claims for private plans grew from 14.4% at the end of October 2021, two weeks after the start of Quebec's first six-month transition period, to 38.0% by the end of April 2022. By the end of 2022, in lockstep with B.C., their share reached 64.8%.

In New Brunswick, where the public drug plan is not the first payor, private plans' adoption of a biosimilar switching policy is happening at a much slower pace. At the start of the province's transition period in June 2021, biosimilars' share of the total eligible amount for biologics was 13.8%. That increased to 19.0% by the time the transition period ended on November 30, 2021. Uptake since has been steady but much slower than in B.C. or Quebec, reaching 34.5% in December 2022.

> "Physicians' prescribing behaviour is much, much more likely to change when a province's public drug plan is the first payor. This results in a halo effect for private plans, paving the way for patients' acceptance of biosimilars and biosimilar switching policies," says Viegas.

Nationally, biosimilars' share of claims for biologics has grown from just 4.2% in January 2019 to 32.0% in December 2022. This growth will likely accelerate in 2023 and 2024, as remaining provinces and territories complete their transition periods. For example, Saskatchewan's transition phase ended on April 30, 2023, and Ontario's ends on December 29, 2023.

CHART 22 | Biosimilars' share of claims for biologics with biosimilar options in Canada and selected provinces, January 2019 – December 2022*



*Initial six- or nine-month transition periods ended as follows: November 25, 2019, in B.C.; November 30, 2021, in New Brunswick; and April 12, 2022, in Quebec. Source: TELUS Interactive Reporting (TIR) database.

Summary

Specialty drugs' share of the total eligible amount declined for the first time in more than 10 years, for two main reasons: significantly more private plans adopted biosimilar switching policies—led by those in provinces where the public plan is first payor—and growth in spending for traditional drugs was much higher than usual. Meanwhile, the number of claimants for specialty drugs moved in the opposite direction, with the largest single-year increase since reporting began more than 10 years ago.

2023 Drug Data Trends & National Benchmarks

4. Drugs by therapeutic class

Snapshot

- Diabetes has overtaken rheumatoid arthritis as the top category by eligible amount
- Drugs for skin disorders further solidified their position as the number three category
- Claims for drugs to treat depression remain elevated compared to pre-pandemic years
- Drugs to treat attention deficit hyperactivity disorder (ADHD) appear poised to overtake antidepressants, while their share of claims is one third that of antidepressants

Top 10 by eligible amount

After years of steady gains, diabetes has taken over the top spot on TELUS Health's list of drug categories by eligible amount. Rheumatoid arthritis (RA), ranked number one for more than 10 years, dropped to second position (charts 23, 24 and 25).

Diabetes drugs and devices accounted for 12.9% of the eligible amount by the end of 2022, up from 12.0% in 2021. Five years ago, by year end 2018, their share was 10.1%.

When the lens is focused on the number of claims, the diabetes category accounted for 7.7% of all claims in 2022, unchanged from 2021 and up from 6.9% in 2018.

"The fact that the growth in spend steadily outpaces the growth in claims is evidence that existing claimants are switching to more costly therapies," notes Vishal Ravikanti, Director, Pharmacy Consulting and Partnerships, Payor Solutions at TELUS Health.

A growing patient population is also a factor in the diabetes category's rise to the top. A 2021 report by the federal government revealed that 10% of Canadians were living with diagnosed type 1 or type 2 diabetes in 2020, up from 6.8% in 2008.

However, increased utilization of higher-cost, second- or third-line therapies is likely the most important factor behind the category's growth in terms of eligible dollars. Although these medications are indicated for those who have been unable to reach their blood-sugar targets to successfully manage the disease, research consistently shows that more than a third of patients fall into this category.

These drugs' positive impact on weight loss is also driving prescribing activity—including off-label use for people who do not have diabetes. In fact, the drug that is most effective for weight loss, Ozempic, ranks second on TELUS Health's top-10 list of products by eligible amount.

Finally, diabetes devices play a role in the category's ascent. Freestyle Libre, a continuous blood glucose monitor that typically costs more than double the cost of first-generation monitors, ranks sixth on the list of top-10 products.

What does the future hold for the diabetes category? "There may be continued growth, especially with more products coming down the pipeline that have shown good clinical efficacy in both diabetes and weight loss," predicts Ravikanti.

Rheumatoid arthritis drugs' share dropped from 12.6% of the eligible amount to 11.2%. Five years ago, the category's share was 12.1%. Meanwhile, their share of claims has consistently sat at 0.4% over the past five years.

"The launch of many lower-cost biosimilars for rheumatoid arthritis, supported by provincial biosimilar switch programs, has certainly slowed down the growth of drug spend in this category," says Ravikanti. For more on the uptake of biosimilars, see page 30.

Among the remaining top 10 categories, drugs for skin disorders have solidified their hold on third position. Their share of the eligible amount was 8.1% in 2022, up from 7.7% in 2021 and well ahead of drug category number four, asthma (5.3%). Five years ago, skin disorders ranked fourth with a share of 5.4%. Meanwhile, their share of claims held somewhat steady at 3.1%, compared to 3.2% in 2018.

> "The growing number of biologic drugs coupled with expanding indications for these drugs are driving the increase in drug-plan spend, explains Ravikanti."

Asthma drugs appear to be experiencing a bit of a roller-coaster ride, ranking third, fourth or fifth over the past five years. In 2022, they ranked fourth, with a share of 5.3% compared to 4.9% in 2021. Five years ago, when they ranked third, their share was 5.6%. In terms of claims, their share was 5.7% in 2022 compared to 5.3% in 2018.

The depression category comprised the fifth-largest category by eligible amount. Its share of 5.2% was virtually unchanged from 2018 (5.1%). On the other hand, its share of claims has climbed, particularly during the pandemic. It was 9.1% in 2018 and 9.5% in 2019, then increased by almost a full percentage point, to 10.4%, during the first year of the pandemic. By the end of the second year, 2021, the category's share of claims was 11.0% and by the end of 2022, it levelled at 10.8%.

The growth rate in utilization is even more apparent when we consider antidepressants' share of claimants, which climbed from 15.9% in 2018 to 19.3% in 2022. Regionally, private plans in Atlantic Canada saw the highest share of claimants: 27.8% in 2022, up from 21.9% in 2018. Plans in Ontario are at the other end of the scale, with 17.2% of claimants using antidepressants in 2022—though that is still a noticeable increase from 14.9% in 2018.

"The highest growth in utilization occurred among young plan members up to 19 years old," notes Ravikanti.

He adds that the impact of the higher number of claims and claimants on the category's share of the eligible amount is negligible due to the fact that this category is highly genericized, resulting in relatively low price points for most antidepressant medications.

The category of drugs for ADHD in adults is the fastest growing one in both eligible amount and number of claims. In 2018 it had ranked ninth with a 3.4% share of the total eligible amount; by the end of 2022, it ranked sixth (for the second year in a row) with a 5.1% share. This latest gain puts the category within a hair's breadth of overtaking depression (5.2%) and asthma (5.3%) drug categories. In 2021, its share was 4.5%.

On the claims side, the category's share grew from 2.3% to 3.6% from 2018 to 2022. It was 3.3% in 2021. In terms of the number of claimants, the growth rate was an astounding 73.5% over the five-year period, from a share of 3.4% in 2018 to 5.9% in 2022.

All regions saw noticeable increases in the number of claimants:

- Quebec is at the forefront, with 9.1% of claimants taking drugs for ADHD in 2022, up from 7.0% in 2018
- 6.4% of claimants in Western Canada took these drugs in 2022, up from 3.1%
- The number of claimants was 6.2% in Atlantic Canada, up from 3.3%
- In Ontario, the number rose from 2.1% to 4.1%

Perhaps contrary to expectations, adults are driving this growth. In fact, the number of adult claimants (51.0%) overtook pediatric claimants (49.0%) in 2022. Five years ago, the split was 42.6% adult and 57.4% pediatric. "The growth rate is highest in the 30- to 39-year-old age band," adds Ravikanti.

Two high-cost categories for very small patient populations occupy the seventh and eighth positions: cancer drugs accounted for 3.8% of the eligible amount in 2022, down from 4.2% in 2021 and close to the 3.9% recorded in 2018.

Their share of claims remains unchanged over five years, at 0.6%. Multiple sclerosis drugs held on to a 3.0% share of the eligible amount in 2022, down from 3.4% in 2021 and 3.6% five years ago. Their share of claims was just 0.1%, unchanged from 2018.

Finishing the list are two high-volume, low-cost categories. Drugs for high blood pressure are experiencing a steady decline in their share of the eligible amount: their share was 2.5% in 2022, down from 2.8% in 2021 and 3.8% in 2018. The category's share of claims is also on the decline, down to 8.2% in 2022 compared to 8.9% in 2018.

Meanwhile, gastrointestinal drugs are new to the top-10 list, displacing the ulcer category and accounting for 2.5% of the eligible amount in 2022. The category represents just 0.8% of claims, a clear indication that higher-cost therapies are the main driver of growth (e.g., biologics to treat Crohn's disease).

Collectively, the top-10 categories by eligible amount accounted for 59.7% of the total in 2022, up from 56.1% in 2018.

CHART 23 | Top 10 drug categories by eligible amount, 2022

For treatment of:	Rank	% of total eligible amount	% of total claims
Diabetes	1	12.9%	7.7%
Rheumatoid arthritis	2	11.2%	0.4%
Skin disorders	3	8.1%	3.1%
Asthma	4	5.3%	5.7%
Depression	5	5.2%	10.8%
ADHD	6	5.1%	3.6%
Cancer	7	3.8%	0.6%
Multiple sclerosis	8	3.0%	0.1%
High blood pressure	9	2.5%	8.2%
Gastrointestinal	10	2.5%	0.8%
% of total eligible amount and claims		**59.7%**	**41.0%**

Source: TELUS Interactive Reporting (TIR) database.

CHART 24 | Rankings of top 10 drug categories by eligible amount, 2018 – 2022

For treatment of:	2018	2019	2020	2021	2022
Diabetes	2	2	2	2	1
Rheumatoid arthritis	1	1	1	1	2
Skin disorders	4	3	3	3	3
Asthma	3	4	4	5	4
Depression	5	5	5	4	5
ADHD/narcolepsy	9	7	7	6	6
Cancer	6	6	6	7	7
Multiple sclerosis	8	8	8	8	8
High blood pressure	7	9	9	9	9
Gastrointestinal	-	-	-	-	10
Ulcers	-	-	10	10	-
Infection	10	10	-	-	-

Source: TELUS Interactive Reporting (TIR) database.

CHART 25 | Top 10 categories' share of the eligible amount, 2018 versus 2022

For treatment of:	2018
Rheumatoid arthritis	12.1%
Diabetes	10.1%
Asthma	5.6%
Skin disorders	5.4%
Depression	5.1%
Cancer	3.9%
High blood pressure	3.8%
Multiple sclerosis	3.6%
ADHD	3.4%
Infection	3.1%
All other categories	43.9%

For treatment of:	2022
Diabetes	12.9%
Rheumatoid arthritis	11.2%
Skin disorders	8.1%
Asthma	5.3%
Depression	5.2%
ADHD	5.1%
Cancer	3.8%
Multiple sclerosis	3.0%
High blood pressure	2.5%
Gastrointestinal	2.5%
All other categories	40.4%

Source: TELUS Interactive Reporting (TIR) database.

Drug pipeline

Looking ahead in 2023 and beyond, new therapies in the diabetes category—which became the largest category by eligible amount in 2022—are expected to have the biggest impact on private drug plans. On the one hand, new higher-cost second-line therapies continue to arrive on the market; on the other hand, dozens of generic versions of the oldest of these second-line therapies are expected to become available.

Two new drugs for migraine are also worth watching. As the first two oral options in a new class of migraine drugs, their overall utilization may grow among patients who avoided the original injectable drugs. Indicated for those who are hardest hit by migraines, these drugs could increase productivity and reduce sick days.

In the biologic space, biosimilar options slowly but steadily grow in number. For drug plans with biosimilar switching policies in place, the savings could be significant. At least one biosimilar for Soliris, which made headlines in 2007 as the world's most expensive drug, will become available.

And possibly on the horizon for Canada: a multimillion-dollar gene therapy that has taken over the title of the most expensive drug in the world.

Get the details in the 2023 TELUS Health Drug Pipeline report.

Summary

After more than 10 years, the RA category conceded its number-one ranking to the diabetes category. Increased utilization of lower-cost biosimilars drove down RA's share of the eligible amount, while increased utilization of higher-cost therapies drove up diabetes' share. Higher-cost therapies are also the main factor behind the strengthening of the skin-disorder category in the number three position. For two other categories in the top 10—depression and ADHD—claimants are the primary drivers of growth.

2023 Drug Data Trends & National Benchmarks

5. Plan management

Snapshot

- More private drug plans implemented mandatory generic substitution policies
- After five years of slow but steady growth, the number of drug plans with annual maximums appears to have levelled off
- Generic substitution policies, prior authorization and coinsurance remain the most utilized tools for plan management, by far

Generic substitution policy

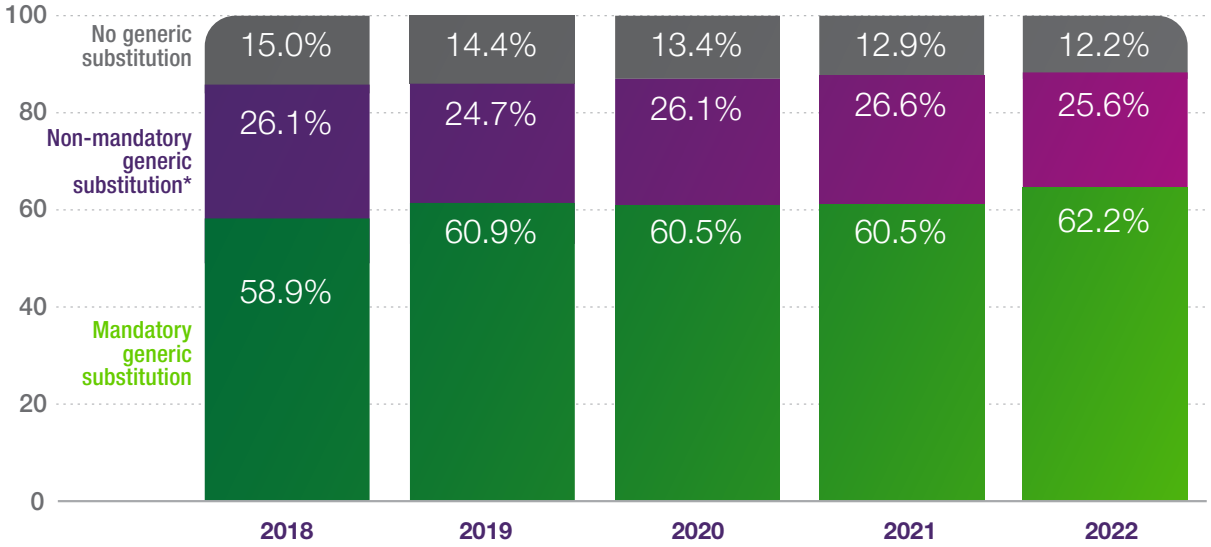
Mandatory generic substitution policies may be on the upswing again, after two years of no growth.

By the end of 2022, 62.2% of certificate or primary card holders had plans that mandated generic substitutions, up from 60.5% in both 2021 and 2020 (chart 26). Five years ago, in 2018, 58.9% of plans included mandatory substitution policies. Note that mandatory generic substitution policies still allow for claimants to access a brand-name drug; however, the plan will reimburse up to the price of the generic drug only.

Most of the gain came from plans that switched from a non-mandatory substitution policy—that is, one that physicians could override—to a mandatory substitution policy. The number of plans with non-mandatory substitution policies declined from 26.6% in 2021 to 25.6% in 2022.

The remaining gain of 0.7 of a percentage point came from plans that implemented mandatory substitution policies in 2022, as the number of plans without any policies in place declined from 12.9% to 12.2%.

CHART 26 | Certificates with plans that include generic substitution policies, 2018 – 2022



*Under a non-mandatory generic substitution policy, the physician can override it and trigger the coverage of the brand-name drug by indicating "No substitution" on the prescription. Source: TELUS Interactive Reporting (TIR) database.

Coinsurance and deductible

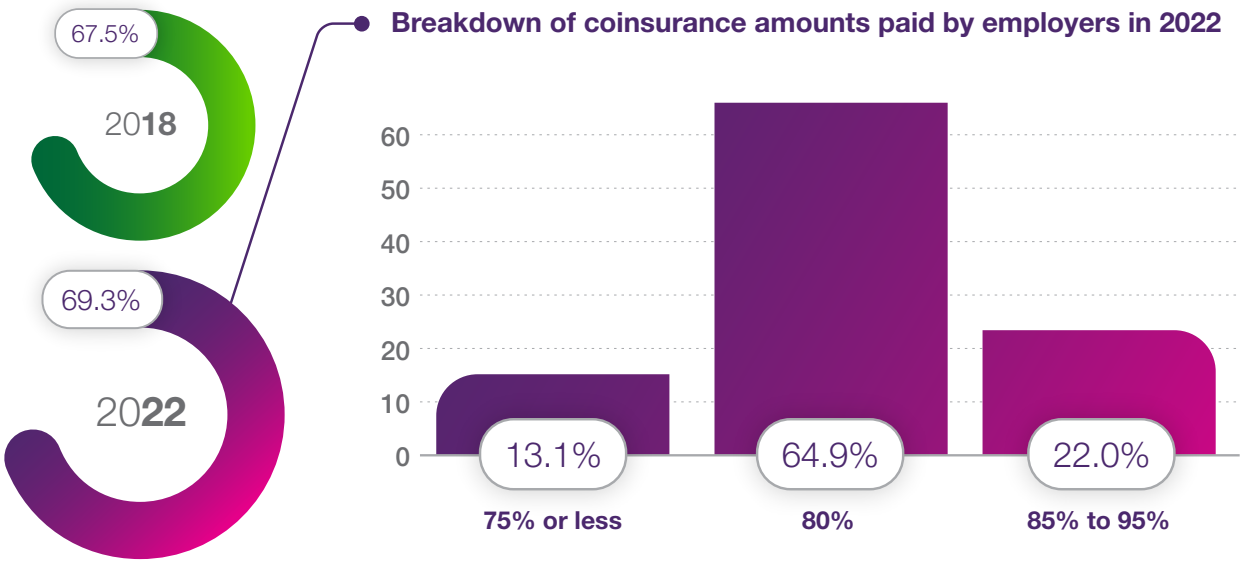
Seven out of 10 (69.3%) certificates included drug plans with coinsurance in 2022, comparable to 2021 (70.1%) and up slightly from 2018 (67.5%) (chart 27).

Among the certificates with coinsurance, by far the most common breakdown was 80% paid by the employer and 20% by the employee (the primary cardholder); 64.9% of coinsurance policies were broken down in this way, consistent with results for at least the past five years. Among remaining certificates, 22.0% allocated 85% to 95% of the costs to the employer, and 13.1% allocated 75% or less of the cost to the employer.

The incidence of deductibles has not increased and they remain much less common than coinsurance: 9.8% of certificates had a plan with an annual deductible in 2022, unchanged from 2021 (9.8%) and marginally down from five years ago (10.3%). Only 11.6% required a deductible for each claim in 2022, virtually unchanged from 2021 (11.5%) and down from 12.9% in 2018.

As in previous years, the most common annual deductible, for 36.1% of plans, was between $50 and $100, followed by deductibles that were $100 or more (32.4%) and less than $50 (31.3%). Per-claim deductibles most often ranged from $4.00 to $5.99 (39.2% of certificates), followed by $2.00 to $3.99 (26.5%) and $10 or more (18.4%).

CHART 27 | Certificates with plans that include coinsurance, 2018 versus 2022



Source: TELUS Interactive Reporting (TIR) database.

Dispensing fee cap

The number of certificates with a dispensing fee cap has changed very little over the past five years; however, the capped amount has shifted, in both directions.

In 2018, 34.0% of certificate holders had a plan that capped coverage for the dispensing fee. Five years later in 2022, that was up marginally to 34.8% (chart 28).

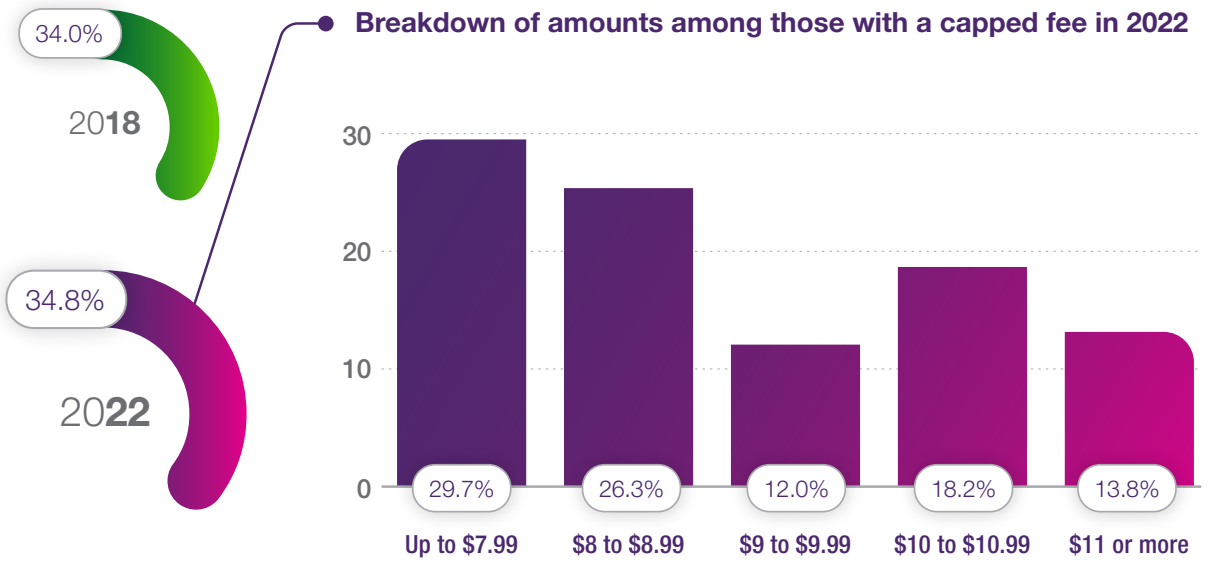
Five years ago, coverage of the fee was most often capped at up to $7.99 (31.6%), followed by a cap of between $8.00 and $8.99 (23.9%). In 2022, there was less of a gap between the two levels, suggesting that plans increased their coverage: 29.7% had capped their fee at up to $7.99 and 26.3% had capped it at $8.00 to $8.99.

On the other hand, the number of certificates with the most generous fee cap appears to have declined: in 2022, 13.8% had a fee cap of between $11.00 and $15.99, down from 15.4% in 2018.

The average dispensing fee in Canada was $11.84 in 2022, compared to $11.35 in 2018. The highest dispensing fee is in Quebec, at $13.70, though 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 Quebec's dispensing fees by adding a reasonable markup to the ingredient cost, which leaves the remaining amount as the dispensing fee. Remaining average fees by region were $11.17 in Ontario, $11.11 in Western Canada and $11.04 in Atlantic Canada.

By store types, pharmacies that are part of banners or chains had the highest average dispensing fees, at $11.90. These pharmacies also processed the highest proportion of claims: 84.7%, compared to a share of 15.1% for independently owned pharmacies, where the average dispensing fees were $11.50. Virtual or mail-order pharmacies had the lowest fees on average, at $8.81, but represented just 0.2% of claims.

CHART 28 | Certificates with plans that include a capped dispensing fee, 2018 versus 2022



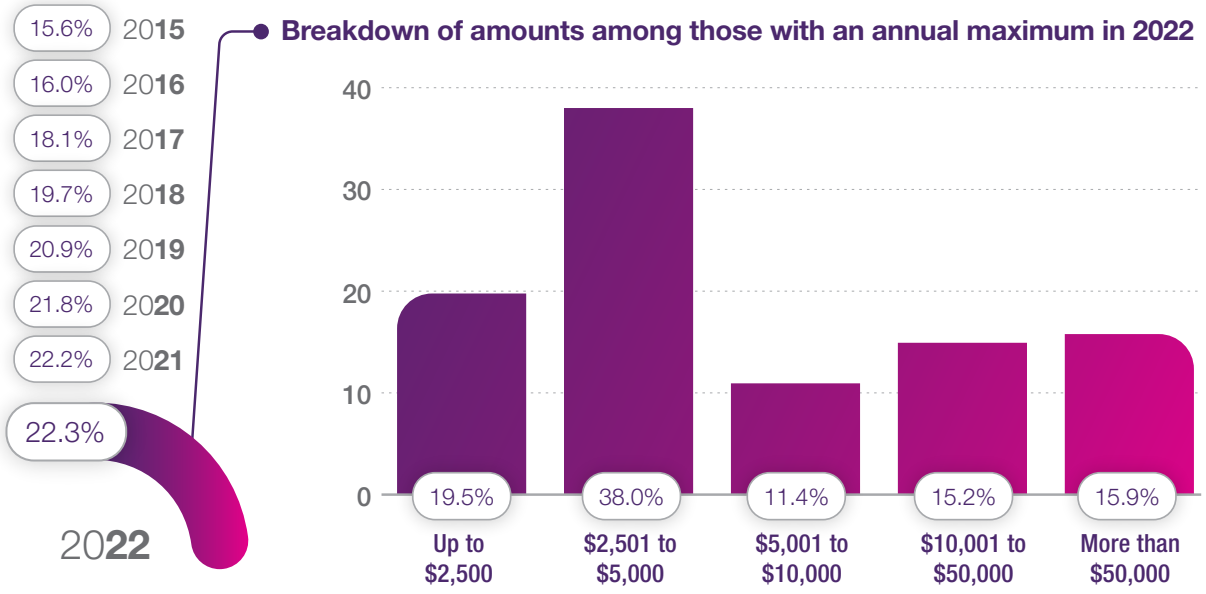
Source: TELUS Interactive Reporting (TIR) database.

Annual maximum

The incidence of drug plans with an annual maximum appears to have plateaued (chart 29). In 2015, 15.6% of certificate holders had a plan that included a maximum. That number climbed steadily for five years, reaching 21.8% in 2020. Growth then slowed to less than half a point in 2021 (22.2%) and was negligible in 2022 (22.3%).

The most common annual maximum is between $2,501 and $5,000 (38.0%), followed by the lowest maximum of up to $2,500 (19.5%) and then, at the other end of the scale, a maximum of more than $50,000 (15.9%).

CHART 29 | Certificates with plans that include an annual drug plan maximum, 2015 to 2022

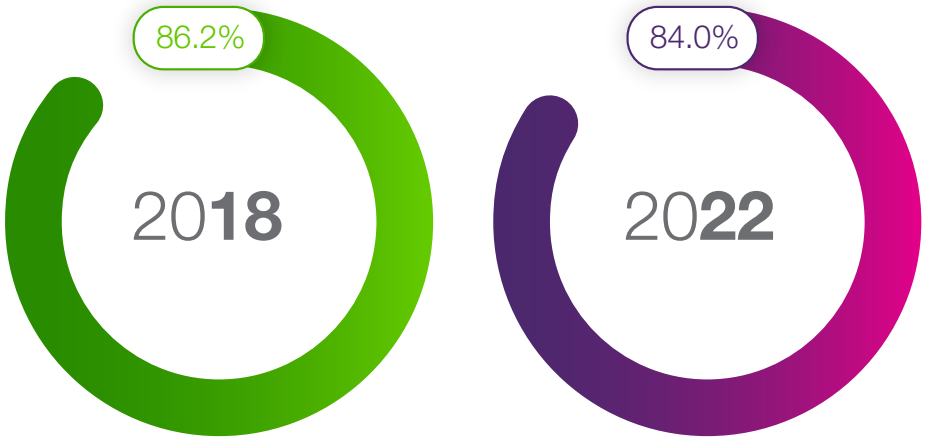


Source: TELUS Interactive Reporting (TIR) database.

Prior authorization

More than eight out of 10 certificates (84.0%) had drug plans with a prior authorization process, unchanged from 2021 (84.0%) and compared to 86.2% five years ago (chart 30).

CHART 30 | Certificates with plans that include prior authorization, 2018 versus 2022

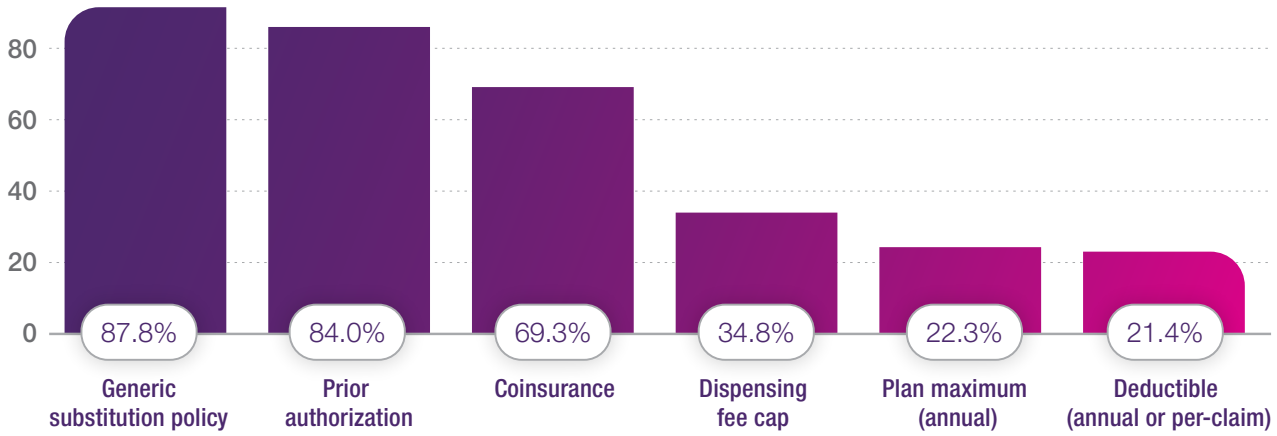


Source: TELUS Interactive Reporting (TIR) database.

Summary

Mandatory generic substitution policies may be trending upward again, and annual drug plan maximums appear to have reached a plateau. Otherwise, there were no notable changes in the utilization of drug plan management tools in 2022.

CHART 31 | Summary of certificates with plans that include the following tools for drug plan management



Source: TELUS Interactive Reporting (TIR) database.

6. Conclusion

On the one hand, 2022 may be described as a “breather” year for private drug plans in some regions, due largely to the mitigating impact of biosimilar drugs on the growth in spending. Their dampening effect will continue in 2023 and 2024 as additional provinces and territories roll out their biosimilar switching policies for public plans, prompting some private payors to adopt similar policies.

As well, reference biologics for a broader range of conditions will see their patents expire in the near future, paving the way for more biosimilars and expanded switching policies.

On the other hand, several findings from this year’s report suggest that 2022, and perhaps 2023, may be the calm before a storm.

Perhaps foremost, private drug plans have yet to experience the full impact of the COVID-19 pandemic. While the number of insureds making claims appears to be rebounding, Canada’s backlogged healthcare system means it may take several more years before plan members catch up with medical appointments, diagnostic tests and surgery. During that time, chronic diseases and serious illnesses, including cancer, may remain undetected or worsen more than they would have in the absence of a pandemic.

For plan members already diagnosed with diabetes, spending will continue to rise, buoyed by real-world evidence of the clinical benefits of certain higher-cost therapies for both diabetes management and weight loss.

Finally, the drug pipeline is becoming increasingly specialized, providing treatment options that are ever-more targeted for conditions affecting larger patient populations, or first-ever treatments for very rare diseases. Many of the latter therapies will fall into the ultra-high range in terms of cost, exceeding $100,000 per treatment or annually. However, perhaps more attention will need to be paid to what’s coming for common conditions. As demonstrated by the diabetes category, new drugs that fall well below the $10,000 threshold of a specialty drug can still have a profound impact on drug spending.

TELUS Health remains committed and prepared to deliver actionable information to plan sponsors, their providers and advisors on the key areas and drivers of change in cost and utilization, as well as the impact of cost-management measures.

2023 Drug Data Trends & National Benchmarks

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