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Reforming private drug coverage in Canada: Inefficient drug benefit design and the barriers to change in unionized settings

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ABSTRACT

Prescription drugs are the highest single cost component for employees' benefits packages in Canada. While industry literature considers cost-containment for prescription drug costs to be a priority for insurers and employers, the implementation of cost-containment measures for private drug plans in Canada remains more of a myth than a reality. Through 18 semi-structured phone interviews conducted with experts from private sector companies, unions, insurers and plan advisors, this study explores the reasons behind this incapacity to implement cost-containment measures by examining how private sector employers negotiate drug benefit design in unionized settings. Respondents were asked questions on how employee benefits are negotiated; the relationships between the players who influence drug benefit design; the role of these players' strategies in influencing plan design; the broad system that underpins drug benefit design; and the potential for a universal pharmacare program in Canada. The study shows that there is consensus about the need to educate employees and employers, more collaboration and data-sharing between these two sets of players, and for external intervention from government to help transform established norms in terms of private drug plan design.

1. Introduction

Canada's universal healthcare system does not cover prescription drugs. Public drug coverage is mostly provided on a provincial basis to seniors and people on social assistance. Many provinces also offer public catastrophic drug coverage for the rest of the population (e.g. for patients receiving public subsidies once they contribute more than 3–4% of their annual income toward prescription drugs) [1]. Most Canadians are covered through private drug plans offered mostly by employers through supplemental health benefits: 51% of Canadian workers have supplemental medical benefits [2], and since work-related health insurance also covers dependents of employees with coverage, as many as two-thirds of Canadians are covered by health insurance plans.

Prescription drug spending in Canada's private sector has increased nearly fivefold in 20 years, from $3.6 billion in 1993 to $15.9 billion in 2013 [3]. Private drug plans in Canada are often considered wasteful because they accept

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paying for higher priced drugs that do not improve health outcomes for users and use costly sub-optimal dispensing intervals for maintenance medications. As a consequence, it is estimated that private drug plans in Canada wasted $5.1 billion in 2012, which is money spent without receiving therapeutic benefits in return [4]. This amount represented 52% of the total expenditures of $9.8 billion by private insurers on prescription drugs for that year [5].

Canadian employers have demonstrated growing concern for cost-containment in the design of their employees' drug benefits. However, the implementation of cost-containment measures for private drug plans remains more of a myth than a reality [6–10] since few plans require caps for dispensing fees, premiums from claimants, mandatory generic substitution or restrictions on more expensive but not therapeutically superior new drugs [9]. The Canadian Life and Health Insurance Association, concerned about the sustainability of private drug coverage in Canada, has asked for government help to reduce costs [11]. Growing administrative costs of private health plans continues to put additional financial pressures on the capacity to offer private health benefits [12].

A lack of published literature on how drug benefits are negotiated and implemented required us to explore the subject in interviews with employers, union representatives, insurers and consultants working for employers or unions. We focused on unionized workplaces. In 2013, approximately 13.3% of all workers in Canada were unionized private sector employees, 18% were unionized public sector employees, and the rest being non-unionized employees [13]. By focusing on drug benefits in unionized settings, we were able to benefit from the insights of union representatives who have significant expertise in supplemental health benefits. Drug benefits in unionized settings are often considered similar to those of non-unionized organizations [14].

2. Methodology

We identified key informants working within the most prominent Canadian organizations in the four organizational categories examined in this study, who provided us with leads to create a cohort of potential interview participants. After initial contact with these key informants, a non-probability sampling technique known as snowball sampling [15] was employed to reach further respondents that had key exposure to the drug benefit design process and could provide insights that could be generalized, to some extent, across their organizational categories. We extended an invitation to over 60 representatives from 14 unions, 9 private sector employers, 19 insurance companies, and 17 benefits consultancies to participate in the research project. Among those invited, 18 experts agreed to participate in the interview process, four of whom were from private firms, five from unions, five from benefits consultancies, and four represented insurance companies. We carried out one-to-one semi-structured interviews between September 2012 and January of 2013.

The study focused on large unionized workplaces that had Administrative Services Only (ASO) plans, where the employer is responsible for the costs of benefit plans and bears the risks associated with it, while insurers are just hired to manage claims. This study focused on ASO arrangements because they are the most common insurance option chosen by large private-sector firms [16]. Those organizations whose activities resided solely in the province of Québec, where the regulation of private drug plans differs [17], were excluded.

Participants were asked to participate in semi-structured phone interviews lasting 20–30 min. With a specific emphasis on drug benefits, questions focused on four main themes: how employee benefits are negotiated; the relationships between the players who influence drug benefit design; the role of these players' strategies in influencing plan design; and the broad system that underpins drug benefit design. With respect to this last theme, the respondents were asked to describe the inequities inherent in the system and their recommendations for reform, including their opinion about a national public drug plan in Canada. One insurer was unable to respond to questions pertaining to the last theme because the time allotted in this respondent's schedule prevented the interview from reaching these questions.

The research design was reviewed and approved by the Carleton University Research Ethics Board. Since the nature of the topic discussed was sensitive for some of the organizations involved, the agreed protocol guaranteed all participants anonymity by not disclosing the names of the participants and their affiliated institutions. Any details which would enable readers to identify the participants or the organizations were deliberately excluded from this paper.

We carried out a standard thematic analysis by transcribing and analyzing the contents of the audio files. Based on the results of the interviews, we developed a narrative encompassing four new themes which differ from the initial themes under which the questions were organized. The contents were then ascribed initial codes and organized into themes and sub-themes based on the transcriptions' contents. The authors relied on their judgment to identify themes from the interview data, as no quantitative standard measuring the prevalence of subject content can adequately capture the depth of such qualitative data [18]. Thus, our strategy to analyze these data involved coding the data into a conceptual framework from which the research results are drawn [19].

3. Research findings

The following four sections describe the core findings through four themes: objectives; tactics and strategies; barriers to change; and recommendations for reform.

3.1. Objectives vis-à-vis drug benefit design

Drug benefit design decisions are arrived at through professional networks of employers, unions, insurers, and benefits consultants. The interviews showed that these sets of players have different interpretations of what is at stake in drug benefit outcomes, their intentions in influencing these outcomes, as well as their perceptions of the other's intentions. Table 1 categorizes these player's intentions in