

# BULLETIN

Number 16

Publications Mail Agreement No. 40048697

June 2005

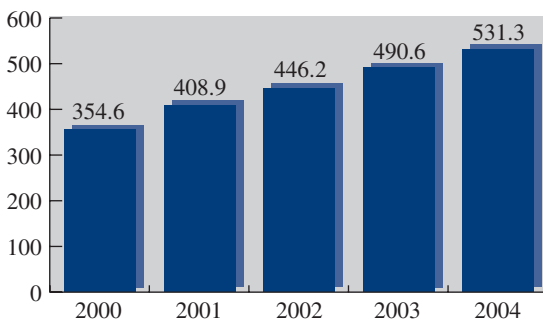
## Review of the 2004 financial results

In 2004, the PSHCP continued to provide valuable protection to our 522,245 members and their eligible dependants. The Trustees are pleased to share with you some of the key financial results of the benefit year ending December 31, 2004. Please note that a comprehensive analysis will be available on the Trust's web site ([www.pshcptrust.ca](http://www.pshcptrust.ca)) in the summer of 2005.

### Overview of the 2004 results

The plan received contributions and interest totaling \$523.9 million, compared to total plan costs of \$531.3 million, for a shortfall of \$7.4 million. Consistent with the Trust Agreement, the Treasury Board of Canada provided additional funding to the Trust to finance the shortfall.

Total Plan Costs (in millions)



The 2004 results, as well as those of prior years, show the continuing cost pressures of funding health care costs. As experienced by other plans in Canada, the rate of increase in our total costs is well in excess of the general increase in consumer products as measured by the Consumer Price Index (CPI). Since 2000, our total plan costs have increased by 50%, compared to 9.7% for the CPI, or \$176.7 million as illustrated in the graph on the left.

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### Some key highlights...

- The plan reimbursed members a total of \$506.6 million. This represents an increase of 8.4% over claims paid in 2003.
- The total cost of the plan reached \$531.3 million. This amount includes paid claims (95.3%), adjudication expenses (3%), and taxes (1.7%).
- 405,118 members (78%) submitted at least one claim during the year.
- Members submitted a total of 2,057,726 claims, which included over 11.7 million different services (e.g. drugs, glasses, medical practitioners, etc).
- The average turnaround time to adjudicate and process your claims was 5.7 days, well below the contract requirement of 9 days.
- The Sun Life Customer Care Centre handled over 550,000 telephone calls.

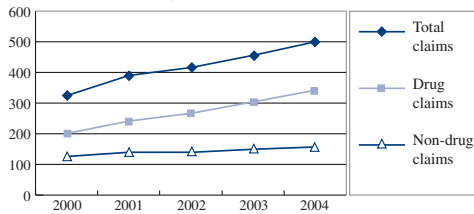
# Review of the 2004 financial results (continued from previous page)

Many factors explain the continuing increase in our plan's costs. Some of the key factors are briefly summarized:

## Prescription drugs

Prescription drug claims, which account for 68% of all Supplementary paid claims under the plan, continue to be the main cost driver. Paid claims for prescription drugs have increased a whopping 70% since 2000, compared to 22% for non-drug claims.

Supplementary Paid Claims (in millions of \$)



Some of the key causes include:

- New and more expensive drug therapies continue to be introduced. These new prescription drugs are often significantly more expensive than existing drugs, such as new biologic drugs used for the treatment of rheumatoid arthritis.
- The use of direct advertising has resulted in more informed plan members and the demand for new and more costly drugs when patients visit their physician.
- Rates of treatment for expensive and chronic conditions such as cardiovascular disease are on the rise as the population gets older.

## Increased utilization

Increased utilization of the plan also accounts for part of the large growth in plan costs. Members and their eligible dependants are using the plan more often. The number of services per member, which determines the rate of utilization,

has increased by 21% over the most recent 5-year period. And the simple fact that there are more members covered by the plan has an impact – the membership has grown by 10% since 2000.

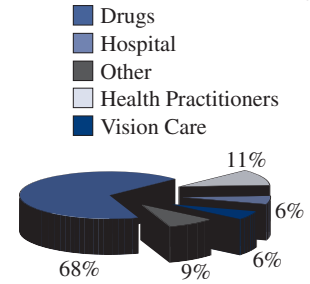
## Cost of products and services

The increase in the cost of products and services also explains a portion of the growth in plan costs. The cost per service provided to members and their eligible dependants under the terms of the plan has increased by 12% since 2000, while the cost per prescription drug has increased at a much higher pace, 25% over the period. This reflects not only inflation but also the change in therapeutic mix for drugs, including the introduction of new ones.

## Breakdown of paid claims

The breakdown of paid claims under the Supplementary plan is shown in the next column.

## Paid Claims – Supplementary Plan



As mentioned, prescription drugs make up the largest portion of paid claims (68%), and are the fastest growing expenses under the plan. Almost half of the drugs paid by the plan are comprised of two categories of drugs: cardiovascular (28.4%) and central nervous system agents (20.3%).

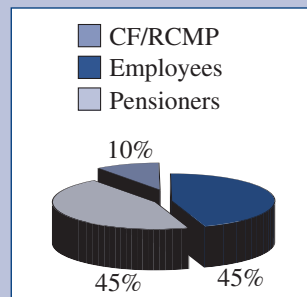
Health practitioners, which include physiotherapists, chiropractors, psychologists, masseurs, nurses, among others, was the second largest component, representing 11% of paid Supplementary claims.

## More information...

We invite you to look at the Trust's web site at [www.pshcpttrust.ca](http://www.pshcpttrust.ca) in the summer of 2005 for a more in-depth analysis of these results.

## Membership information

As at December 31, 2004, the Plan covered 522,245 members, an increase of 1.1% over 2003. Employees and pensioners each represent 45%, while dependants of the members of the Canadian Forces and RCMP represent 10%.



## Membership growth – 2004 over 2003

| Member group | 2003    | 2004    | Change |
|--------------|---------|---------|--------|
| Employees    | 231,616 | 233,471 | 0.8%   |
| Pensioners   | 230,020 | 233,834 | 1.7%   |
| CF/RCMP      | 54,680  | 54,940  | 0.5%   |
| Total        | 516,316 | 522,245 | 1.1%   |

The membership grew by 5,929 members, or 1.1% during 2004. The pensioner group was the fastest growing group with a growth rate of 1.7%, resulting in the number of pensioners in the plan now just exceeding the number of employees. The employee and CF/RCMP memberships both had growth rates of less than 1% during 2004.

# Modifications to the Plan

The Trustees of the PSHCP have the responsibility of interpreting the provisions of the Plan. On an on-going basis, the Trustees identify and modify, whenever necessary and subject to the Parties' approval, clauses of the Plan that are difficult and challenging to interpret. In some circumstances, the Trustees must also provide adjudication guidelines to the Plan Administrator to assist them in adjudicating your claims efficiently and according to the intent of the Plan. We are pleased to provide the following information to assist you in understanding some of the decisions made by the Trustees.

## Hospital Provision

The hospital provision provides specified reimbursement for expenses incurred for semi-private or private room accommodation in the event of hospitalization. To be eligible, expenses must be incurred in a hospital as defined by the Plan. The Trustees reviewed the wording of the hospital provision and proceeded with two minor changes. These changes were introduced for clarification purposes only and did not change the scope of coverage.

**1** In the first instance, it became apparent that the French wording of a specific clause of the hospital provision did not provide the same clarity as the English wording. To ensure consistency in both official languages, the French version of the plan document was amended to reiterate that expenses for semi-private and/or private room

accommodation are eligible only if incurred **in a hospital as defined by the Plan.**

**2** In the second case, the Trustees decided to clarify the clause pertaining to an existing exclusion under the hospital provision dealing with co-insurance fees and other similar fees. As you know, the Plan provides reimbursement, up to specified amounts, for the cost of hospital room charges other than standard ward charges (i.e. semi-private or private accommodation). It excludes however co-insurance charges or similar charges for hospital care which are in excess of charges payable by a government health or hospital plan. The **bold words** in the revised text that follows are the ones that have been added to the current provision:

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“No benefit is payable for:

- co-insurance charges or similar charges for hospital care which are in excess of charges payable by a provincial or territorial government health or hospital insurance plan, except ***charges as provided under the terms of the hospital provision.*** ***However,*** co-insurance charges for a chronic care hospital for a patient who is confined to a chronic care hospital, and has made at least one claim for such charges before September 1, 1992 and makes a further claim for the same period of confinement, are eligible.”
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## Private duty nursing expenses

These expenses are eligible up to the maximum specified in the Plan, if they are prescribed by a physician and incurred for the services of private duty nurses (i.e. nurses, as defined by the Plan, and who practice on a private basis or who work for a nursing agency such as V.O.N.), who provide medically required nursing care to a particular patient in his/her private residence for a prescribed period of time.

The Plan does not allow claims for nursing services rendered by salaried employees of a facility such as a nursing home. Nurses working in such a facility receive a salary from the establishment for the services they provide to a number of patients under their care. For clarity purposes, the Trustees have amended the Plan under the Exclusions section of the Medical Practitioners benefit and added a fourth clause as follows:

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“No benefit is payable for:

- expenses incurred for nursing services provided by salaried employees of a facility where the member or dependant resides in such facility.”
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# Modifications to the Plan (continued from previous page)

## Ground Ambulance Transportation Expenses

These expenses are eligible if incurred for licensed **emergency** ground ambulance services to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation, where medically necessary. Ambulance

transportation to pre-arranged appointments, even to a clinic within a hospital, are not eligible. For clarity purposes, the Plan document has been modified to make specific reference to “licensed **emergency** ground ambulance services”.

## Contraceptive drugs

The Plan Administrator has from time to time declined claims for contraceptive drugs on the basis that they did not qualify as eligible drugs. Indeed, the Plan provides coverage for **oral contraceptives only**. All other expenses for contraceptives are **excluded** by the Plan. Therefore, drugs such as Ortho Evra, a skin patch, the Mirena insert, an intra-uterine device, and Depo-Provera (if prescribed for contraceptive purposes), an injectible drug, are not covered by the Plan.

It should be noted that since some claims for the Mirena insert have been paid in error in the past, when used for indications other than contraception, the Plan Administrator will continue to reimburse claims until August 31, 2005.

The Plan also provides that, to be eligible, a drug must be prescribed for an indication recommended by the manufacturer. Depo-Provera has other indications recommended by the manufacturer. Effective September 1, 2005, if you are prescribed the drug Depo-Provera, the Plan Administrator may require medical information regarding the condition for which the drug was prescribed in order to adjudicate your claim.

## Physician’s services and laboratory services

Certain physician and/or laboratory services may be covered by the Plan under the Medical Practitioners benefit if such services are not eligible under the participant’s provincial/territorial health insurance plan but are eligible under one or more other provincial/ territorial health insurance plans. Periodically, when changes are made by various provincial/ territorial health plans, the Trustees are required to review the eligibility of specific services. The following informs you of recent decisions made by the Trustees in this respect.

### Circumcision for newborns

Effective September 1, 2005, the PSHCP will no longer provide coverage for routine circumcisions for newborns since no provincial/territorial health insurance plan covers the procedure. Members should note that circumcision, if medically required, remains covered under the various provincial/territorial health insurance plans.

### Cryosurgery of the prostate

Retroactive to April 1, 2004, the Plan covers the physician’s fees portion of expenses for cryosurgery of the prostate since Alberta Health Care has decided to cover these services when certain medical conditions exist. Alberta Health Care is the only provincial/ territorial plan that currently insures these services. The Trustees have authorized the Plan Administrator to adjudicate these claims on the basis of guidelines similar to those adopted by Alberta Health Care.

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