The

INSIDE STORY®

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What's Inside

DRUG POOLING IS PART OF THE SOLUTION, BUT NOT THE WHOLE SOLUTION

...WHAT IT IS AND WHAT WE NEED IN THE FUTURE

EP3, industry drug pool, CDIPC—needless to say, the insurance industry has always had a lot of insider lingo. These new terms—combined with some complicated underlying concepts—can be seriously hard to get our heads around. Case in point: the insurance industry's drug pooling framework where recurring high-cost drug claims are brought together to allow movement of business, increase plan sustainability, and mitigate risk. Definitely complex. And the environment is set to get even more complicated with more high-cost drugs on the horizon. That's why we decided to take a deep dive into industry drug pooling including touching base with some real experts who are right in the middle of it.

First, here's how the industry drug pooling framework came about

You may have been hearing the term "industry drug pooling" thrown around since 2013. That's when the Canadian Life and Health Insurance Association (CLHIA)—the not-for-profit membership organization that represents the insurance industry—worked with member insurers to establish a framework for insurers to pool *recurring* high-cost drug claims. Hence, the drug pooling framework was born so that by reducing the impact of recurrent drugs, insurers could provide plan sponsors (with insured drug programs) with more protection from a one-off large claim and to maintain their ability to move their business if desired. In addition to bringing the drug pooling concept to life, the CLHIA established the Canadian Drug Insurance Pooling Corporation (CDIPC) to administer it for the 24 participating Canadian group health insurers—essentially the entire industry.

Ironically, the industry thought that high-cost drugs were daunting back in 2013—little did they know the degree of new high-cost drugs that would soon be coming down the pike. In fact, as Gary Walters, principal consultant, Cedar Hill Group Inc., explains, the beginning of the concept goes way, way back. "Actually, it all started where all great ideas begin—after-hours shop talk. As a client and I (then a reinsurer) watched the final Euro soccer match in a sports bar in 2004, we started discussing our concerns regarding how the industry would be able to handle the impact of high-cost drugs starting to enter the market."

Gary adds, "Sustainability was also on our minds as it was becoming clear that the government's national pharmaceutical strategy wasn't going to address catastrophic drugs any time soon. The more we talked, the more we realized that sharing the risk associated with high-cost drugs could offer some relief. Over the next few years, it was a concept that started to pick up steam, and then in 2009, we found that front-line insurers were receptive to the drug pooling concept at a CIA [Canadian Institute of Actuaries] meeting. Next, the CLHIA established a task force to start working out all the details."

The framework includes two main components

As an overall concept, the industry drug pooling framework is logical; it makes perfect sense. Where the brain strain begins to set in is regarding all the intricacies of applying the framework. The good news is that as a plan sponsor—although it's important to have a solid understanding of what drug pooling means for your plan—fortunately, figuring out the details is up to your plan advisor and insurer. Number crunching and running scenarios is their thing (unbelievably, even their passion). So here are the "important-to-know" aspects of the framework to keep in mind as your advisors and insurer work through the fine details day to day.

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1. The framework includes EP3s...

- → Each of the 24 participating insurers, including GSC, places eligible high-cost drug claims from all of their fully insured group drug plans into their own proprietary pools called extended drug policy protection plans or EP3s. Catchy, right? This establishes an arrangement that provides pooling protection. The pooling level is negotiated between each plan sponsor and the insurer.
- → It's important to note that, in keeping with the principles set out by CDIPC to help maintain sustainability even with recurring high-cost claims, insurers must set premiums for plan sponsor's fully insured drug plans *without* including any pooled high-cost drug claims experience. So the premiums for your EP3 pool do not depend on your claims from that pool.
- → In addition, in theory, the idea is that the EP3 approach remedies the situation in the past where plan sponsors with recurring high-cost drug claims may have had difficulty changing insurers because the high-cost drug claims were still connected to the plan sponsor's group, painting a picture of bad claims experience. This is the CDIPC principle of transferability.

2. And the framework also includes an industry drug pool...

- → When the costs of recurring high-cost drug claims exceed the initial threshold specified by CDIPC for two consecutive calendar years, the industry drug pool supports the EP3 by removing much of the effect of high-cost recurrent drug claims.
- → In the background, the 24 participating insurers spread the cost and the risk of the high-cost claims among all of the insurers by putting the claims into an industry-wide drug pool administered by CDIPC. You can think of it as an industry-sponsored reinsurer.

Plan sponsors, take note... Drug pooling in action

As a plan sponsor, EP3 pooling is the most important aspect to understand:

- → GSC automatically assigns all fully insured plan sponsors to one of our mandatory EP3 drug pools where their eligible high-cost claims will be pooled. The premiums charged to a plan sponsor for these EP3 drug pools does not depend on the claims made by the plan sponsor's group in this pool.
- → When the combined claims of a plan member and their dependents (referred to as a "certificate") reach $65,000 or more for two consecutive calendar years, the certificate's claims have reached what is referred to as the initial threshold. Now on to the industry drug pool…

The industry drug pool acts behind the scenes; it doesn't really affect your world.

- → At the end of each year, GSC submits the amount of any certificate's total annual drug claims above $32,500 to the industry drug pool. $32,500 is referred to as the ongoing threshold.
- → The industry drug pooling happens behind the scenes with all 24 participating insurers sharing the risk and cost of all the insurers' pooled claims that exceed the thresholds. The industry pooling protects each of the EP3 pools from high-cost recurrent drugs.

Although EP3s and the industry drug pool are distinct—in that the EP3s are internal to each insurer, whereas the industry drug pool is industry-wide—both are necessary. As a result of the two components, plan sponsors shouldn't have reason to resort to restricting reimbursement for high-cost drugs. And in turn, plan members should continue to receive coverage even when their plan is incurring ongoing high-cost drug claims.

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Gary explains that "while working through the drug pooling concept, we realized that affordability for plan sponsors with high-cost drug claims really boiled down to dealing with recurrent high-cost claims. There is also a reputational risk associated with not being able to provide plan members with new life-sustaining drugs or with plan sponsors no longer being able to continue their drug plan due to the impact of an ongoing high-cost claim on their premiums.

"This led to the EP3 concept as a way to protect plan sponsors from the misfortune of having a high-cost recurrent drug and the consequent impact on their premiums and thus, manage the reputational risk. Of course, we also realized that recurring claims could significantly impact EP3 pooling, particularly for smaller insurers, so establishing an industry drug pool was also necessary. For large insurers, the industry pool was necessary to allow for the EP3 pools and could be considered the price of mitigating reputational risk across the industry."

Drug pooling in practice today

Dan Berty, executive director, CDIPC, thinks that for the most part, the framework is doing what it was intended to do. "At the industry level, the industry-wide drug pool is working behind the scenes to share the costs of high-cost drugs across all 24 insurers. And at the individual-insurer level, EP3 pooling is working well in terms of creating a greater degree of consistency regarding managing the costs of drugs below the industry pool threshold, whereas, prior to CDIPC, insured plans were tackling things in multiple directions. There are certainly opportunities for fine tuning, but overall, at the two levels, the framework is working well."

In terms of bumps along the road, Erin Crump—our very own GSC director of pricing & corporate analytics—who works day to day with the framework, feels that a main issue is misunderstanding. "There is still a lot of confusion at all levels among advisors, brokers, insurers, and plan sponsors. Communication is definitely a trickle down from the insurer because a plan sponsor's understanding depends on what information they get from brokers and advisors who get their information from the insurers. If the broker or advisor doesn't explain it well—or doesn't fully understand it—the plan sponsors are also confused."

Gary agrees and feels that "one of the mistakes we made was leaving the explanation of everything solely to the insurers on an individual company basis where communicating the details of the company's specific EP3 overshadowed communicating the general principles. It's led to a lot of confusion and misunderstanding. For instance, although EP3 is the most important aspect for plan sponsors to understand, the focus seems to be more on the industry drug pool, which is completely behind the scenes and doesn't impact the relationship between plan sponsors and insurers."

Overall it seems that some insurers did a good job with communication, and others less so, but as Dan explains, "Some insurers are more heavily weighted on a fully insured book of business so their emphasis was to tell the drug pooling story because it's a big piece of what they do. Others have much less of a weight on fully insured business—their business is more distributed in the ASO and refund market, so although pooling is important, it's less of an emphasis."

In addition, Dan elaborates, "In any case, most plan sponsors aren't in the business of understanding the depth of insurance. They rely on the broker and advisor community as a proxy from the insurer. However, it's pretty clear that understanding pooling for brokers, advisors, and plan sponsors is more like a five to six out of ten rather than, let's say, an eight out of ten. But it's a complex story and for a broker or advisor it's just a small piece of everything else."

Dan also touches on the principle of transferability explaining that he feels it is being achieved but only to a degree. "There is enough anecdotal evidence from brokers and from off-line insurer discussions that suggests plans with a certificate with very large claims don't typically move, or at best, it is highly unusual. It seems that insurers are not overly interested in providing quotes when claims are in excess of $250,000. Thus, I'd characterize transferability as working to a degree but not without challenges."

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Going forward…

Fortunately, regarding communications, Dan's role has been expanded to include an emphasis on providing education more broadly on what the framework is all about. For example, he feels there is a lot of misunderstanding regarding the rising costs of pooling charges. However, currently CDIPC doesn't have access to the data; it's up to the insurers to tell the story of their cost trend. However, Dan explains that CDIPC is going to try to compile some of that information so that CDIPC can show at the industry level the data that backs up why costs are what they are.

"For plan sponsors these costs essentially represent the cost of the claims within the EP3, but because the financials behind the framework are very complex, plan sponsors may not necessarily think of the pooling charges in this way," Dan explains. "For instance, in terms of costs, it's helpful for plan sponsors to understand that there isn't a standard starting point for EP3 pooling; it typically starts between $10,000 and $15,000, then enters the industry drug pool at the threshold of $32,500. For the first year of a high-drug cost claim, amounts over the EP3 pool's starting point are at least partly pooled in the plan's designated EP3 pool. That said, the insurer is prohibited from experience rating the plan. Then in the second year anything from $32,500 to a maximum pooling amount of half a million dollars is covered by all insurers through CDIPC. So even in year two—and then beyond year two—there is the cost of covering drugs in this range, which is shared by all plan sponsors. And now there are many more drugs that fall into that category."

Interestingly, even with more communication and even if the framework were crystal clear to everyone involved, Gary feels that it's important for the industry to recognize that drug pooling on its own was never intended as a long-term solution to very high priced drugs, it just buys us additional time to develop a more comprehensive solution.

Not *the* long-term solution

Even given that the number and dollar amount of high-cost drugs has far exceeded what anyone could ever have expected way back when discussion about the framework began, Gary explains that drug pooling should only ever be considered part of the solution. "The bigger question is: do high-cost drugs represent a societal issue that everyone needs to get involved in? I would say yes. Insurers, advisors, plan sponsors, government, health care prescribers, and the pharma industry—we all need to collaborate because we certainly won't find solutions by all going in different directions. We need to talk inclusively and constructively."

Dan agrees, explaining that, "From what I can see, without the framework some plans would have had to halt coverage, which obviously would have had negative effects. So the framework has met its intent in that regard—and it will continue to do so—but the high cost of drugs is definitely a bigger societal issue that, as time goes on, is becoming more urgent to tackle."

Erin also feels that there is a lot more work that needs to be done beyond the framework: "Drug pooling doesn't make plans sustainable in the long term, and we don't want plan sponsors limiting their plans with strategies like drug caps. That hurts the most vulnerable plan members in their population. So we need to take a multi-faceted approach."

So what does our plunge into the industry drug pooling framework tell us for the future? The final words are really creativity and collaboration.

Sources:

Canadian Drug Insurance Pooling Corporation website, retrieved March 2017: http://cdipc-scmam.ca/

Canadian Life and Health Insurance Association website, Canadian Drug Insurance Pooling Corporation, retrieved March 2017: https://www.clhia.ca/domino/html/clhia/CLHIA_LP4W_LND_Webstation.nsf/page/1E92C4ED60A4002F852579CA00678818?OpenDocument

Canadian Life and Health Insurance Industry Launches Industry Initiative to Protect Canadians' Drug Coverage, Canadian Life and Health Insurance Association, April 3, 2012, retrieved March 2017: https://www.clhia.ca/domino/html/clhia/clhia_lp4w_lnd_webstation.nsf/page/B573ED1EB3CE940685257EAC0065911C

COMMUNITY GIVING PROGRAM

HERE'S HOW WE **ADD** TO THE **GREATER GOOD**…

Frontline care—like dental services, vision care, prescription drugs, disease management, and mental health supports—can act as a catalyst for change. That's why the GSC Community Giving Program is focused on supporting organizations and initiatives that provide frontline care for underinsured or uninsured populations. And all grant recipients include a navigator component—this means ongoing positive change as clients are referred to any additional services they may need.

GSC frontline care™

Frontline care in action

Saskatoon Student Wellness Towards Community Health – Interdisciplinary Clinical Services

Known as SWITCH, the Student Wellness Initiative Towards Community Health is a free, student-run, health and wellness clinic in Saskatoon, Saskatchewan. It was initiated by students in 2005 and currently over 400 student volunteers from various colleges continue to operate it. In addition to providing a safe place to connect with people and spend time, it offers outreach services including nutritional advice, educational programming for adults and children, child-minding, and a homework help centre for people of all ages. Visitors can enjoy free coffee or tea, as well as a free meal including fruits and vegetables. In addition to these services, an essential aspect of SWITCH is its wide range of clinical services.

Multidisciplinary teams of students and mentors

Saskatoon's marginalized population benefits from SWITCH's clinical services. The clinic sees many clients that are homeless, uninsured, unemployed, or single parents. Most of the clients that access the services are Aboriginal. On each clinic shift, a physician and social worker act as mentors overseeing students from various health care disciplines. Additional health care professionals—like a nurse, physiotherapist, speech language therapist, pharmacist, and chiropractor—join the multidisciplinary team whenever possible. With this model, SWITCH contributes to the training of future health care professionals while improving the health of some of Saskatoon's most vulnerable people.

This approach not only enables patients to receive funded health care services, but also non-funded services like counselling, physiotherapy, and chiropractic aid—all for free. The SWITCH social worker's extensive knowledge of the services available in and around Saskatoon enables them to act as a navigator. Plus educational and/or cultural programming is offered during every clinic shift, and specialty topics like free income tax preparation and ID clinics are now part of the services offered at SWITCH.

Continuing to help those most in need

Compared to other student-run clinics in Canada, SWITCH offers the largest variety of services—many of which are clinical services that GSC funding is making possible. As a result, more people who are in need are receiving essential clinical care often for chronic diseases such as diabetes, arthritis, and mental health issues. Fortunately, from the spring of 2016 to the fall, there were 3,617 visits to access clinical services, programming, or for a warm and safe environment, and 262 students volunteered their time for a combined total of 1141 shifts (4564 hours). To learn more, visit switchclinic.com.

What's UP...

INITIATIVES UNDERWAY TO COMBAT OPIOID MISUSE

Alberta: The College of Physicians and Surgeons has released a new standard of practice: *Prescribing: Drugs with Potential for Misuse or Diversion,* which sets out a number of rules to ensure doctors prescribe opioids responsibly. For instance, the rules include that doctors must check an independent source for a patient's medical history and in the meantime, only prescribe a minimal dosage. Doctors must also justify their prescribing decisions based on documented patient assessments. In addition, the doctor must be cautious when prescribing opioids and first discuss other treatment options and the risks and benefits. For more information, visit www.cpsa.ca/wp-content/uploads/2017/03/cpsa-media-release-standard-prescribing-drugs-with-potential-for-misuse-abuse.pdf?x91570.

British Columbia: The British Columbia Centre on Substance Use and the Ministry of Health have released *A Guideline for the Clinical Management of Opioid Use Disorder.* It is currently for educational purposes and then as of June 5, 2017, it will become the official guideline for British Columbia. Recommendations include buprenorphine/naloxone (trade name Suboxone) as the preferred first-line option for treatment of opioid addiction to help wean patients off opioid use. The guideline also strongly recommends against offering withdrawal management/detox as a standalone treatment, unless there is a plan to transition the patient to additional addiction treatment following withdrawal management. For more information, visit www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines.

Nova Scotia: The government has announced plans to spend $1.1 million on distributing about 5,000 free naloxone kits (an antidote for opioid overdoses) through the police, jails, and community pharmacies. The government considers this an immediate response to the opioid issue while a task force develops a comprehensive plan. Other initiatives being considered include whether to set up a supervised, safe-injection site in the province, as well as how to reduce the practice of many doctors of prescribing high levels of prescription opioids for pain relief. For more information, visit http://thechronicleherald.ca/canada/1449298-nova-scotia-moves-to-head-off-overdose-deaths-amid-growing-flood-of-fentanyl.

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$3.5 MILLION FOR GIFT CARDS TO NUDGE SMOKERS TO QUIT

The Ontario Ministry of Health and Long-Term Care awarded $3.5 million to the University of Ottawa Heart Institute—in collaboration with Lakehead University's *Moving on to Being Free* program—to implement an innovative smoking cessation program. The program aims to make nicotine replacement therapies more accessible and more affordable by way of Quit Cards that act as gift cards.

Only a minority of hospitals in Canada have policies or procedures in place to identify and then help smokers admitted to hospital quit smoking. In addition, many smokers report that the cost of smoking cessation medications is a main barrier to quitting. Accordingly, the Quit Card project distributed more than 7,500 Quit Cards to smokers through 80 hospitals and specialty care clinics.

Smokers can use the Quit Cards to purchase single or combination nicotine replacement therapies like nicotine patches, gum, inhalers, lozenges, or mist at any Ontario pharmacy. Only medications specified on the card by drug identification number (DIN) are eligible and the card is processed by the pharmacy just like a drug insurance card. Each card has an initial value of $150 and a patient can load an additional $300 based on need.

In addition to the Quit Card, smokers will be enrolled in automated follow-up support programs and can access smoking cessation counselling after discharge. The Quit Cards were distributed to patients until March 31, 2017, and must be used by April 30, 2017. The project will evaluate the participants' one and six months smoking abstinence rates.

For more information, visit https://www.ottawaheart.ca/media-release/35-million-make-smoking-cessation-more-affordable-ontarians.

OUT & ABOUT... *Events not to miss*

We're hitting the road with the GSC 2017 Health Study: *Come Health or High Water*

Don't forget to come out and learn what the data is saying about strategies to keep health benefits plans afloat in the wake of numerous industry developments. The latest and greatest claims data analysis and research will provide important insights.

We look forward to seeing you there.

VANCOUVER	APRIL 10
EDMONTON	APRIL 11
CALGARY	APRIL 12
WINNIPEG	APRIL 19
HAMILTON	APRIL 27
MONTREAL	MAY 11
VICTORIA	JUNE 1
HALIFAX	JUNE 6

The Value of Generics and Biosimilar Medicines – May 15, 2017

Ritz-Carlton Hotel, Toronto, Ontario
http://www.benefitscanada.com/microsite/value-of-generic-and-biosimilar-medicines/2017/
Ned Pojskic will be speaking about optimal listing strategies from a payor perspective.

Healthy Outcomes Conference – June 13-14, 2017

Shangri-La Hotel, Toronto, Ontario
http://www.benefitscanada.com/conferences/healthy-outcomes-conference
Peter Gove will be speaking about inspiring employers to move towards healthier outcomes. GSC is an event sponsor.

April Haiku

EP3 we say
And people are all confused
Read it one more time!

FITBIT WINNER

Congratulations to **HEATHER GILDNER**, of **Toronto, ON**, the winner of our monthly draw for a Fitbit. Through this contest, one name will be drawn each month from plan members who have registered for Plan Member Online Services for that month.

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greenshield.ca

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