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De-mystifying the Trillium Drug Program (TDP)

Before we get started, Follow the Script *apologizes for being Ontario-centric with this feature article. We have noticed a lot of misinformation being circulated about an upcoming change to the Trillium Drug Program (TDP) recently announced, and we are going to step up and take a crack at alleviating any confusion out there. Non-Ontarians may want to keep reading to compare Ontario's program with programs in your own province, or you can skip ahead to page four for our interview with GSC pharmacist Andrea Staruch.*

What's the TDP?

The TDP is one of the programs under the Ministry of Health and Long-Term Care's Ontario Drug Benefits (ODB) umbrella and is designed to provide financial relief to households with high drug costs relative to their income. The program covers drugs listed on the ODB formulary and also enables TDP participants to apply to the Exceptional Access Program for drugs not covered by ODB.

The TDP is not meant to replace private drug insurance plans; it is intended to assist Ontario residents with drug expenses once *other coverage is exhausted*. As more and more high-cost specialty drugs come on the market, with many of them treating common chronic conditions, the TDP is becoming increasingly important for many Ontarians.

All Ontarians under age 65 with a valid Health Card are eligible for the TDP but the program is most relevant for those who do not qualify for ODB under another category and members of households that do not have a private insurance plan at all or have a plan that pays less than 100 per cent of drug costs. Eligible Ontarians aren't automatically covered for the TDP – there's an application process – and an annual deductible has to be satisfied before benefits can be received.

The TDP deductible

The annual TDP deductible is based on *household net income* and the number of members of the household: it's calculated as approximately four per cent of the household's combined net income. To minimize the financial burden, this deductible is divided into four quarters throughout the benefit year, which runs from August 1 to July 31.

The deductible is satisfied once a household's out-of-pocket expenses for ODB-eligible prescription drugs equal the deductible amount for the quarter. Once the deductible is met, participants are required to pay only $2.00 per eligible prescription for the rest of the quarter.

How does private insurance work with this?

For participants with private insurance (including GSC plan members), the TDP is *the payor of last resort* in the pre-deductible period; only the out-of-pocket amount paid on ODB-eligible drugs is recorded and counted towards the deductible. Ideally this is what happens:

- → If the private plan is pay direct, participants submit their original receipts to the TDP. Or, if participants are paying the full cost of the drug at the pharmacy, they submit their receipts to the private plan first, then send the receipts and their claim statement to the TDP.
- → The private plan reimburses the covered portion of the participants' expenses.
- → The TDP records the amount the participants spend out-of-pocket (i.e., the co-pays) on ODB-eligible prescription drugs towards their household's deductible.
- → Once the deductible is met, participants send their receipts to the TDP first and are reimbursed for ODB-eligible drug expenses.

In theory, as the deductible is divided into four quarters throughout the benefit year, the TDP and the private carrier alternate between first and last payor. But, in reality, we know *that is not happening today* because private-payor claims cannot be electronically coordinated with the TDP at the point of transaction.

The process of mailing original receipts results in processing delays of up to six weeks or longer and translates into even longer administrative delays in satisfying the quarterly deductible. In addition, pharmacies are unaware of a participant's deductible status, and therefore, *do not know when to switch the TDP to be first payor*. As a result, in most cases, private payors continue to be the primary payor even in the post-deductible phase.

What's changing? Electronic coordination of benefits between TDP and private plans

With a projected starting date in the fall of 2017, the Ontario Ministry of Health and Long-Term Care will implement electronic coordination of benefits (COB). This will allow pharmacies to submit claims to the TDP after the initial adjudication by the private carrier and will remove the requirement for participants to submit original receipts to the TDP.

Claims will be accepted by the TDP and out-of-pocket amounts (i.e., co-pay) will be tracked and applied towards the deductible. Tracking the out-of-pocket expenses in real time will enable participants to access TDP benefits immediately upon satisfying the quarterly deductible. Once the deductible is satisfied, the TDP will not only accept the claim, but will also start reimbursing for the full drug expense. It is at this point that pharmacies ***should*** switch the TDP to be first payor.

It's important to note that the structure of the TDP itself will not change. These fall 2017 changes will simply make it easier to determine when the participant reaches eligibility for TDP reimbursement. However, the challenge will continue to be with pharmacies who are unaware of a participant's deductible status and, therefore, don't know when to switch to the TDP as the first payor.

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Impact to private drug plans

While it may seem logical that more coordination of benefits would lead to a lower drug spend, that's not necessarily true unless the plan sponsor implements greater amounts of cost-sharing with plan members. To satisfy the deductible, the TDP only considers out-of-pocket expenses borne strictly by the plan member (i.e., employee-paid premiums, deductibles, and co-pays). Any amount paid by the plan sponsor is **not** considered an eligible expense by the TDP. Likewise, any amount paid by a third party other than the plan member (i.e., spouse's drug plan) or reimbursed through health care spending account or manufacturer-sponsored co-pay assistance program **will not** be eligible to satisfy the deductible. Based on the current structure of most private drug plans, this means the vast majority of plan members will never satisfy the TDP deductible; therefore, their benefits plan will not see a decrease in drug spend.

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To better understand the plan member population who may reach the TDP deductible, GSC recently conducted an analysis of our claims data. This analysis was based on a median income of $78,790* making the typical TDP deductible just over $3,000 per year. The results showed that less than nine per cent of plan members had estimated annualized co-pays that reached the $3,000 threshold. Furthermore, many of those claimants are likely to have secondary private drug plans and/or other forms of financial assistance for high-cost drugs that would reduce their out-of-pocket expenses. In other words, the vast majority of plan members will never satisfy their TDP deductible.

How does the TDP compare with other provincial plan drug programs?

The main difference between the TDP and the "pharmacare" programs in provinces like British Columbia, Saskatchewan, and Manitoba is in how the deductible is satisfied. Where Ontario only counts the plan member's out-of-pocket expenses towards the deductible, provinces such as B.C., count the entire drug cost and are indifferent to who bears the costs of the drug (i.e., plan member or private drug plan). This makes determination of eligibility for the pharmacare programs fairly straightforward: once a threshold in total drug spend is reached, the plan member is eligible for the provincially-funded program.

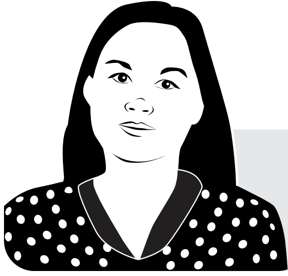
A positive step forward for the TDP

Electronic coordination of benefits with the TDP is a promising change that brings Ontario a step closer to more effective coordination between public and private payors. However, to ensure more broad-based coordination, other changes will be needed, including better mechanisms of communication with pharmacies regarding plan members' TDP eligibility. The Ministry of Health and Long-Term Care has promised a more extensive re-structuring of the public drug plan by 2019, and an explicit focus on greater coordination with private drug plans has been cited as one of the pillars of that restructuring.

You can be sure that if and when there are additional changes to any of the public drug plans in Canada, GSC will keep you informed.

*Statistics Canada, www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/famil108a-eng.htm

BEHIND THE COUNTER



Coordinating benefits plans in real life

To complement our feature article on the Trillium Drug Program, we talked to GSC pharmacist Andrea Staruch about handling coordination of drug benefits "at the counter."

FtS: Hello Andrea. The focus of our feature this issue is to address all the information that's been swirling around about Ontario's Trillium Drug Program. So for this interview with you, we want to take it into the pharmacy and explain to people how a pharmacist tries to coordinate benefits with different payors – Trillium – but also any other provincial government program versus private payors. What happens in real life when you have a patient in front of you, and you have to figure out who should pay?

Andrea: It's well engrained for anyone working at a pharmacy in Ontario that for anyone over the age of 65, it's government first; for anyone under 65, it's going to be government last. That's the Ontario Drug Benefit Program.

FtS: Got it. And Trillium?

Andrea: The way it's supposed to work for Trillium is, when a person has two plans, the claims go to the private plan first. But once the person meets their deductible – which has to be entirely out of pocket – the two plans get switched. Trillium pays first. Many pharmacists, however, are under the misconception that when there's a private plan, the private payor always pays first, and therefore they always bill accordingly. Another problem is that, even if the pharmacist knows the plans should be switched once the deductible is met, they don't currently have a way of knowing when the deductible has been met. In other words, they don't have the information necessary to know when to make the switch. And to be frank, unless the system changes to explicitly prompt the pharmacist to make that switch, they probably never will.

FtS: OK, so today the only person who really has the information about whether the Trillium deductible is met, besides Trillium themselves, is the patient.

Andrea: Well, yes, but quite often they're not really sure either. A lot of people will ask me about it…"*where am I in my deductible…when will I be done…*" But I don't have that information.

FtS: Trillium sounds like a good thing in theory, but it seems that the system cannot connect the dots to help people get their benefits. What's the answer to that? What should be happening?

Andrea: This is actually an infrequent problem. The majority of people on Trillium don't have private plans. Think about it: the deductible is roughly four per cent of your *household* income and that has to be out of pocket. For instance, those drug company programs that say they will reimburse you for your Trillium deductible? That's not allowed. The deductible has to be satisfied entirely out of the patient's pocket and most people won't ever reach that four per cent threshold.

FtS: So it's going to be a very small population of plan members with private plans who will satisfy their Trillium deductible.

Andrea: Definitely. The only time I can see it happening is when someone has, for instance, a 20 per cent co-pay **and** they're taking a very high-cost drug. But the pharmacy still won't know when to switch over to Trillium…

FtS: Will the change coming in the fall – electronic coordination between private plans and Trillium – help pharmacies understand how the process is designed to work?

Andrea: It will help if there's education and communication from both Trillium and the private payors. Pharmacies first need to understand that the switch needs to be made once the deductible is satisfied. Although pharmacists still won't know the amount of the deductible, they could be made aware that when Trillium starts to pay the co-pay portion of a claim, that's an indication that the deductible has been satisfied. That could prompt them to switch the order to make Trillium first payor.

FtS: Basically if the pharmacy and/or the patient isn't aware and somewhat educated, this switch probably isn't going to happen for them.

Andrea: Unless the patient says something, it likely will not.

FtS: Now let's change tracks slightly and talk about coordination of benefits between a couple of private plans. What's that like for a pharmacist?

Andrea: For private plans it's pretty straightforward. The patient's own plan goes first, their spouse's plan goes second – usually there's no more than two plans involved. Although there might be a government plan if the patient is over 65…in that case the government plan goes first, then your private plan, then your spouse's private plan. If it's a child, coordination is based on the earlier of the parents' birthdays during the year. If the father's birthday is in August and the mother's is in February, the mother's plan pays first.

FtS: So that's easy, pharmacies nail that. Are there coordination situations where pharmacies struggle?

Andrea: They shouldn't. That's not to say that they don't. There are the drug company assistance cards that need to be administered, and they say on the cards themselves that they must be the secondary payor.

FtS: You know how the coordination works, you see both sides – pharmacy and benefits plan – but don't some pharmacists miss things like that?

Andrea: Yes, sometimes it's the pharmacy assistants doing the billings in the pharmacy. And they may not be up to speed. And some pharmacists have wonderful clinical knowledge but they don't know the first thing about billing. We're not taught that in pharmacy school.

FtS: So the schools don't reflect real-life situations. Do you end up getting trained in all this insurance stuff on the job at the store?

Andrea: I was lucky in that I was in a co-op program, so I was exposed to billings first hand when I was still a student. But most students won't get training on billings before they start working.

FtS: Thank you Andrea, this has been interesting and eye-opening.

DRUG REVIEW AT GSC...

To give you an idea of what drugs might impact your benefits plan next, every quarter *Follow the Script* highlights some of the drugs recently reviewed by GSC's Pharmacy and Therapeutic (P&T) Committee. We start this edition with a drug familiar to most readers – Humira, but for a new indication:

GSC CLASSIFICATION[1]	NEW DRUG[2]	GENERAL INFORMATION	COST[3]	COVERAGE DETAILS[4]
INFLAMMATORY DISEASE				
Biologic; High-cost; Specialty (Tier 5)	Humira® (adalimumab)	Uveitis is a rare inflammatory disease characterized by swelling and destruction of eye tissue which can result in reduced vision or even blindness.[5] There are two types: infectious (caused by a bacteria or virus) and non-infectious (caused by direct injury or due to other underlying disease). Non-infectious uveitis represents about 78% of all uveitis cases.[6] Based on the location of inflammation, it can further be classified as: anterior (front), intermediate (center), posterior (back), and pan-uveitis (all three regions). Intermediate, posterior, and pan-uveitis are considered the most severe and highly recurrent forms of uveitis and if left untreated can often cause blindness. Treatments for uveitis primarily aim to eliminate inflammation and pain, prevent further tissue damage, and restore vision loss before more serious complications can occur. Although uveitis can occur at any age, it commonly affects individuals of working age.[7] Existing treatment options for non-infectious uveitis include topical corticosteroids; however, due to the location of posterior, intermediate, and pan-uveitis, oral corticosteroids are generally recommended. Humira, a biologic available in Canada since 2004 and the first biologic approved by Health Canada to treat uveitis, now offers a new treatment option for non-infectious uveitis (intermediate, posterior, and pan-uveitis) in adults with an inadequate response to corticosteroids or for those who are corticosteroid-dependent. It is administered by subcutaneous injection every other week.	**$$$$** Approximately $20,000 per year	→ Specialty drug PPN → Requires prior approval

LUNG DISEASE				
Traditional; High-cost; Specialty (Tier 5)	Uptravi™ (selexipag)	Pulmonary hypertension (PH) is a rare, chronic, complex, and rapidly progressive lung disease. In pulmonary arterial hypertension (PAH), the arteries of the lungs become scarred or narrowed, resulting in restricted blood flow and continuous high pressure in the lungs making it more difficult for the heart to pump blood through these arteries. PAH can be the result of other medical conditions (e.g., heart defect, autoimmune disease, blood clots) or in some cases no cause can be identified (idiopathic). Because symptoms are non-specific (shortness of breath, light-headedness, chest pain, etc.) and overlap with many other conditions, PAH is often misdiagnosed or diagnosed when the patient is experiencing more severe symptoms. There is an estimated 5,000 Canadians diagnosed with PH.[8] There is currently no cure for PAH and if left untreated can be fatal. Current treatments focus on relieving symptoms and slowing disease progression. In Canada there are currently nine approved PAH treatments that act on four major pathways: endothelin receptor antagonists, prostanoids, phosphodiesterase type-5 (PDE-5) inhibitors, and soluble guanylate cyclase (sGC) stimulators. In general, patients whose disease is not well controlled with a single drug therapy are started on combination therapy with a second drug from a different class.[9] Uptravi is a new treatment option for PAH that targets the prostanoid pathway. Compared to others in its class (injectables), Uptravi is the first oral medication and is indicated for earlier stages of disease progression. It has been granted Health Canada approval for idiopathic PAH, heritable PAH, PAH associated with connective tissue disorders, and PAH associated with congenital heart disease in adults with mild-moderate symptoms. It is administered orally twice daily.	**$$$$** Approximately $46,800 per year	→ Specialty drug PPN → Requires prior approval

Notes:

[1] *Biologic* refers to drugs produced through biotechnology and listed in Schedule D of the Food and Drugs Act; *Traditional* generally refers to small molecule compounds derived from chemical synthesis and also includes drugs not listed in Schedule D of the Food and Drugs Act; *High-cost* refers to drugs subject to *GSC's High Cost Drug Policies; Specialty (Tier 5)* refers to drugs with an expected annual treatment cost of $10,000 or more (certain drugs approaching the threshold may also be considered high cost if clinical evidence warrants)
[2] Brand (generic)
[3] Based on manufacturer list price, does not reflect pharmacy markup and dispensing fee. $ <1,000; $$ 1,000–4,999; $$$ 5,000–9,999; $$$$ 10,000–49,999; $$$$$ ≥50,000
[4] Applicable to all formularies unless otherwise noted. PPN refers to GSC's preferred pharmacy network program.
[5, 7] National Eye Institute, Uveitis, https://nei.nih.gov/health/uveitis/uveitis
[6] Chan SM, Hudson M, Weis E., Can J Ophthalmol 2007; 42(6):860-4.
[8] Pulmonary Arterial Hypertension, Pulmonary Hypertension Association of Canada, http://www.phacanada.ca/en/about-ph/download-pdfs/#
[9] Drugs for Pulmonary Arterial Hypertension, CADTH, https://www.cadth.ca/sites/default/files/pdf/TR0006-PAH-InBrief-e.pdf