The

INSIDE STORY®

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RECENT TELEVISION COVERAGE INVESTIGATES CANADA'S RISING DRUG PRICES

FOR INDUSTRY INSIDERS, THERE'S MORE TO THE STORY...

It is not too often that our world of health benefits gets widespread media attention, but if you happened to catch the recent episode of The Fifth Estate called *The High Cost of Pharmaceuticals: Canada's Drug Problem*, you know that it touched on some very timely issues for our industry. However, with the show's one-hour timeframe and target audience of the average Canadian, it's impossible to include all the ins and outs of some complex issues. To keep the discussion going and provide additional insight for industry insiders—like plan sponsors and advisors—we contacted Stephen Frank, senior vice president, policy, at the Canadian Life and Health Insurance Association, who was interviewed on the show. Stephen shared with us what was left on the cutting-room floor…

Missed the show?

Watch it online here:

www.cbc.ca/fifth/episodes/2014-2015/the-high-cost-of-phamaceuticals-canadas-drug-problem

Setting the scene

The Fifth Estate explains that although some Canadians have limited or no drug coverage, most Canadians—approximately 80%—do have coverage. And indigenous, elderly, and poor people, as well as those in hospital are usually receiving drug coverage by way of a public plan. The rest of us are covered by private plans, typically through employers. Then getting down to the issue at hand: although employer plans traditionally have been very generous covering almost every drug available, this notion—that we can continue to afford any drug at any price—is at the heart of Canada's drug problem. Accordingly, this notion needs to change.

Needless to say, we agree with this aspect of the show's premise—especially when we factor into the equation that many of the new high-cost drugs entering the market cost hundreds of thousands of dollars per year. But what is the solution? How can we bring down Canada's drug costs? To get to the "how?" first The Fifth Estate investigated the "why?" Just why is it that Canada has the second-highest drug prices in the world, after only the United States?[1]

First stop: the doctor's office

Perhaps a contributing factor to high drug prices is that, although certain drug therapies have the same efficacy, doctors don't always prescribe the cheapest option. For instance, although Canadian Diabetes Association guidelines recommend doctors prescribe the drug metformin—an effective and low-cost option—research shows that one-third of newly diagnosed diabetics covered by private insurance plans start on a more expensive drug first, before ever trying metformin.[2]

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This prescribing trend triggers another "why?"—a journalist's favourite question (and of course, one we are also exceedingly fond of). So assuming there is no medical reason to steer clear of metformin, why do many physicians opt for prescribing higher-cost drug options?

The Fifth Estate's findings include that doctors who have more contact with and information from drug companies tend to prescribe more expensive drugs and more brand-name drugs, and they make more inappropriate prescribing decisions.[3] Marketing works! In addition, often drug-company sales representatives use hard-sell tactics like undermining prescribing guidelines and suggesting off-label uses to push higher-cost drugs.[4] Could misinformed prescribing practices—influenced by drug company marketing—be contributing to unnecessary spending?

Stephen's take was that while most doctors are now on board regarding generics versus brands because the science is very clear around comparable efficacy, there may be more of a struggle, for example, around first-line versus second-line therapies and biosimilars. Stephen added that to be fair to physicians, their prescribing decisions are based on patient care, not cost. Building physician knowledge regarding the cost-side of drugs would be useful and is arguably very necessary in the years to come.

The role and responsibilities of private carriers

Further illustrating the magnitude of the higher-cost prescribing issues, research conducted for the show comparing the difference between what insurance companies paid for more expensive drugs versus what could have been paid if doctors prescribed a cheaper version was $3 billion per year between 2011 and 2015—approximately $15 billion over five years.[5]

Clearly, addressing drug marketing practices and inappropriate prescribing is important. But what about other aspects of the drug transaction? What about plan design and specifically, whether insurers have a responsibility to help employers make cost-effective choices for their plans? This is one area where Stephen felt that a lot was left on the CBC's cutting-room floor.

"Overall, it's just not correct to suggest that private plans are standing still, that we're not addressing these issues. Every year the dollar amount difference between covering more expensive versus less expensive drugs gets smaller and smaller. The real point is that the world is changing very rapidly for private payors. Fifteen years ago, a typical private plan was basically open; whatever the physician prescribed, we reimbursed. This is increasingly not the case as everyone makes an effort to move toward increased plan management.

"For example, every carrier in Canada, including GSC, has solutions for their plan sponsors, like mandatory generic substitution and criteria regarding step therapies. However, there still is a perception among employees that 'if I don't get exactly what my physician prescribed, it could be detrimental to my health' and employers are very reticent to make changes that could be perceived as negative for employees. As a result, it's not a question of whether or not plan management is happening, it's a question of how quickly employers will allow it to happen. It's about how long will it take us to get there, not whether we will get there at all."

Along these lines regarding the insurer's responsibility, The Fifth Estate also suggested that insurers have no incentive to help employers decrease their costs with the idea that the bigger the employer claims, the more the insurer makes in administrative fees. Stephen was quick to correct this misconception: "Nothing could be further from the truth. We need to have costs in line with our customers' ability to pay. Having rapid escalation in price that is going to push it out of reach of our plan sponsors is not in our interest."

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From problems to solutions...

Through their investigation, although The Fifth Estate teased out a lot of the critical issues, they also presented hope for the future in that physicians, employers, employees, and private payors can all play a part in helping curb rising drug costs. An example of progress is the work of the pan-Canadian Pharmaceutical Alliance (pCPA) where all 13 provinces and territories—and now also federal drug plans—are working together to achieve greater value for brand-name and generic drugs for publicly funded drug programs.

However, the provinces are only one piece of what The Fifth Estate refers to as Canada's patchwork approach to drug coverage because of the many public and private payors. Is the solution for Canada to try to increase purchasing power by moving to a single drug-price negotiating and purchasing agency like New Zealand's pharmaceutical management agency called PHARMAC? Canada is the only country worldwide that has a publicly funded universal health program that does not include a publicly funded universal drug program—not that Canada hasn't been studying and discussing it since the 1960s.[6]

What is PHARMAC?

Established in 1993, PHARMAC—Pharmaceutical Management Agency—is New Zealand's government agency that decides which drugs to publicly fund in New Zealand.

It was established in 1993 with the goal of ensuring that New Zealanders get the best possible health outcomes from money the government spends on drugs used in the community.

Since then, PHARMAC's role has expanded to include making funding decisions about cancer medicines, vaccines, and hemophilia treatments, which are funded by district health boards.

PHARMAC also makes decisions about drugs funded in hospitals and it negotiates national contracts for medical devices used in hospitals.

Although the show touches mainly on the potential benefits of this kind of approach, there are just as many drawbacks—maybe more depending on who you talk to. For instance, critics of nationalizing prescription drug coverage caution that it would result in a significant pull-back in coverage for the majority of Canadians. "You can always save money by rationalizing access," Stephen explains. "But that's the risk if we focus too much on cost and not enough on access. The right approach will balance cost savings and access." Slow access to new drug innovations is also a real concern. New Zealand falls behind most developed countries when it comes to speedy access to new drugs.[7]

What Canada needs is a collaborative approach

Continuing the solutions discussion, Stephen felt that a lot was left on the cutting-room floor: "Overall, it really depends on what is meant by pharmacare. If it means a much more integrated mix of our public and private systems—one where we work collaboratively around pricing and access to drugs—then yes, we should move in that direction. For example, countries like the Netherlands, Germany, Japan, and Korea, have knit together a private and public system where they aren't hung up on 'public' versus 'private'. Instead, they've just built a system that works. By contrast, the New Zealand system, where they have nationalized everything and pared back what they can offer is too restrictive.

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"What we should be looking at is bringing private insurers to the table together with governments to negotiate pricing for *everybody*. What we have now where the pCPA negotiates lower prices that only apply to public plans, just doesn't make sense. A collaborative public/private approach would achieve even more leverage in pricing negotiations—and *everyone* would share equally in the lower prices. It's analogous to what is already the case on the generic side; provinces cap generic drug prices, but the lower price applies to everybody, not just the provinces. We need a similar approach on the branded side."

Interestingly, also in terms of governments becoming part of the solution, The Fifth Estate interviewed Canada's Minister of Health Jane Philpott. She describes her plans to continue to push provincial-federal negotiations to lower generic drug pricing, and she plans to change Canadian regulations to force patented drug companies to lower their prices. This involves a review of the Patented Medicine Prices Review Board (PMPRB), the federal body mandated with ensuring that the prices of patented medicines sold in Canada are not excessive.

Stephen thinks the government is moving in the right direction. "We're very encouraged by what Minister Philpott is saying. We need to review the PMPRB because it hasn't been reviewed since it was created in 1987, and the world has changed enormously since then. The goal should be to turn the PMPRB into a real consumer protection agency with a very clear mandate and instructions so that it is doing everything possible to bring costs down for Canadians. And of course, we need to make sure the PMPRB has all the tools it needs to do just that."

Stephen, any last words for our readers?

"To sum it up, when you look globally regarding how other countries have addressed rising drug prices, you see that there are two approaches. We could make a dramatic, complex, and costly overhaul sweeping everything under the government umbrella—an overhaul that also brings with it a ton of risk and is restrictive. Alternatively, we could implement some very simple and quick measures to create a balanced, mixed public/private drug program. This collaborative public/private option is the best opportunity, and the good news is that it's right there within our reach. We've been asking governments for this kind of collaboration for years now. We ask every opportunity we get, and we'll continue to have the discussions until we spark the catalyst that will finally bring governments and private payors together. It's time we all got on it!"

Sources:

[1], [5] *The High Cost of Pharmaceuticals: Canada's Drug Problem*, The Fifth Estate, Episode 42, Broadcast date: January 13, 2017, Web page: Episodes, Retrieved February 2017: http://www.cbc.ca/fifth/episodes/2014-2015/the-high-cost-of-phamaceuticals-canadas-drug-problem.

[2–6], [7] *The High Cost of Pharmaceuticals: Canada's Drug Problem*, The Fifth Estate, Episode 42, Broadcast date: January 13, 2017, Online broadcast, Retrieved February 2017: http://www.cbc.ca/fifth/episodes/2014-2015/the-high-cost-of-phamaceuticals-canadas-drug-problem.

What's UP...

NOVA SCOTIA HUMAN RIGHTS BOARD RULES IN FAVOUR OF COVERING MEDICAL MARIJUANA

On January 30, 2017, an independent Nova Scotia human rights board ruled that a complainant's health plan must cover his medical marijuana prescriptions for pain management. The man, who is suffering from chronic pain, had argued that he faced discrimination in accessing coverage based on his disability. The board's ruling states that the health plan contravened the province's Human Rights Act and that it must now cover the man's medical marijuana expenses up to and including the full amount of his most recent prescription. The insurer had denied coverage as of May 2014.

Since medical marijuana was prescribed for pain management, the board considered it a medical necessity and concluded that the man's health plan includes conditions and rules for the coverage of medical marijuana as an eligible expense. For example, since medical marijuana requires a doctor's prescription by law, it does not fall within the plan's exclusions.

The man's medical marijuana expenses will be eligible only when purchased from a producer licensed by Health Canada or a person legally authorized to produce it for the man under the Access to Cannabis for Medical Purposes Regulations, and the claim must be supported by an official receipt.

What does this mean for your plan? It's important to note that medical marijuana is not typically covered under health benefits plans for a number of reasons, including that it is not yet approved by Health Canada for safety, efficacy, and quality and that a drug identification number has not been issued for it. However, it's generally up to each plan sponsor to decide whether they want to cover medical marijuana under their plan. For example, under GSC plans, medical marijuana can already be reimbursed through a health care spending account.

Accordingly, the ruling in Nova Scotia has not changed GSC's current eligibility requirements, processing guidelines, or reimbursement practices around medical marijuana; each plan is unique and coverage is up to each plan sponsor's discretion. GSC will continue to review the ruling in Nova Scotia—and keep a close eye on any new developments surrounding medical marijuana coverage overall.

To learn more, visit http://novascotia.ca/news/release/?id=20170202003.

DRAFT GUIDELINE DESIGNED TO SLOW CANADA'S OPIOID EPIDEMIC

On January 30, 2017, draft recommendations for Canadian physicians regarding the use of opioids in chronic non-cancer pain—which call for more cautious prescribing of opioids to patients with chronic pain—were posted online for public comment. The guideline development team gathered feedback until the end of February 2017.

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As you may recall from the November 2016 edition of *The Inside Story*, concerns about what is being referred to as Canada's opioid crisis triggered Health Canada to fund the development of an evidence-based guideline for prescribing opioids in chronic non-cancer pain patients. As a result, over the past two years, an expert team developed the 2017 draft guideline.

So what's the feedback about the guideline so far? In terms of positive feedback, some feel that the guideline will help remedy the situation that in the past the benefits of opioid use may have been overstated and the harm understated. Many also feel that the guideline represents an important shift because it states clearly that physicians should recommend non-opioid methods before opioids are even considered. In addition, it provides a clear upper ceiling for opioid prescribing—one that is based on solid scientific evidence. In terms of negative feedback so far, there is concern that the guideline's recommendations do not address acute pain like that immediately after an injury or surgery.

After considering all of the feedback submitted, the development team will release the final guideline in March 2017. We'll be sure to update you then.

For more information and to review the draft guidelines, visit http://nationalpaincentre.mcmaster.ca/guidelines.html.

THE COST OF SMOKING-ATTRIBUTABLE DISEASES WORLDWIDE

Unlike previous studies that quantified the economic cost of smoking-attributable diseases on society in high income countries, a recent study measures this cost throughout the world, including low- and middle-income countries. The study *Global economic cost of smoking-attributable diseases* concludes that smoking imposes a heavy economic burden everywhere, especially in Europe and North America where smoking is prevalent.

For the study, a researcher from the World Health Organization analyzed data from 152 countries, representing 97% of the world's smokers in Africa, the Americas, the Eastern Mediterranean, Europe, Southeast Asia, and the Western Pacific. The study considered direct costs associated with smoking-attributable diseases (like medical care), as well as indirect costs (like lost productivity and disability). The study also included a review of 33 studies of direct costs, as well as data from the World Health Organization and the World Bank. The analysis did not include the health and economic harms caused by second-hand smoke or smokeless forms of tobacco, the investigators said.

Findings include that in 2012, smoking-attributable diseases caused 12% of all deaths among adults 30 to 69 years old worldwide, with the highest proportion in Europe and the Americas.

> **"THIS COST THE WORLD ECONOMY MORE THAN US$1.4 TRILLION WITH NEARLY 40% OF THIS BORNE BY LOW- AND MIDDLE-INCOME COUNTRIES."**

The researchers feel that the findings emphasize the urgent need for countries to implement stronger tobacco control measures.

To learn more, visit http://tobaccocontrol.bmj.com/content/early/2017/01/04/tobaccocontrol-2016-053305.short?g=w_tobaccocontrol_ahead_tab.

COMMUNITY GIVING PROGRAM

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

Paving the way for a brighter future

Take a look at how our grant recipients are making a difference

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

Halton Peel Dental Association – Smile Days

The Halton Peel Dental Association (HPDA) is one of the Ontario Dental Association's 39 regional associations—and it's the largest one covering the regions of Halton and Peel, which includes Mississauga, Brampton, Oakville, Milton, and Caledon. In addition to providing educational programs for dentists, the HPDA has also become a strong advocate for issues affecting dentistry and conducts a range of public education programs. For example, HPDA members visit local schools and long-term care centres to provide dental education and oral health aids. In 2017, the HPDA is launching a brand-new initiative called Smile Days.

Free dental care days – Now that's something to smile about

The HPDA is recruiting dentists to volunteer their skills and provide basic dental services—for free—during two Smile Days in April as part of National Oral Health Month. Three private clinics will host the Smile Days—one in North Mississauga, one in South Mississauga, and another in Oakville. To help as many people as possible who are uninsured or underinsured, the HPDA is collaborating with community partners—like local charities, food banks, and shelters—by asking them to raise awareness of the event to their clients. Holding the clinics right in the communities where people live, rather than at one centralized location, will make the free dental services more easily accessible, encouraging participation.

Keep smiling because it's the first, but not the last

Funding from GSC is making it possible for the HPDA to set a solid foundation for success by launching this year's inaugural Smile Days, as well as Smile Days for three additional years. Not only will the Smile Days provide important dental treatment and oral care education to people in need, they will also encourage a culture of volunteerism in the dental profession. Each year the goal is to expand the Smile Days both in terms of increasing the number of patients, as well as the number of volunteer dentists and collaborating community partners. To learn more, please visit www.hpda.ca.

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.

WINDSOR	MARCH 21
LONDON	MARCH 22
KITCHENER	MARCH 23
TORONTO	MARCH 28
OTTAWA	MARCH 29
VANCOUVER	APRIL 10
EDMONTON	APRIL 11
CALGARY	APRIL 12
WINNIPEG	APRIL 19
HAMILTON	APRIL 27
MONTREAL	MAY 11
VICTORIA	JUNE 1
HALIFAX	JUNE 6

■ SOLD OUT

March Haiku

More to the story
Was on the cutting-room floor
Thank you Stephen Frank

WINNER OF THE DRAW FOR A FITBIT

Congratulations to **LAUREN ELLIS**, of **Southhampton, 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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