The INSIDE STORY®

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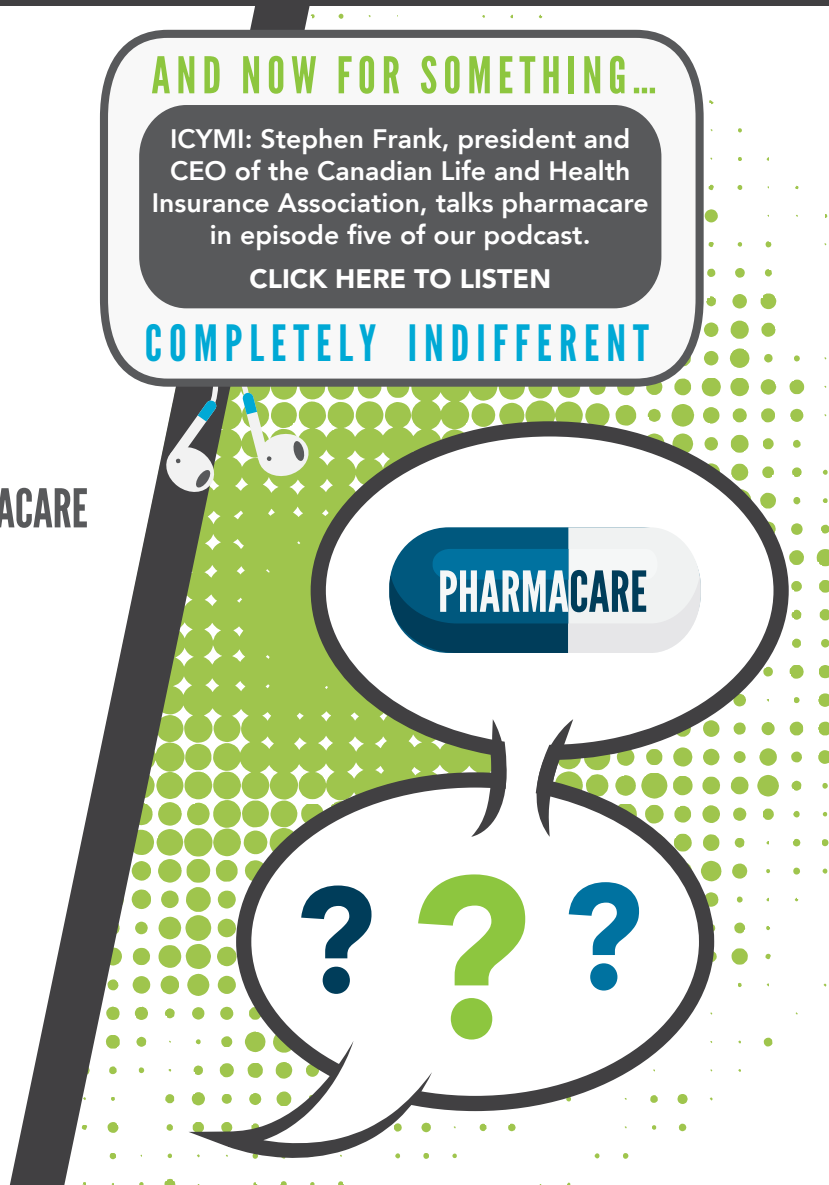

THESE DAYS EVERYONE'S TALKING ABOUT PHARMACARE

...LET'S EXPLORE WHAT THAT COULD MEAN

An estimated 10% to 20% of Canadians do not have adequate drug coverage through Canada's mix of public and private plans.[1] The question for most is not whether filling the drug coverage gap is necessary… or whether change is on the horizon… the question is, what form should the change take? The term "pharmacare" is thrown around a lot as a possible solution, but debate abounds as to what this could mean, so let's explore the pharmacare possibilities.

Canada's current approach already includes 'pharmacare'

In terms of providing publicly funded drugs for a population, a pharmacare program can be universal—meaning that it covers the whole population—or it can target specific groups within the overall population.

The concept of *national universal drug coverage*, a single system of public insurance coverage where the government provides all medically necessary prescription drugs equitably to all Canadians, has been debated for over 60 years by a wide range of experts, government bodies, and research studies.[2] For many, this is the default definition of national pharmacare.

Under this definition, Canada currently does not have a national pharmacare program. What we do have are different regions of Canada taking different approaches to providing publicly funded drugs to specific population groups—but all under the same banner: provincial pharmacare.

The design taken by each province and territory varies regarding a number of factors, including which population groups are targeted, which types of drugs are covered, and how it is financed. For example, targeted populations include low-income earners, people with certain diseases and conditions, children, and seniors. Ontario's recent creation (and now reform) of OHIP+ is an example of a program that targets children and youth.

OHIP+ was launched under Ontario's former Liberal government with the vision that those under 25 in Ontario (so not nationally and not all Ontarians) receive government coverage for most (but not all) drugs. However, now that the Progressive Conservatives are in power, we are already seeing changes. At the time of writing, although the details are few, the new government announced that under OHIP+ children and youth who are not covered by private plans will continue to receive eligible prescriptions for free, but those covered by private plans will bill those plans first, with the government covering any remaining eligible costs of prescriptions.

WHO'S FALLING THROUGH THE DRUG COVERAGE CRACKS?

- → It is estimated that 2% of Canadians have no drug insurance coverage at all and of those who do not have drug coverage, 26.5% cannot afford their prescription medicines.[3]
- → Those who cannot afford their medications often include older adults—like those between 55 and 64 years old—where one in eight cannot afford their medications but are not old enough to qualify for public drug benefit plans aimed at seniors.[4]
- → In addition, 10% of people who have some form of coverage are still not able to afford some of their prescriptions.[5]

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Typically, drug financing by provincial and territorial pharmacare programs includes a mix of entirely publicly financed drugs, as well as drugs where a portion of the cost is publicly covered and the remainder is paid out-of-pocket and/or through private coverage like a group health benefits plan.

And in terms of private plans, approximately 25.3 million people—or 70.5% of Canada's population—have full or partial drug coverage through approximately 113,000 private drug coverage plans sponsored by employers, unions, professional associations, or purchased individually.[6] These plans are purchased from 132 private health insurance providers across the country that offer various types and amounts of coverage.[7]

It is this mix of private and public approaches across Canada that has led to our system often being referred to as a "patchwork" of coverage. Canadians who are not covered by our mix of public and private plans fall into the drug coverage gap. But how best to fill this gap? Answering this has led to the decades-long debate that is now picking up steam.

SNAPSHOT OF TODAY'S PUBLICLY FUNDED DRUG COVERAGE

The April 2018 report from the House of Commons health committee—*Pharmacare now: prescription medicine coverage for all Canadians, Report on the Standing Committee of Health*—provides an overview of prescription drug coverage in Canada. Here's a snapshot:

The federal government provides drug coverage for approximately 3% of the population through plans for First Nations and Inuit, members of the Canadian Armed Forces, veterans and the RCMP, federal inmates, certain classes of refugees, and federal public servants.

Provincial and territorial governments offer approximately 70 different prescription drug programs that take various forms, but fall into three categories:

1. **Catastrophic prescription drug coverage** is offered by just over half of Canada's provinces and territories with varying benefit payment structures (premiums, deductibles, and co-payments) as well as caps on out-of-pocket payments.

2. **General public prescription drug coverage** is offered by the following four provinces for people who may not have access to another form of drug coverage:
   - → **Quebec:** requires residents to have drug coverage either through a private plan or through the government's public plan. All private plans must offer the equivalent coverage of what is offered in the government public plan.
   - → **Alberta:** offers a supplementary health insurance program for residents under the age of 65 and dependents.
   - → **New Brunswick:** offers coverage to residents who do not have drug coverage through their employer or a government plan, or whose other forms of drug coverage do not cover a necessary drug.
   - → **Prince Edward Island:** offers coverage for generic drugs listed on the province's formulary to residents 65 and older who do not have private prescription drug coverage.

3. **Targeted prescription drug plans** are offered to special populations that vary by province and territory (i.e., special populations like low-income earners, people with specific illnesses that require high-cost drugs, children, and seniors).

To learn more and access the full report, visit: http://publications.gc.ca/site/eng/9.855506/publication.html.

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Buckle up, change is definitely coming

With national pharmacare phasing in and out of debate since the 1960s, why is it now in the spotlight?

A main reason is in response to ongoing concerns about rising drug costs. As industry insiders, you know firsthand the myriad issues continuing to make rising drug costs a major concern. In fact, in 2015 Canada's per capita drug expenditure ranked third-highest among 29 OECD countries, behind only the United States and Switzerland.[8]

This cost trend is predicted to continue as high-cost specialty drugs are increasingly used to treat complex chronic conditions like hepatitis C, cancer, and rheumatoid arthritis. And then, of course, biologics also come with high price tags, as do many drugs to treat rare diseases. Combined, this all adds up to increasing unaffordability for both public and private plans. Accordingly, drug plan reform is back on the table—but what could pharmacare of the future look like?

Exploring Canada's pharmacare of the future

On April 18, 2018, the House of Commons health committee released the report *Pharmacare now: prescription medicine coverage for all Canadians, Report on the Standing Committee of Health.* The report recommends a national universal pharmacare program. Specifically, expanding the Canada Health Act to include prescription drugs dispensed outside of hospitals as an insured service to create a universal, single public-payor prescription drug program for all Canadians.

The idea is that funding would be cost-shared between federal, provincial, and territorial governments. The program would also include the development of a national voluntary prescription drug formulary through collaboration between federal, provincial, and territorial governments, health-care providers, patients, and Indigenous communities. These groups would help guide reimbursement decisions and promote consistency in drug coverage listing decisions across the country. Based on estimates from the federal parliamentary budget officer, the committee suggested that this kind of universal plan could realize $4.2 billion in savings on Canada's current bill.[9]

Now on to the practical: how would this vision operationally come about? Although feedback on the report is varied, there is a common theme that even some of the committee members acknowledge: the report leaves many questions unanswered, such as questions around costs and jurisdictional implementation.

The roots of the confusion may hark back to before the report's release when the federal budget established the Advisory Council on the Implementation of National Pharmacare to be chaired by Dr. Erik Hoskins (previously Ontario's Minister of Health and originator of the OHIP+ program). The words "implementation" and "national pharmacare" in the advisory council's name led many to assume that the government plans to implement the default definition of national pharmacare (remember, that's a national single-payor system covering a list of drugs considered medically necessary).

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> **IN 2015, CANADA'S PER CAPITA DRUG EXPENDITURE RANKED THIRD-HIGHEST AMONG 29 OECD COUNTRIES, BEHIND ONLY THE UNITED STATES AND SWITZERLAND.**

However, just a day after the budget was tabled, Minister of Finance Bill Morneau said that although the goal is to fill the drug coverage gap, this does not necessarily mean building a whole new system. Minister Morneau also voiced concerns about the potential financial burden of a national pharmacare program, suggesting that a gap-filling approach would be the "fiscally responsible" route (comments consistent with the concerns voiced by the Canadian Life and Health Insurance Association—more to come on that, keep reading).[10]

Regarding costs, the report recognizes the associated costs by stating that, before potential savings are realized, a national pharmacare program would need to assume significant costs currently borne by the private sector—significant as in $10.7 billion.[11] Accordingly, the committee feels that realizing the $4.2 billion in savings would involve:

- → Cost-sharing between federal, provincial, and territorial governments.
- → Expanding and building capacity within the Canadian Agency for Drugs and Technology in Health and the pan-Canadian Pharmaceutical Alliance to support the development of a pan-Canadian formulary and more robust price negotiations.
- → Undertaking consultations with employers, unions, private drug plans, and the Canadian public to identify the best possible approach towards financing this new program.

In addition, shedding some light on how funding as well as jurisdictional implementation might work, the report's recommendations include that "the Government of Canada provide additional funding to provinces and territories through the Canada Health Transfer to support the inclusion of prescription drugs dispensed outside of hospitals as an insured service under provincial and territorial public health insurance programs under the Canada Health Act."[12]

More recently, there have been developments regarding what the Advisory Council on the Implementation of National Pharmacare plans to accomplish. On June 20, 2018, the minister of health and the minister of finance announced that the federal government had appointed six members to form the council chaired by Dr. Hoskins. They also clarified that the council will be conducting a fiscal, economic, and social assessment of domestic and international pharmacare models.[13] On June 29, 2018, Dr. Hoskins attended a meeting of Canada's federal, provincial, and territorial health ministers. He outlined various pharmacare issues with answers still to be determined regarding how broad the final recommendation will be and who will pay for it.

Over the next few months, the council will consult with Canadians, health care experts, patients, interested stakeholders, and provincial, territorial, and Indigenous leaders to learn their views on pharmacare. Part of this consultation process will include an online questionnaire that Canadians can submit to share their views with the council. There is also a discussion paper—called *Towards Implementation of National Pharmacare*—available online that provides an overview of Canada's current drug coverage system.

So all of this to what end? The council will consider all input as it develops an interim report for the minister of health and minister of finance, targeted for submission later this year. Then the council is aiming to submit their final report in the spring of 2019 just prior to the October 21, 2019, federal election. The final report will provide the federal government with recommendations on how to best move forward on implementing a national pharmacare program. Will it reflect the default definition of national pharmacare or another approach to drug coverage reform? Time will tell; in the meantime, we can certainly explore other approaches.

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Thinking beyond the default

The House of Commons health committee's vision is in the spirit of the default description of national pharmacare. However, there are a number of other models of reform that have a different take on how best to address the coverage gap. For example, here are some commonly discussed variations of what pharmacare could mean for Canada:

- → **Collaboration between public and private payors to negotiate reduced drug costs through the pan-Canadian Pharmaceutical Alliance (pCPA):** This partnership has already achieved significant savings on some high-volume generic drugs.
- → **A national minimum formulary:** All public and private payors would be required to reimburse a yet-to-be defined list of the most common/essential medications. The number "125" is often cited for the size of the list. In our current environment, this could eliminate or force change to the emerging trend of hard dollar "drug caps" in benefit plans, but it may also lead to some plan sponsors not paying above the minimum formulary, leaving the question of who will pay for new, more expensive, but ultimately life-saving drug therapies.
- → **A negotiated agreement between public and private payors on "orphan drugs":** These drugs treat rare conditions so there is not a huge demand for them. As a result, there is little incentive for drug manufacturers to focus on orphan-drug research. Accordingly, to offset their research and development costs, the drugs have hefty price tags. If the government provided coverage for them, not only would more patients be able to afford them, but drug companies would also have more incentive to develop them in the first place.

The insurance industry's take?

In response to the House of Commons health committee's pharmacare report, Stephen Frank, president and CEO of the Canadian Life and Health Insurance Association (CLHIA), expressed concern about the financial burden associated with the committee's recommendations. In addition, Stephen emphasized many of the issues he previously discussed as part of **GSC podcast episode five** (if you haven't heard it yet, head over to the GSC website):

"Pharmacare is a growing discussion that's happening provincially and on a pan-Canadian basis and also now federally. The CLHIA has been really trying to make sure we've been part of that discussion so we have a voice and an influence. This is because private plans are extremely important. Private plans provide fantastic coverage and service to those who have them, and people who have them overwhelmingly appreciate them. So what we don't want is change to have unintended consequences where there is a pullback by employers or a pullback in the availability of private coverage. Any change needs to be done in a thoughtful way and needs to have a full understanding of the implications of different models. The trick for our industry is to be very proactive coming up with solutions even though it means change for us."

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PRIVATE PLANS LEADING THE WAY THROUGH INNOVATION AND COST CONTAINMENT

Although access to innovative new products is challenged by high costs, new products are still reaching the population through private plans.

In addition, the insurance industry has worked collaboratively to create a high-cost drug pool to support small- to mid-size employer plans.

…And although more collaboration is necessary in the future, work with public payors—like the pan-Canadian Pharmaceutical Alliance—has brought some cost relief. Reform of the Patented Medicine Prices Review Board is also in progress and this is essential to managing future costs.

As for GSC? Given that GSC's mission is *to create innovative solutions that provide access to better health*, it will come as no surprise that GSC fully supports finding a way to fill this gap and provide drug coverage to fellow Canadians in need. As Steve Bradie, GSC's president, explains:

"To be clear, our industry fully supports any initiative that will identify and provide drug coverage to fellow citizens who do not have access to pharmaceuticals. We are a rich country and no one should be left without appropriate access to life-sustaining and life-saving medications. But we think the majority of Canadians are well served by their private plans. And that the jobs that those plans generate in our industry are a significant contributor to the Canadian economy."

Similar to the CLHIA, GSC's perspective is that private drug plans are serving an important role in providing robust coverage and tax-effective compensation to the majority of Canadians. Accordingly, filling the health coverage gap should be accomplished without the loss of private drug plans.

Shape the future with innovative ideas

Needless to say, these are interesting times for all Canadians and especially all of us in the insurance industry. But change won't happen overnight. There is a two-year window until the next federal election, which provides an opportunity to help shape the future. GSC is already part of the conversation on how best to fill the drug coverage gap, and we hope others in our world join in too. Innovative ideas anyone? We know we'll be stretching ourselves to consider strategies that may not have been considered in the past. We're on it!

Sources:

[1, 6-9, 11, 12] *Pharmacare now: prescription medicine coverage for all Canadians*, Report on the Standing Committee of Health, House of Commons, April 2018. Retrieved July 2018: http://publications.gc.ca/site/eng/9.855506/publication.html.

[2] "Canadian Pharmacare: Looking Back, Looking Forward," Steven G. Morgan and Jamie R. Daw, US National Library of Medicine, National Institutes of Health, August 2012. Retrieved July 2018: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3430151/.

[3-5] *A Prescription for a Healthier Canada, Rx: PharmAccord*, Canadian Pharmacists Association, 2017. Retrieved July 2018: https://www.pharmacists.ca/cpha-ca/assets/File/cpha-on-the-issues/PharmAccord_Final_Online.pdf.

[10] "Translating the budget's 'pharmacare' promise, It was a roller-coaster week for health care advocates awaiting a pharmacare program for prescription drugs," Kelly Crowe, CBC News, March 3, 2018. Retrieved June 2018: https://www.cbc.ca/news/health/second-opinion-budget-pharmacare-1.4560101 and "Commons committee recommends single-payer pharmacare system," Kyle Duggan, iPolitics, April 18, 2018. Retrieved June 2018: https://ipolitics.ca/2018/04/18/commons-committee-recommends-single-payer-pharmacare-system/.

[13] Government of Canada launches Advisory Council on the Implementation of National Pharmacare, Health Canada, Government of Canada, June 20, 2018. Retrieved July 2018: https://www.canada.ca/en/health-canada/news/2018/06/government-of-canada-launches-advisory-council-on-the-implementation-of-national-pharmacare.html.

What's UP...

HEPATITIS C TESTING RECOMMENDED FOR CANADIANS BORN BETWEEN 1945 AND 1975

Recently updated guidelines for testing and treating hepatitis C recommend that Canadians should be tested not just based on possible risk factors, but also based on when they were born. The majority of people with chronic hepatitis C in Canada were born between 1945 and 1975, yet it is estimated that up to 70% of this group has not been tested. However, because it can take decades before seeing symptoms, 40-70% of those infected may not be aware that they have the virus. People at high risk for hepatitis C include those who shared needles for IV drug use; had a tattoo or body piercing done with unsterile equipment; had unprotected sex with multiple partners; or received a blood transfusion, blood product, or an organ transplant prior to 1992.

Estimates also include that more than 250,000 Canadians may be infected with hepatitis C and that between two-thirds and three-quarters of them were born from 1945 to 1975. As a result, the updated guideline—*The management of chronic hepatitis C: 2018 guideline update from the Canadian Association for the Study of the Liver*—recommends that anyone born within this timeframe should be tested. Basing testing on age is similar to other testing practices like blood pressure or cholesterol checks and colonoscopies.

Most people exposed to the hepatitis C virus are able to clear the infection. However, chronic infection can lead to cirrhosis of the liver or liver cancer. When someone develops symptoms they already have advanced liver issues. Also, once sick, the treatments don't work as well in that they can cure the infection, but not completely reverse the liver damage. Screening for the virus involves an inexpensive blood test.

For more information and to access the guideline, visit http://www.cmaj.ca/content/190/22/E677.

PLAN SPONSORS UNDERESTIMATE THE INCIDENCE OF CHRONIC CONDITIONS

Findings from the 21st edition of *The Sanofi Canada Healthcare Survey* include that plan sponsors worry about the impact of unmanaged chronic disease on workplace productivity; however, they underestimate the proportion of their workforce with a chronic condition. Fifty-eight per cent of surveyed plan members report having at least one chronic disease or condition, yet plan sponsors estimate that just 29% have a chronic condition. Among those with a chronic condition, 47% report missing work or finding it more difficult to do their jobs due to their condition. This rises to 72% for those with a mental health condition like depression or anxiety.

Fortunately, 84% of plan members with a chronic disease would like to know more about their condition and how to treat it. For example, the majority of plan members are keen to meet with health care professionals (who are not doctors) to learn their personal risk for a wide range of diseases. In addition to personal health risk screening, 75% of plan members are interested in coaching from a pharmacist as a benefit in their plan, and 68% of plan sponsors are interested in providing coverage for coaching services by a pharmacist. Overall, 79% of plan sponsors would like their health benefits plan to do more to support plan members with chronic diseases.

Additional findings include…

→ *Satisfaction with benefit plans:* Most plan members are positive about the quality of their health benefits plan. Variables that boost satisfaction include that the plan member has excellent/very good health, is satisfied with their job, has a household income greater than $100K, and in terms of their plan, that it has workplace wellness programs and a health care spending account. Variables that lead to lower satisfaction include poor personal health, low job satisfaction, and household income below $30,000, and regarding their plan, that it does not have a wellness program or a health care spending account.

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→ *Benefits use:* Drugs continue to be number one with 85% of plan members using their drug plan at least once in the past year; 85% also used their dental plan at least once. Regarding paramedical services, 53% submitted at least one claim in the past year. In terms of medical cannabis, 64% of plan members agree that their plan should cover it when it is authorized by a doctor. By contrast, only 34% of plan sponsors feel their plan should cover medical cannabis, and 8% report that their plan already covers it.

→ *Plan design:* The biggest concern is drug plan sustainability: (33% for plan sponsors in non-unionized workplaces and 34% for those in unionized environments). The second-biggest concern was dental plan sustainability (27%) for non-unionized and, for unionized, the inability to make major changes to their plan due to collective bargaining agreements (30%).

→ *Communications:* 66% of plan members report that they would agree to receiving information on personal health issues based on their use of benefits like their drug claims. Topics of most interest include information about their medications (52%), recommended local health care professionals or experts (51%), and how to manage their conditions (47%). Similarly, 64% of plan sponsors indicate that they would be interested in their insurer sending targeted health information to consenting plan members.

The report also includes "Top 10 Calls for Action" for plan sponsors and benefit providers. It's a summary of learnings drawn from the survey results and the experience of the survey's advisory board members.

To find out more and to access the report, visit http://www.sanofi.ca/l/ca/en/layout.jsp?cnt=65B67ABD-BEF6-487B-8FC1-5D06FF8568ED.

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

Halifax Benefits Summit

September 20, 2018, Delta Hotel Halifax, Halifax, Nova Scotia

https://www.benefitscanada.com/conferences/halifax-benefits-summit?oft_id=33864047&oft_k=aSNGkMVU&oft_lk=l8TpwL&oft_d=636662153191900000

Marilyn Jung, GSC's pharmacy strategy analyst, will be speaking about biosimilars and the evidence supporting patient transition programs.

July/ August Haiku

What is pharmacare
And who will pay in the end
A vexing question

FITBIT WINNER

Congratulations to **J. NOREJKO**, of **ST. ANNS, 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.

Windsor	1.800.265.5615	**Vancouver**	1.800.665.1494
London	1.800.265.4429	**Montréal**	1.855.789.9214
Toronto	1.800.268.6613	**Atlantic**	1.844.666.0667
Calgary	1.888.962.8533	**Customer Service**	1.888.711.1119

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