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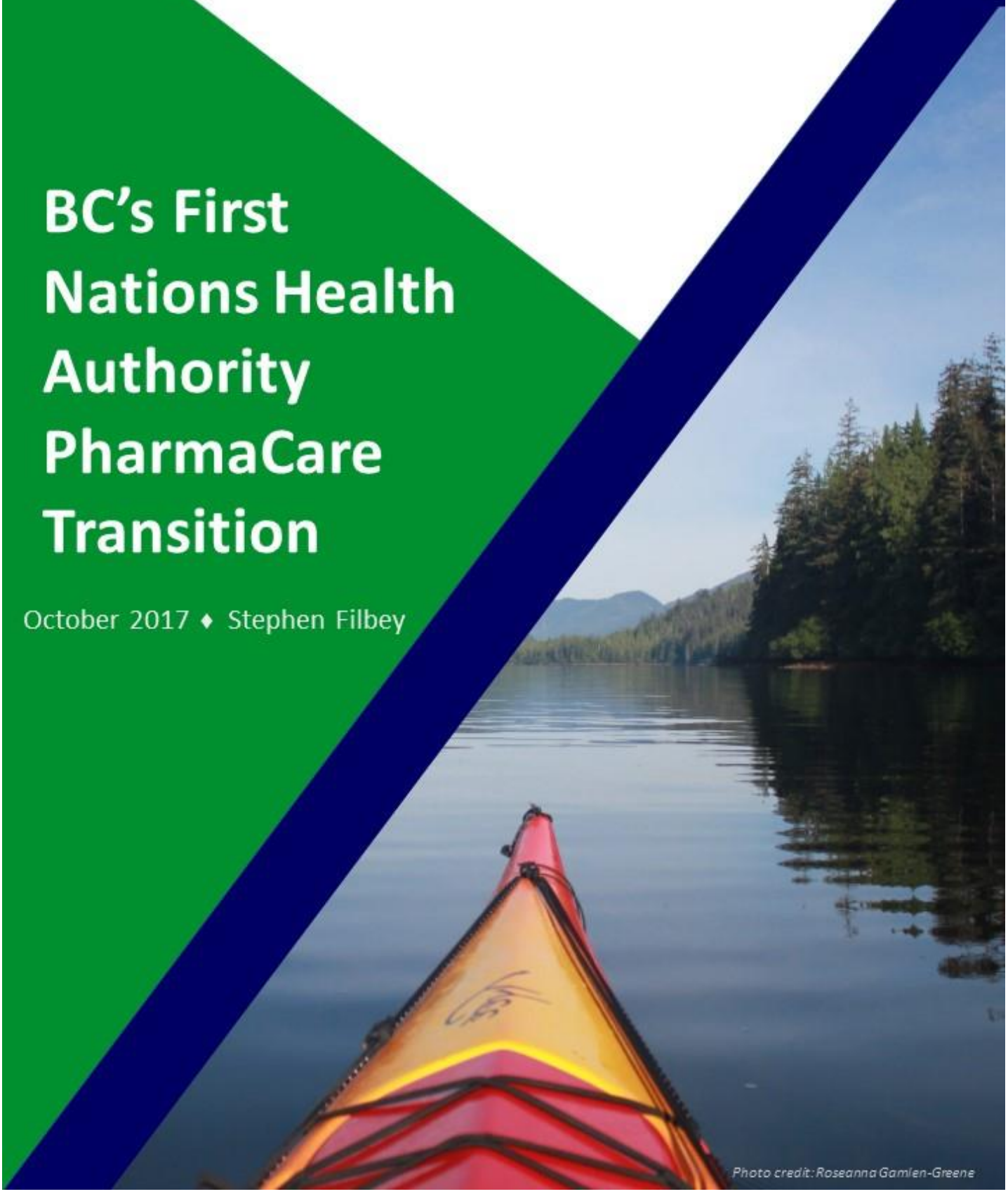
# BC's First Nations Health Authority PharmaCare Transition

October 2017 ♦ Stephen Filbey



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## Executive Brief

The First Nations Health Authority (FNHA), formed in 2013 in the province of British Columbia, is the first province-wide health authority of its kind in Canada. Its objective is the full transferral of programs, services, and responsibilities that were under Health Canada's First Nations Inuit Health Branch (FNIHB) – Pacific Region's former jurisdiction. One of the many components of the FNIHB's programs is the Non-Insured Health Benefits (NIHB) program. Still in its early days as a health authority, it has not been idle. It would be more accurate to describe the FNHA as ambitiously adhering to its guiding vision to "transform the health and well-being of BC's First Nations and Aboriginal people by dramatically changing healthcare for the better."[1]

The birth of FNHA is not the only *Canada's first* for this organization. On October 1, 2017, the FNHA succeeded in partnering with BC PharmaCare to deliver the transition of the largest portion of its services, mainly the Prescription Drug Program and Over-The-Counter (OTC) coverage. The remaining services and programs associated with Vision, Dental and Medical Supplies & Equipment will be fully integrated through a yet to be identified third-party service provider in the near future.

The NIHB drug formulary program is a payer of last resort while the BC PharmaCare Drug Benefit Program is a first-payer plan. The transition to a newly formed program under BC PharmaCare, Plan W, will result in a significant shift from a payer of last resort to a first-payer system for the 143,000 plus membersof FNHA. The transition will mostly happen behind the scene, and there has been a comprehensive information and outreach campaign to help prepare and build awareness with a focus on both individuals and healthcare providers. Patients have been and continue to be directed to contact the FNHA should they experience any challenges or require assistance. It is expected that Plan W will, for most individuals, provide the same coverage they have experienced in terms of specific prescription medications. The plan is also a fully paid service so no income reporting is required and all fees are covered by the plan. With such a comprehensive public payer transition, FNHA has estimated that approximately 10% of its members will experience various challenges in accessing the drugs they are currently using to manage their health. This percentage is expected to be higher for compounded preparations and OTC products that have previously been covered through Health Canada's NIHB program.

At its most basic level, the FNHA / BC PharmaCare Plan W mirrors BC PharmaCare Plan I, and not the NIHB drug formulary. In addition it does cover some OTCs previously covered through NIHB, provides access to all other BC PharmaCare plans if patients qualify, and allows patient access to BC's Agencies and their drug formularies such as the BC Cancer Agency, BC Centre for Excellence in HIV/AIDS, BC Renal Agency and BC Transplant. Although this provides greater service and formulary alignment across the province it does not come without consequences. There are differences between BC PharmaCare Plan W and the NIHB drug formularies and various

[1] First Nations Health Authority Website, September 2017. Link: http://www.fnha.ca/about/fnha-overview

strategies will be implemented to address these issues such as grandparenting coverage in some cases, or medication transitions.

The main groupings of challenges identified are: drugs previously covered by NIHB but will no longer be covered under PharmaCare Plan W, exceptional special authorities, special authority plan transitions, reassessment of drug therapy, alteration of therapy consideration in the same drug class, change in strength or format, change in manufacturer, and out-of-province coverage. For most, there will be no changes and the transition should be seamlessly accomplished in the background, while for others, there will be significant consequences that may result in a change in drug therapy.

The BC experience with therapeutic substitution policy in 2003, clearly demonstrated that drug formulary changes can be "associated with higher overall healthcare utilization."[2] It is my opinion that similar outcomes are likely with this transition and changes in treatment will be associated with a spectrum of personal experiences from seamless to more complicated treatment challenges.

To improve our medical system, change on this scale is inevitable. Transitions such as this however, offer a unique opportunity to measure both the human impact and financial outcomes. I would like to have seen a well thought out, formal approach to capture and publish the results. I hope this has not been a missed opportunity.

## Accessing Plan W, First Payer Coverage

To access coverage a BC Service Card and Status Card are required. The transition was designed to happen seamlessly in the background without the need for extensive paperwork, forms or other administrative tasks. Like the NIHB program, PharmaCare Plan W is a 100% coverage plan having no income remittance or testing and no fees. The BC Medical Services Plan (MSP) fees are also covered by FNHA.

The BC PharmaCare Plan I and its FNHA counterpart, Plan W, are both First-Payer plans which represent a significant shift from the patient perspective, especially for those who have third-party insurance coverage, for example through an employer. In cases where the patient's drugs are covered under PharamCare Plan W, the new system will result in the retention of any remaining portions of their drug plan that may have a life-time cap.

The FNHA program should result in greater alignment with provincial practices and services, offer greater familiarity of services through the various healthcare providers including doctors, pharmacists, and nurse practitioners, provide expanded access to the other BC Agency services

[2] Skinner B.J., Gray J.R, Attara. GP, Increased health costs from mandated therapeutic Substitution of proton pump inhibitors in British Columbia, Alimentary Pharmacology & Therapeutics; 29, 882-891

and better position the FNHA to transform benefits to reflect the cultures and perspectives of BC First Nations.[1]

## Special Authorities

Over 100,000 Special Authorities (SA's) were arranged and put in place to ensure continuity of coverage on October 1st. In the situation where Plan W does not cover an existing medication, Exceptional SA's are in place providing grandfathering. Patients may experience changes with respect to SA coverage in that many SA's are indefinite but others require renewal. In those cases where renewal is required, doctors will need to apply for SA within 4 – 6 months. There remains some uncertainty and need for greater clarification with respect to the renewal situation where patients must apply for SA within the 4 – 6 month window. What remains unclear, is how will the SA strategy interlock with the Reassessment of Therapy and Drug Alternative Consideration strategies when patients may not fully qualify under PharmaCare Plan W for their SA drug therapy. If challenges are encountered, patients have been directed to contact FNHA. There are also certain drugs intended for short-term treatments, these will be granted a 35-day expiration period.

## Other PharmaCare Plan W Challenges

For a small subset of patients, there are the following four other potential challenges imposed by the transition:

**Reassessment of Therapy:** For some therapies where other options exist and the current drug is not covered after October 1st, physicians will be asked to reassess therapy and make changes where possible to drugs which are covered under PharmaCare Plan W. A few specifics the FNHA has noted have been Diabetes (Acarbose and Repaglinide), Denosumab, Cefzil and its generics, Terconazole vaginal, and Retinal program drugs.

**Drug Alternative Considerations:** When a drug is not covered by PharmaCare Plan W and there exist other drugs within the same class of drugs that are covered, patients will be required to switch to a product that has coverage in the same drug class. Physicians will be asked to consider an alternative drug that is covered and it is expected that there are more than 1,800 individuals who will be affected. FNHA has identified the following products as falling into this category of change: Alfuzosin, eye drops (Fucithalmic, Moxifloxacin and Nepafenac), Sitagliptin +/- Metformin and DermOtic ear drops.

**Change in Strength or Format:** There are many expected instances where certain strengths or formats are not covered, in these situations a change in dose or drug is not expected. Patients will be required to only change strength or format depending on the situation. One example is Ramipril, where the 15 mg strength is not covered but the 5 mg and 10 mg are covered. A change in format for example, would be a change from an ointment to a cream. All of these changes can take place at the pharmacy level of the healthcare system.

**Change in Manufacturer:** With a multitude of generic products on the Canadian market, PharmaCare Plan W will not cover all the products. In many situations, only some of the manufactured generics of each drug are covered. PharmaCare has a Lowest Cost Alternative (LCA) policy where coverage is capped at the price of the LCA and this policy applies throughout Plan W where LCA's are designated. Patients are able to use a generic that is covered or any other product with the same active ingredient, including the Brand Name products, but coverage is up to the cost of the LCA. This may result in patients switching from one manufacturer's product to another.

## BC Agencies

Within the BC medical system exists some highly specialized agencies: BC Cancer Agency, BC Centre for Excellence in HIV/AIDS, BC Renal Agency, and BC Transplant. Each Agency is responsible for their drug formulary which is separate from BC PharmaCare's various plans including Plan I and Plan W. After the October 1st transition these agencies will continue to be accessed directly through physician offices by referral. Prescribed medications covered by their formularies will be dispensed through each Agency's unique pharmacy distribution chain. This represents a significant shift and may result in changes for patients in terms of where they are able to pick up their prescriptions.

NIHB will provide 6 months of ongoing coverage for existing patients falling under these Agencies to ensure a continuance of coverage and service. FNHA is supporting patients through the process of registering with the provincial Agencies. Patients are asked to contact FNHA to address any specific challenges.[1]

## Out-of-Province Travel

Perhaps the least obvious challenge, having been serviced under a federal program, is that BC PharmaCare and FNHA are provincial and as a result, out-of-province drug coverage becomes problematic. Patients are encouraged to fill prescriptions in advance of leaving the province, advised to obtain the maximum day's supply of their medications, and to consider PharmaCare's Travel Supply Policy.

In those situations where out of province prescriptions are filled, clients are asked to pay out-of-pocket and submit official pharmacy receipts for reimbursement.

## Areas Not Addressed

There are many aspects of the transition that have not been addressed in this brief overview. I would ask that you contact FNHA and BC PharmaCare directly, as they both have information available on their websites. FNHA has been very responsive, provided multiple updates, and has made a significant effort in orchestrating its over-all communication strategy during this complex transitional task.

## Respecting & Honoring Change

For those having to navigate this transition, perhaps the best way to respect their experience, is to measure the human and the financial impact so BC, and indeed Canada, can better understand the full scope of making changes to improve our system. I would be curious to know if it would be less expensive in the long run, to simply grandfather all coverage as a cost of making improvements, and only apply the formulary changes with those accessing the system with new prescriptions. It would be nice to see a publication on the transition and the various real-world -outcomes.

## About the Author

**Stephen Filbey** is the founder and Principal Consultant at WestPAR Consultancy Inc. He is an accomplished professional with more than 30 years of experience in the pharmaceutical and related industries and has been working throughout the western provinces for 27 years. Over the 10 most recent years, Stephen has guided more than 40 organization in developing and implementing Reimbursement, Market Access, Advocacy and Policy Strategies throughout Western Canada, addressing rare disease, oncology, non-oncology and medical device files. He has successfully negotiated multiple agreements with BC PharmaCare, BC Cancer Agency, Alberta Health, Saskatchewan Pharmaceutical Services Unit and the Saskatchewan Cancer Agency, and has contributed to pCPA strategy development from a western perspective.

Stephen holds a Bachelor's degree in Science from the University of Windsor and has completed a one year, non-accredited Continuing Medical Education & Needs Assessment Internship through the department of CME at the University of Calgary.

## Acknowledgements

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*FNHA:* *Source*

*BC PharmaCare:* *Source*

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## References

1 First Nations Health Authority Website, September 2017. Link: http://www.fnha.ca/about/fnha-overview

2 Skinner B.J., Gray J.R, Attara. GP, Increased health costs from mandated therapeutic Substitution of proton pump inhibitors in British Columbia, Alimentary Pharmacology & Therapeutics; 29, 882-891