Breaking through Silos

Why bridging drug costs, health benefits and primary care is essential for Canada’s health

A TELUS Health industry discussion paper

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About this Paper

This discussion paper was developed to explore the intersection between cost management and health outcomes within the complex private health benefit ecosystem. In it, the authors and industry leaders highlight the need to redefine collaboration among private payors, physicians and pharmacists and look at how technology can enable this collaboration to enhance health outcomes and reduce costs.

Although public payors play a key role in the Canadian healthcare system (and there is a need to better integrate public and private coverage), this paper focuses on the opportunities to improve collaboration within the private payor market.

Interviews were conducted with thirteen leaders involved in supporting the complex private health benefit ecosystem – private payors, brokers and consultants, as well as industry associations, pharmacists, family physicians and specialists.

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We want to hear from you!
Join the conversation and let us know what you think.
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Executive Background: A primer on private drug plans

“Before we can get to a place where we can leverage technology effectively, we need clarity at a system level. We need government and private payors to get thinking ‘we’re in this together.’ And, we need to be clear on where we’re truly competing in the market and where collaboration can benefit us all.”

Stephen Frank, Vice-President, Policy Development and Health at Canadian Life and Health Insurance Association (CLHIA)

Public versus private coverage

In the Canadian healthcare system, private payors are a key contributor and player. While physician visits and hospital care are publicly funded, publicly funded drug coverage varies by province. Therefore, a large portion of drug costs are paid for through private drug plans or out of patients’ own pockets.

In Canada supplementary health insurance takes over where government coverage ends, and in 2013 accounted for $22B or roughly 13% of total direct health care spending and 45% of the overall Canadian drug expenditures. Similarly, drugs account for nearly 45% of all private health insurance spending.

2013 Total Direct Health Care Spending

Source: Canadian Life and Health Insurance Association
This section provides a simple overview of the various players involved in the provision of health benefits. It’s important to note that regardless of how the risk is managed and shared, ultimately all drug claim costs flow back to the employer and impact their health benefit rates and their bottom line.

Employers and other plan sponsors

Most employers in Canada offer health benefit plans to employees as part of their total compensation package. The extent of the drug coverage offered to their employees is at an employer’s discretion*, but employers are typically not equipped to directly manage a drug plan any more than they are to manage their pension plan. Instead, they rely on the expertise of the insurance carrier or pharmacy benefit manager (PBM) to manage the drug plan for them.

Employers are the most prevalent type of plan sponsors, although unions, multi-employer trusts, boards of trade and professional associations can also provide benefit plans to their constituencies. In this ecosystem, plan sponsors are the ultimate customer. They decide on what coverage to provide and pay the bill. All others are suppliers.

*except in Quebec, where employer drug plans must provide coverage at a level equal to or better than Regie de l’assurance maladie du Québec (RAMQ) provincial drug plan.

Caption: multiple stakeholders, sometimes with competing interests, comprise the complex health benefits ecosystem. The question of who pays is a critical – yet perhaps the most misunderstood – part of the benefit-cost equation.
Private payors

The payor’s job is to manage drug plan risk and administer it on an employer’s behalf. They need to assess the risk of employees becoming ill and needing to make a drug claim, as well as the volatility and variability of drug costs. They use this assessment to determine the annual premium they will charge the employer.

The payor market is fragmented and competitive. Each seeks to differentiate themselves as the payor of choice for employers and, from a business standpoint, there is little incentive for collaboration. Yet, there is an emerging recognition that collaboration – or ‘co-opetition’ – will be highly desirable as the sector steps up to new challenges.

Administrative services only (ASO)

Some employers choose to manage their own drug plan risk and select an Administrative Services Only (ASO) arrangement with an insurance carrier. In these arrangements, the insurer pays drug claims and then bills the employer for the cost of the claims plus an agreed upon service charge, on a transaction or a percentage of the claims paid. With an ASO drug plan, the employer takes all the risk for the variability and volatility of drug costs.

Pooling

Even employers who choose to take on the benefit plan risk via an ASO plan often have an upper limit of risk tolerability they are willing or able to take on. Most purchase insurance protection called pooling. For potentially high cost or volatile claims, pooling transfers the liability of an individual claim that is greater than the pooling level to a group insurance pool that is created to share the risk. To benefit from this protection, plan sponsors are required to pay a pool charge to the insurance company. For example if the pooling threshold for drug claims is $10,000 and a plan sponsor has a claim for $25,000, the first $10,000 of the claim will be paid by the plan sponsor and the remaining $15,000 liability will be transferred to the pool.

As employers choose how to manage mounting costs, they do so with limited visibility. Whether it is due to privacy, lack of evidence or limited understanding of benefit plan management, it is a very real challenge for employers to see or understand where their drug plan dollars are being spent, why these costs are rising, or whether their spending is making employees healthier, happier or more engaged and productive. They have no way to truly assess if their drug plan is ideally designed to address their employees’ demographics, health status, and most common chronic conditions.
Dispelling Misconceptions

While healthcare budgets continue to decrease globally, the cost of drugs – and the cost of health benefit plans – is on the rise. In Canada, $22.2 billion is spent annually on drugs alone through public and private direct care plans. Over the past decade, 20% of drugs approved and nearly 30% of drugs under clinical development today are more costly biologic specialty drugs.

As a result, private drug benefit plans are becoming more complex and the implications for patients can be significant. For example, drugs that are prescribed may not be covered. In some cases the portion reimbursed to an individual for certain costly treatments is not adequate for a patient's budget, meaning prescriptions for much needed therapies may go unfilled, leaving a patient's health at risk. Despite the seriousness, these and other implications remain largely unexplored due to two commonly held misconceptions:

**Misconception 1:**
- most drugs will be included in the health benefit plans offered by employers to employees and their dependents;

**Misconception 2:**
- all drug costs are paid for by insurers, not employers

These misconceptions exist for valid historical reasons. In the past private drug plans – i.e., drug plans provided by employers – were generous and typically covered almost any drug prescribed. However, the introduction of new, groundbreaking and more costly specialty and biologic medications has changed the landscape. While the risk of health benefit plans is underwritten by private payors, it is in fact employers who ultimately pay the majority of the bill through annual premiums. In addition, some of Canada’s large employers are actually self-insured, meaning the costs are held by the employers themselves and, by extension, their employees.

**Funding fundamentals: who pays?**

Plainly stated, in Canada there exists general distaste for discussing cost-cutting relative to health benefits coverage. After all, how can for-profit organizations deny an insured individual coverage for an essential treatment?

Yet, as in other aspects of Canada’s health system, sustainability is a critical issue that cannot be ignored. The increasing costs of benefit plans have given employers no option but to find ways to rein in their health plan budgets. Taking charge of the increasing drug plan costs, which account for 45% of all private plan spending, is a clear way to achieve overall sustainability of the plan or cost reductions, depending on the plan’s objectives. Employers are working with payors to design benefit plans that do just that.

**Where cost management and care meet**

This paper explores an uncomfortable intersection between cost management and health outcomes. In speaking with stakeholders throughout this complex ecosystem it was clear that there exists a willingness for open discourse, education, understanding and, ultimately for collaboration and change.

Why? Because each constituency is ultimately invested in contributing to improved health outcomes. Furthermore, each sees redefining collaboration to create an affordable and sustainable system as the lynchpin to success. Finally, there is a commonly-held observation that everyone must care about costs: insurers and plan sponsors, as well as plan members, public payors, physicians and pharmacists. It’s time for change.

The question is how? How do we redefine collaboration in the siloed private payor market? How can digital technology enable this collaboration to enhance health outcomes and ultimately reduce costs?

These are the fundamental questions explored in this paper. It was informed by leaders and influencers representing key sectors of Canada’s healthcare and insurance continuum: insurers, insurance brokers and consultants; industry associations representing insurers, pharmacists and pharmaceutical companies; as well as practicing pharmacists, family physicians and specialists.

Although public payors play a key role in the Canadian healthcare system and there is a need to better integrate public and private coverage, this paper focuses on the opportunities to improve collaboration within the private payor market.

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1 This paper uses the general term “private payors” or “payors” to denote all the players that are involved in non-governmental, privately funded healthcare. This includes insurance carriers, as well as players that are not licensed to take on risk, such as pharmacy benefit managers, claims adjudicators or third party administrators who manage the benefits and pay the claims, but don’t necessarily provide “insurance”.
Why drug plan costs are rising

Overall drug costs have remained relatively stable over the last few years due to the large number of high-volume medications that lost patent protection and saw lower-cost generic alternatives enter the market. In addition, provincial drug reform has driven down the cost of some generics to as low as 18% of the brand name drug cost. These two factors have tempered the impact of the growth of new high-cost specialty medications, which are significant drivers of private drug plan costs. Although the average prescription cost for a private drug plan went up 2.4% last year, the impact of specialty drugs is quite different.

Although there is no formal definition of specialty medications, they are generally distinguished by the following characteristics: a need for intensive patient training and compliance assistance, limited or exclusive product availability and distribution, specialized product handling and/or administration requirements and generally cost, on average, more than $10,000 per year.

In 2014 specialty medications represented 22% of total private drug plan spend but only 0.4% of the claims. The average cost of a prescription for a specialty medication is $2,760 versus $53 for all other drugs. Specialty drugs increased 6% in one year, versus a 0.8% decrease for all other drugs.

Source: TELUS Health data warehouse, 2013 to 2014
Redefining Collaboration

“The more openness and dialogue the better, especially in times of tight resources; there’s no reason to make it harder than it needs to be.”

Dr. Jane Purvis, Rheumatologist, Past President, Ontario Rheumatology Association

The payor-provider-patient ecosystem is siloed. While solid links among some players exist – payors and employers, for example; others, most notably physicians, are left out of the mix almost entirely.

The collaboration that does exist is mainly point-to-point, rather than multi-directional, and leaves important gaps that prevent the most effective provision of care and the most efficient delivery of cost-effective treatments.

Silos inhibit best care provision

At best, these silos make it cumbersome for all players to coordinate their efforts to ensure that the right drugs are prescribed to patients and that, at the same time, these drugs are covered by a patient’s drug plan and are the most cost-effective option. At worst, it creates a highly ineffective and inefficient reality that negatively impacts all:

- Patients are unintentionally prescribed medications that are not covered by their benefit plans or require additional forms or paperwork to be submitted to the payor. This sometimes requires return visits to their physician, additional time away from work and associated discomfort or health risks associated with a delay in receiving treatment.

- Physicians are burdened with additional appointments, cumbersome paperwork, returning calls to pharmacists and the concern that a patient has gone untreated.

- Pharmacists spend time on the phone clarifying coverage with payors and with physicians to have prescriptions changed. They also take time explaining discrepancies to patients.

Potential Therapy Delays

1. Doctor provides Rx
   - Physician
   - Patient

2. Patient goes to pharmacy
   - Patient
   - Pharmacy

3. Rx requires special authorization
   - Pharmacist
   - Patient

4. Patient may return for another Rx
   - Patient
   - Physician
Despite these disconnects, all players in the ecosystem agree that the single most important goal is achieving the best possible outcomes for patients. Jeannette Wang, Shoppers Drug Mart's Senior Vice-President Professional Affairs and Pharmacy Services sums up what's important: “At the end of the day, we want to help make the right decisions for our patients – whether it's access to medication, or helping patients at the pharmacy counter, or making better clinical decisions. It has to be about the patient.”

Case in Point

Payor-Physician Collaboration

Pan-Canadian criteria for rheumatology biologics

Over the course of 2014, the Canadian Life and Health Insurance Association (CLHIA) and the respective provincial and the Canadian rheumatology associations have been collaborating closely to establish a common national minimum clinical standard for access to a biologic drug for the treatment of rheumatoid arthritis. The intent is to leverage the detailed expert knowledge of the rheumatologist community across Canada to set and maintain a minimum clinical standard for access to a biologic that is based on the most up-to-date clinical evidence. Ultimately, the goal is for private payers to generally provide access to a biologic on at least as favourable a basis as what is agreed to in the minimum clinical standard.

This collaboration represents an industry first. CLHIA anticipates firming up agreed-to criteria with the associations by mid-2015.

Great-West Life's Director of Group Strategic Relationships, Ben Harrison was part of the process. His take is that “the collaboration between the CLHIA and the rheumatology associations epitomizes the type of engagement that can be possible – and that we’d like to see more of with the physician community in general. Clinicians were open to learning and working with the insurance community and helping us balance what we call a ‘dual bottom-line philosophy’; that is, balancing the cost management needs of plan sponsors with the health outcomes of plan members.”

“...balancing the cost management needs of plan sponsors with the health outcomes of plan members.”

Ben Harrison, Director, Group Strategic Relationships, Great-West Life
Decoding the ‘Coverage/No-Coverage’ Black Box

“Every minute that you spend holding on the phone with a payor is a minute you could be with a patient.”

Chris Dalseg, Director of Business Development, Bioscript Pharmacy

Collaboration among payors and healthcare providers is relatively new. It is evolving rapidly and differs for pharmacists and physicians. Yet, in each case, care provision is hampered by limited insight into patient’s drug benefit coverage – seen as a ‘black box’ by many providers.

Today, the payor intersection with pharmacists is more defined than with physicians. This is to be expected, given that pharmacists are the first line of connection between a patient’s prescription and their drug coverage. Even so, pharmacists’ access to information regarding drug plan design is surprisingly limited.

Collaboration roadblock

The Pharmacy Claim Standard (PCS) was developed in the late 1980’s by the Canadian Pharmacists Association (CPhA) and industry stakeholders to replace paper claims and to provide online processing and adjudication of prescription drug claims. It provides a common platform language to share data across electronic communication networks and is used to adjudicate over 1.3 million pharmacy claims on a daily basis in Canada*.

The PCS is provided by CPhA at a minimal fee and has served the profession and the pharmacy industry for over 20 years. Today, however, it requires significant changes to address evolving needs. The expanding scope of pharmacists’ practice, the increasing number of high-cost drugs and the associated complexities of adjudication and co-ordination of benefits to insurers requires a communication protocol that is essentially a superhighway; one that connects pharmacy systems with benefit management systems. Today’s protocol is more akin to a gravel road. Without enhancements, the sharing of electronic information about drug claims will remain severely limited.

*Source; Canadian Pharmacists Association, July 2014
Pharmacists: an expanded role

Pharmacy adjudication systems were designed to simply determine if a drug is covered and, if so, by how much. The basic plan design information received in real time by pharmacists is generally limited to a binary ‘covered; not covered’ response and the amount to be reimbursed.

When a pharmacist receives a message that the drug is not covered, there is limited capability to provide an explanation as to why, or which other drugs may be covered. As Alan Kyte, practicing community pharmacist and Principal at Mercer notes, “Healthcare providers that deal with benefits on the drug side have very little understanding of how private insurance works, and they have virtually no visibility into benefit plans.” Without this information, they are restricted in the extent of support they can provide the patient or their physician. And they need to take time away from patients to contact payors or physicians to clarify options.

Phillip Emberley, Director, Pharmacy Innovation with the Canadian Pharmacists Association also sees opportunities for pharmacists to play an expanded role. “We know the stressors on plan sponsors and we need to be equipped with information to leverage our full scope of practice. There are bigger issues that we can collaborate on more effectively – like diabetes management, for example – and really make a meaningful impact on people’s health and quality of life.”

Case in Point

Payor-Pharmacist Collaboration

Diabetes support

In March 2015, Shoppers Drug Mart released the Sustainable Solutions Report: Pharmacist Interventions in Diabetes. The Diabetes Support Program facilitated access to services for Great-West Life plan members living with diabetes and showed how a 30-minute pharmacist intervention can make a significant impact.

Following a pharmacist-administered A1C test to determine the patient’s average blood sugar level over the previous three months, pharmacists provided patients with advice on how to control their illness, and modify their lifestyle, diet and other behaviors – and in some cases, referred them to a physician.

As a result, the number of patients that reached the target A1C level tripled after the first intervention with a pharmacist. Furthermore, 45% of participants had a clinically significant reduction in their A1C levels.

While the program was originally launched through a direct communication campaign from Great-West Life to eligible plan members, Shoppers Drug Mart pharmacists were able to also support program promotion at the point of care using drug claims details available to them.

As pharmacists’ scope of practice continues to expand – for instance empowering pharmacists to order lab tests or adapt prescriptions – there are greater opportunities for pharmacists to make a difference in patients’ management of their diabetes by providing accessible, expert service.
Physicians: intensifying patient advocacy

For physicians, visibility into drug plan coverage is virtually non-existent, which means they are prescribing without the benefit of knowing if there are cost or coverage implications that will affect a patient’s adherence to treatment. The impact is significant: about one in ten Canadians do not adhere to treatment because they cannot afford their prescription medications, which can put them at increased risk of adverse health outcomes.

“Physicians are advocating for their patient without having an understanding of who pays; if an employer can’t afford to pay or won’t without prior authorization, then the advocacy for that patient falls apart,” says Cathy Fuchs, Practice Leader, White Willow Benefit Consultants Incorporated.

Physicians regularly see the negative impact of prescribing drugs for which a patient is not covered. “There’s a big gap between what we think patients are doing with their meds and what they’re actually doing,” says Dr. Kevin Samson, East Wellington Family Health Team. “If I prescribe a drug, it doesn’t mean the patient fills the prescription or is taking it appropriately. If they don’t have coverage or can’t afford the payment, they may opt to go without or reduce their dose to make the prescription last longer. Having drug coverage information available during consultation would alleviate that. It’s almost negligent that we’re not doing this already.”

About one in ten Canadians do not adhere to treatment because they cannot afford their prescription medications, which can put them at increased risk of adverse health outcomes.
Technology: Supporting an accountable ‘care economy’

“Technology is an enabling tool, but not a panacea. There still needs to be very collaborative effort between a patient, a provider, a pharmacy and an insurer in making sure patients get the best outcome.”

Jeanette Wang, Senior Vice-President Professional Affairs and Pharmacy Services, Shoppers Drug Mart

One important step forward in collaboration is to decode the ‘black box’ on plan coverage for pharmacists and physicians so that they can expand their awareness of the economics of care. While this idea may have been unpalatable from a clinical perspective a few years ago (and may still be with some today); given the complexities of today’s tiered plan coverage, capitations, exclusions, prior authorizations and stepped therapies, it is becoming essential to collaborate with the provider community to ensure they have the right information at the right time in the right way.

Supporting accountability

Supporting accountability is a systemic challenge as well as a cultural one. “Physicians don’t necessarily see themselves as having a relationship with benefit plans; their responsibility is, understandably, to the patient,” says Marilee Mark, Vice-President Market Development, Group Benefits, Sun Life Financial. She goes on to explain that “having information about plan coverage and other resources and options available at the time a care plan is being developed by the physician and before a prescription or referral is made is a primary opportunity to improve patient outcomes. And, there’s additional untapped opportunity to have enhanced plan information available to pharmacists at the point they are reviewing the prescription prior to filling.”

There are many advantages to sharing drug plan information and relative cost of medications with physicians at the point of prescription. Improved medication adherence, more cost-effective yet equally effective therapies and a simplified patient-physician-pharmacist experience, are but a few.

“Physicians may be reticent to make decisions based on costs, but we need to start changing that mindset. We need to make it simple for them. Technology can do this,” notes Stephen Frank, Vice-President, Policy Development and Health, CLHIA. “Physicians currently have no visibility into the relative costs of the drug choices they are making. If they did, health outcomes being near-equal, would they consider an alternative if the cost implications were significant?”

Mobile access to drug plan information

Even though no systemic approach exists, connecting physicians with drug plan information is already being approached in a variety of ways.

For example, Medavie Blue Cross worked with an advisory panel of physicians when it developed its drug cost comparison mobile app that allows physicians to see the relative cost of medications by therapeutic category. “When we worked directly with the physicians, and shared data on the wide range of cost for drugs in a given class, the lights went on for them,” says Shelley Kee, Vice-President Group Business (Atlantic Canada) for Medavie Blue Cross. “They saw the clear connection between their patients’ coverage and the choices they as physicians made when prescribing one drug over another.”

Sun Life has gone down the path of developing a mobile app that provides details of coverage, cost and alternatives that employees can access and share with their physician and pharmacist at the point of prescribing. And Great-West Life has invested in similar mobile applications that allow plan members to access information about their drug plan with a particular focus on supporting medication adherence.
It’s understandable that to-date payers have been focusing their information-sharing efforts on employers and employees – the customers they know best. “To envision a solution where physicians have visibility into plan design, through to pharmacy requires a whole host of actors coming together who see themselves as part of an ecosystem,” says Stephen Frank, Vice-President, Policy Development and Health, CLHIA.

The EMR gateway

Electronic medical record (EMR) solutions are an important mechanism with which to equip physicians with drug plan information. EMRs have achieved significant adoption rates and are used by nearly 80% of physicians across Canada.

Because EMRs are a part of physicians’ day-to-day clinical activities, they can provide a digital entry point for drug benefit information that is already incorporated into physician workflow and connected with other aspects of the healthcare continuum. Doing so would eliminate a host of process challenges and ensure patients are receiving needed medications affordably and quickly.

Ben Harrison, Director, Group Strategic Relationships at Great-West Life articulates a reminder about the importance of relationships and collaboration with the provider communities. “These communities are relatively new relationships – there is still work to be done about understanding how they would like to use technology and what it means to them.” And, he offers a challenge to the collective status quo: “We insurers see technology as a means to provide better service to our plan members and also as an opportunity for cost management. I would be curious to see physicians’ perspective on technology. This is where more discussion needs to happen.”

A next chapter: expanding focus from cost to value

While the complexities of the siloed private payor landscape are undeniable, so too is the desire of various parties to find a new, collaborative way forward. There is a common recognition that a more transparent ecosystem will enhance health outcomes and reduce costs. But what lies beyond?

A next chapter could be to expand our collective focus from reducing costs to deriving more value from the system. From a technology standpoint, the possibilities are relatively straightforward: health analytics offer the possibility to deliver insights into the payor-provider-patient ecosystem that would enable linking data to mission-critical national health and wellness objectives. Information could be harnessed to examine pressing issues and inform action to address healthcare fundamentals, such as cost drivers, quality of care and timely access to care.

Yet, this chapter remains unresolved and may prove to be the most challenging to define. Privacy, managing consent and security are but a few pivotal issues on which stakeholders, including policy makers, will need to align.
Canadian Life and Health Insurance Association
Canadian Institute for Health Information’s National Health Expenditure Database (NHEX)
CMAJ February 21, 2012 vol. 184 no. 3; The effect of cost on adherence to prescription medications in Canada; Michael R. Law, PhD, Lucy Cheng, MSc, Irfan A. Dhalla, MD MSc, Deborah Heard, BASc, Steven G. Morgan, PhD