Submission

on the

NATIONAL PHARMACARE DISCUSSION PAPER

to the

Advisory Council on the Implementation of National Pharmacare

by the

Canadian Life and Health Insurance Association

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EXECUTIVE SUMMARY

Canada's life and health insurers are committed to working in partnership with federal, provincial, and territorial governments to ensure all Canadians have access to affordable prescription medicines. The work of the Advisory Council on the Implementation of Pharmacare is an important opportunity to build understanding of the problems with our current system and propose changes that will protect and enhance existing benefit plan, ensure drug coverage for everyone, and ensure affordability for consumers and taxpayers.

Canada's life and health insurers play an important role in providing prescription drug coverage to Canadians. Life and health insurers provide more than 25 million Canadians with access to a wide range of prescription drugs and other health supports through extended health care plans. As a key player in the system, the industry recognizes that real problems exist and that the time has come to take meaningful steps to make improvements for the benefit of all Canadians.

Improving the system requires more than simply "filling the gaps". Rather, improvements must involve systemic reform to address access to medications, as well as the cost and financial sustainability of the system.

The industry believes that there are three key elements that any reform of the prescription drug system must embody. These include:

Protecting and enhancing existing benefit plans

Private health benefit plans provide more coverage and choice for Canadians compared to public coverage. Canadians use their health benefits plans to access a wide variety of health services, including prescription medicines, vision care, dental care, mental health supports and many other services. These services both help prevent illness and contribute to overall wellness for Canadians.

Providing drug coverage for everyone

Governments should ensure that all Canadians can access and afford the medicines they need so that no one is excluded from coverage and are able to take their needed medications as prescribed. To achieve this, governments should establish a list of the medicines that everyone should be covered for through workplace plans for those who have a plan, and by government for those who don't. This list of drugs would be based on scientific evidence and include expensive drugs and drugs for rare disorders.

Ensuring affordability for consumers and taxpayers

Generally, two approaches for pharmacare have been put forward. One is for governments to nationalize all drug coverage and pay for all drugs directly on a first dollar basis. The second is to build from our current mixed system and to implement smart structural reform. The fiscal implications of these approaches have dramatically different outcomes for governments. Building off the current mixed private-public pharmacare model would minimize the overall fiscal impact to government and has the potential to address the issues we are trying to fix.

Regardless of the approach, it is important that governments work collaboratively and with private insurers to meet the objectives of ensuring everyone has access to their needed medications and to address the relatively high costs faced by Canadians.

INTRODUCTION

The Canadian Life and Health Insurance Association ("CLHIA") is pleased to provide its submission to the Advisory Council on the Implementation of National Pharmacare.

Canada's life and health insurers play a key role in providing a social safety net to Canadians. The industry protects 79% of Canadians through a wide variety of life, health, and pension products. The industry paid $92 billion (almost $1.8 billion a week) in benefits in 2017, with over 90% paid to living policyholders.

In the area of health care, life and health insurers provide more than 25 million Canadians with access to a wide range of prescription drugs and other health supports through extended health care plans. This includes approximately 6.5 million employees in the broader public service and their dependents. In 2017, insurers paid out $11.3 billion in drug claims through extended health care plans.

The industry believes the renewed interest in national pharmacare offers a unique opportunity to improve the prescription drug system in Canada. Working collaboratively, we can meet the objectives of ensuring that everyone has access to their needed medications and to address the relatively high costs faced by Canadians compared to other developed countries. Improvements should follow three key elements:

Protecting & Enhancing Health Benefits*:* A reformed system must ensure the continued viability of the health benefits plans that the majority of Canadians rely upon and value today.

Drug Coverage for Everyone: All Canadians should have access to proven and cost-effective prescription medicines regardless of where they live across the country. The objective should be to increase accessibility while ensuring that no Canadian loses access to medicines they need and have access to today.

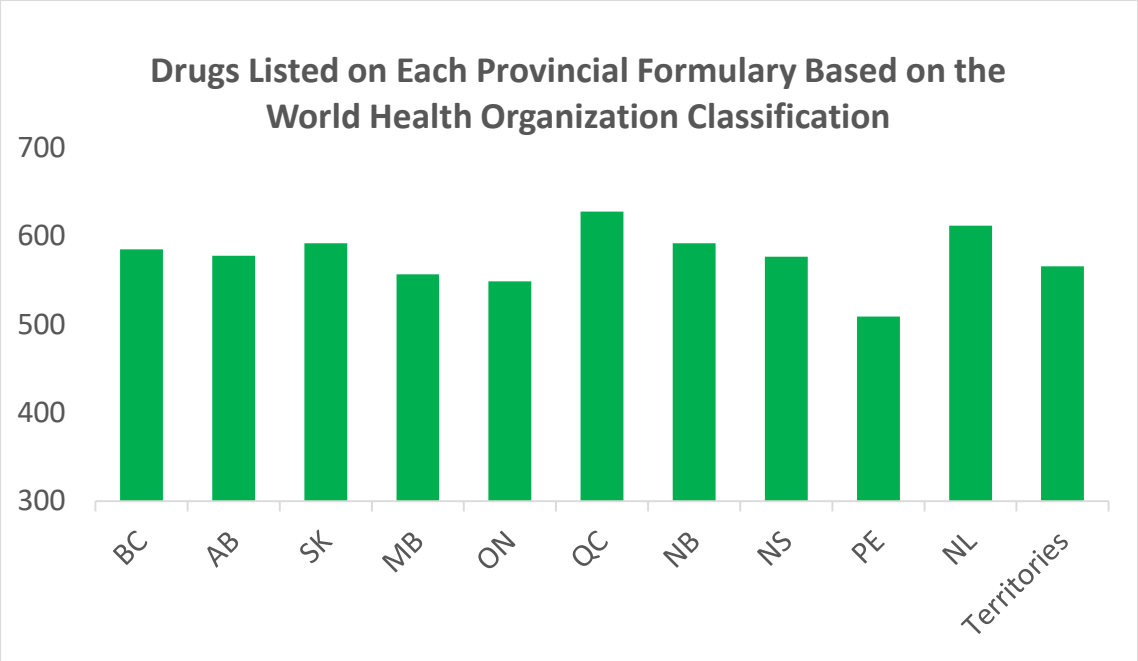
Affordability for Consumers & Taxpayers: No Canadian should suffer undue financial hardship because of the cost of the prescription medicines they need. Reform needs to be balanced to make effective use of taxpayer dollars.

It is also the industry's view that reform can be achieved on a timely and effective basis by enacting smart reforms that not only ensure that those who either have no coverage or inadequate coverage are protected going forward while building on the strengths of the current system to ensure that no one loses the coverage they currently have, whether it be private or public.

UNDERSTANDING THE PROBLEM TO BE SOLVED

Access to prescription drug coverage in Canada has evolved over time and is a mix between public and private plans. Public plans differ across the country with the most comprehensive coverage in Quebec. While the current system works well for the vast majority of Canadians, it also results in differences in access to certain medications and variations in out-of-pocket expenses that may be a barrier to some.

For example, a drug that is covered for an individual in one province may not be covered in another province. As shown below, the World Health Organization provides the number of drugs on each provincial plan based on their Anatomical Therapeutic Chemical (classification ATC-5). It shows that the number of drugs varies by province, with Quebec offering the most generous plan.[1]



There is also variation between the public and private systems, as those with private coverage may be eligible for a different set of drugs not offered through the public system. The net result is that the out-of-pocket burden for individuals will vary depending on the province in which they live and/or the provisions of their workplace benefit plan. In addition, we know that prices for drugs are relatively high in Canada and that the system can be complex to navigate.

<u>Gaps in coverage and out-of-pocket costs are a barrier to some Canadians</u>

Research has demonstrated that a small number of Canadians do not have coverage for prescription drugs, either through public or private plans. For example, research by the Conference Board of Canada[2]

[1] Institute of Fiscal Studies and Democracy at the University of Ottawa, *National Pharmacare in Canada – Choosing a Path Forward*, Summer 2018. The World Health Organization groups drugs by their Anatomical Therapeutic Chemical (ATC-5).

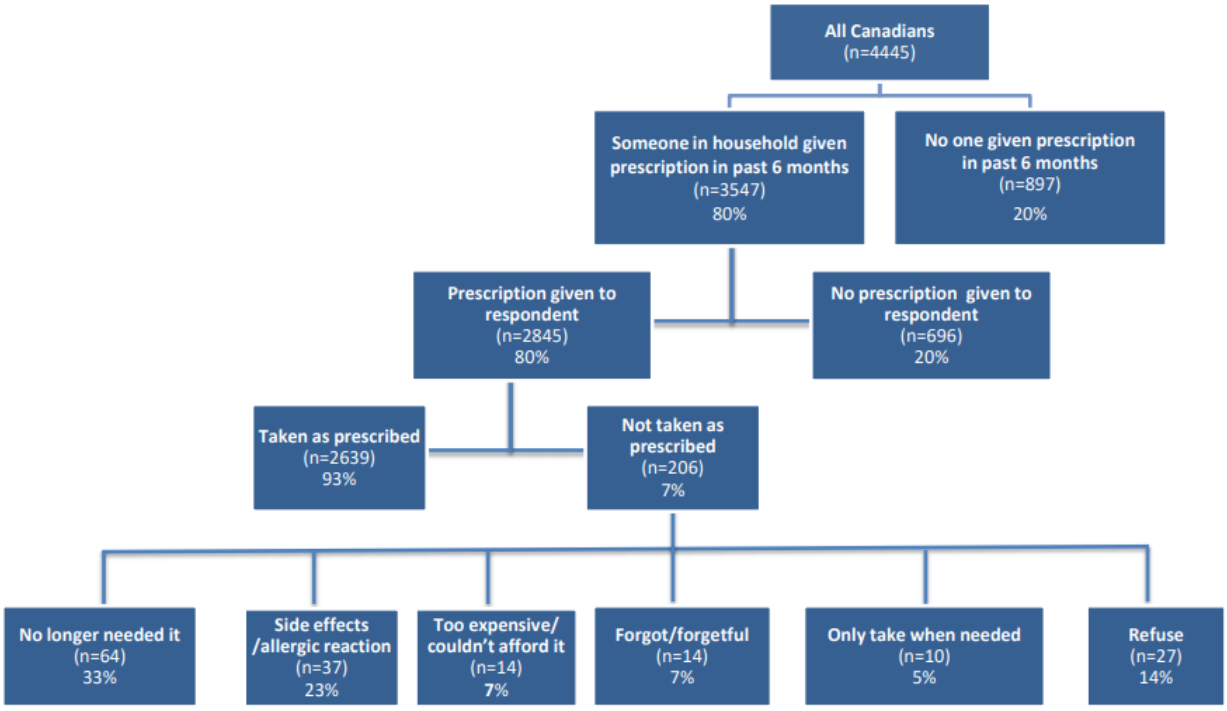
[2] Based on the Conference Board of Canada's paper *Understanding the Gap: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage.*

and a recent study by the Canadian Health Policy Institute[3] show that about 1.8% of Canadians are not automatically enrolled in some form of drug plan. It is interesting to note that those individuals included in the 1.8% actually do have access to a provincial drug program once certain criteria are met -- however, they must take the proactive step to apply for coverage to demonstrate they have met the criteria.

Research has also identified some unacceptable cost barriers for a small number of Canadians that results in them not taking their prescriptions as prescribed. Canada needs to do better in this regard. Nanos research recently completed one of the most comprehensive surveys of Canadians to understand how many are not taking their medications as prescribed and, more importantly, why. As illustrated below, while 7% of Canadians are not filling their prescriptions as prescribed, cost is the reason for less than 1%. In fact, the most common reasons cited for not taking their prescriptions as indicated were that they no longer needed the drug, reported side effects or an allergic reaction to the drug, or the medication was too strong.

While research indicates that there are a small number of Canadians who face barriers to access as a result of deductibles and co-payments on private and public plans, the industry wants to work with the government to find ways to ensure that out-of-pocket amounts do not cause individuals to not take their needed medications. [4]

The Nanos Survey of Canadians' Prescription Drug Use – Highlights

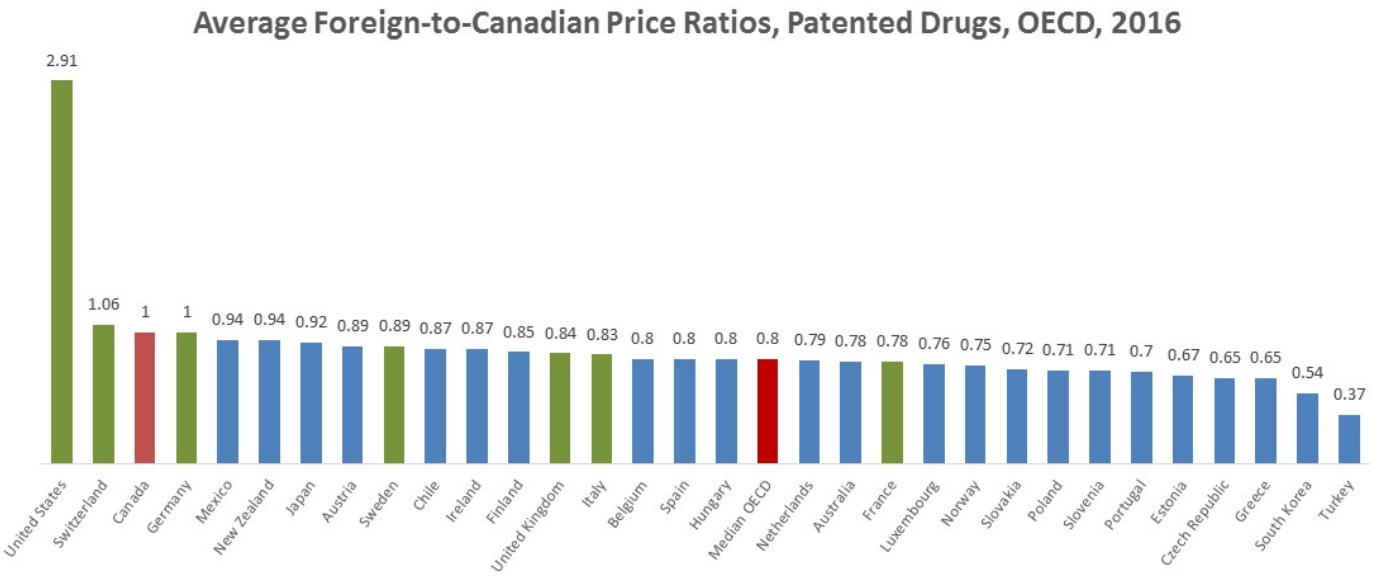


<u>Prices are high in Canada – we need to work together to bring them down</u>

[3] Canadian Health Policy Institute's study *Prescription drug plan coverage 2016: how many Canadians were insured, under-insured or uninsured?*

[4] Nanos, *Prescription use among Canadians.* The survey used a representative sample of 4,445 Canadians with two targeted subsamples: Canadians with child(ren) who received a prescription in the last six months (n=590) and Canadians who have personally received a prescription in the last six months (n=2,845).

The industry agrees with Health Canada that drug prices in Canada are too high relative to other developed countries. Research from the Patented Medicine Prices Review Board (PMPRB) shows that Canadian patented drug prices are among the highest in the world. Among all OECD member countries, only the United States and Switzerland have higher patented drug prices than Canada. In 2016, median OECD prices for patented drugs were on average 20% below those in Canada, as shown below.[5]



According to OECD data, Canada spent $860 USD per capita in 2017 on pharmaceuticals. This is well above the average amount spent on pharmaceuticals among OECD countries in 2017 ($529 USD). In fact, only three OECD countries (Japan, Switzerland, and the United States) spent more per capita. [6]

There are a couple regulatory factors that contribute to Canada's high prices for prescription drugs:

- Regulatory approach: The PMPRB, which sets the maximum price for new drugs in Canada, has historically targeted the median price of seven of the highest priced countries (France, Germany, Italy, Sweden, Switzerland, U.K. and U.S.). Over time, this has allowed a drift in prices in Canada towards the higher end of the global pricing lists. It is for this reason that we are very supportive of the federal government's recently announced proposed changes to the PMPRB's approach to regulating prices. We believe that they will, over time, result in a meaningful reduction in prices for all Canadians.

- Approach to negotiating drug prices: Unlike most other countries, Canada does not leverage the full buying power of the Canadian market to negotiate lower prescription drugs prices for all citizens. Currently, the pan-Canadian Pharmaceutical Alliance (pCPA) negotiates lower prices (for the public system) while employers, private insurers, and those paying out-of-pocket are left to pay the higher list prices. In response, many insurers have individually started to negotiate directly with drug manufacturers. This results in Canadians paying many different prices for the same drugs in Canada. This almost certainly results in higher aggregate costs than could be achieved through collaboration.

[5] Patented Medicine Prices Review Board. PMPRB comparator countries include US, Switzerland, Germany, Sweden, UK, Italy, and France.
[6] OECD Data, Pharmaceutical spending.

The industry does not support a strict “fill the gaps” approach to solving the dual issues of access and prices. We believe that improving the system is warranted that collectively achieves the three key elements outlined in the introduction.

PROTECTING & ENHANCING HEALTH BENEFITS

Canadians highly value their existing health benefit plans

Given the importance of workplace benefit plans to employers and employees and the generous coverage they provide, it is important to understand what the implications of a government-run, single-payer pharmacare model could be for coverage of prescription drugs and other health supports for Canadians.

A growing percentage and number of Canadians continue to enjoy strong workplace health benefits.[7] There is a perception, by some, that access to private workplace benefits is declining. The facts tell a different story. The number of Canadians with workplace benefit plans has increased over the past 10 years from 71% to 79%.

The number of Canadians with workplace benefit plans has increased over the past **10 years** from **71% to 79%**, demonstrating the continued value of these plans to both **employers and employees**.

Canadians use their health benefits plans to access a wide variety of health services, including prescription medicines, vision care, dental care, mental health supports and many other services. These services both help prevent illness and contribute to overall wellness for Canadians. Through many ancillary programs offered by insurers, the industry plays a key role in helping Canadians manage their overall health. For instance, 1 in 5 Canadians will experience a mental health problem in a given year, and by age 40, about 50% of the population will have or have had a mental illness.[8] Studies have shown how beneficial therapy services covered through health benefit plans can be to helping those with mental health issues.[9] Currently, access to needed psychological care is limited, which is why treatment through workplace health plans is so important.

[7] Details on how workplace benefit plans work can be found in the Appendix.

[8] Canadian Mental Health Association's *Fast Fact about Mental Illness.*

[9] Hunsley, J., Elliott, K., & Therrien, Z. (2013). The Efficacy and Effectiveness of Psychological Treatments. (ISBN 978-1-926793-09-2). http://www.cpa.ca/docs/File/Practice/TheEfficacyAndEffectivenessOfPsychologicalTreatments_web.pdf

We know that Canadians with private coverage highly value what they have and do not support reforms that would put their coverage at risk. In fact, 87% of Canadians surveyed said they place a great deal or quite a bit of value on their benefit plans. Further, 66% of employees indicated that they would probably or definitely leave their employer if they stopped providing coverage for extended health benefits. [10]

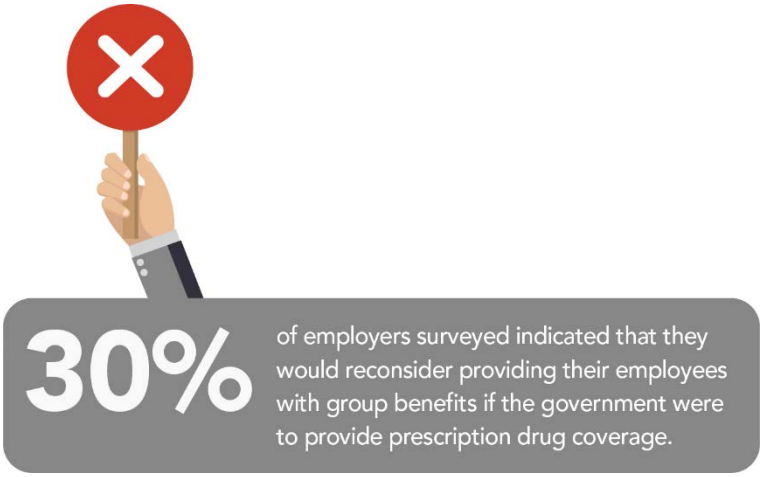
Employers also place a great deal of value in offering benefit plans to their employees. Some of the reasons that employers offer benefit plans to employees are that they:

- attract and retain employees as benefits are an important element of total compensation;
- provide employees with access to more medications through their benefit plans than would be available on public formularies;
- provide support for mental health concerns – the leading cause of disability in Canada;
- support employee health to reduce absence/injury and improve productivity;
- drive employee satisfaction; and
- are a key negotiating tool in collective agreements for some employers.

Two-thirds of employers believe governments should support workplace benefit plans, further reinforcing the important role they play.[11]

However, it is concerning that in a recent survey of small businesses in Ontario, 30% of employers surveyed indicated that they would reconsider providing their employees with group benefits if the government were to provide prescription drug coverage.

[10] Based on a survey of 3,000 individual Canadians conducted by Abacus Data in March 2018.
[11] Based on a survey of 356 businesses across Ontario conducted by Abacus Data in March 2018.



Employer plan sponsors benefit from offering integrated health supports, with prescription drug coverage being an essential backbone to these plans. This would mean a government run single payer pharmacare model could put individuals' access to other health supports at risk.[12] Canadians recognize how damaging this would be with over half of the Canadians surveyed indicating that it would be a bad outcome if a government run single payer pharmacare model meant employers could decide to drop group health insurance plans for their employees altogether. [13]

Private plans ensure faster access to new medications

Workplace extended health benefit plans provide more coverage and choice for Canadians compared to public coverage. For instance, employer sponsored benefit plans typically offer coverage of 10,000 to 12,000 drugs. In comparison, public provincial plans offer coverage for between 2,000 and 8,000 drugs, with the majority offering around 4,000.

Private drug plans are also more likely to offer new, innovative drugs approved by Health Canada. Newer drugs offer better health outcomes for some as they often provide the latest treatment advances, first-in-class therapies, or more targeted therapies for rare diseases. According to research by the Canadian Health Policy Institute, of the 479 new drugs approved by Health Canada from 2008 to 2017, 87% were covered by at least one private drug plan, compared to 45% that were covered by at least one public plan. It also takes less time for private drug plans to offer new drugs. The same study found that, on average, it took 142 days for private plans to offer new drugs, compared to 449 days for public drug plans. [14]

Nationalizing drug coverage would mean 7.7 million Canadians could see loss of coverage to what they already have– those with depression, cancer, diabetes and pain issues would be particularly impacted [15]

More than 7.7 million Canadians are taking medications that are not currently listed on their respective provincial drug plans. If drug coverage were nationalized these individuals' access to their needed medications could be at risk.

[12] Based on a survey of 356 businesses across Ontario conducted by Abacus Data in March 2018.
[13] Based on a survey of 3,000 individual Canadians conducted by Abacus Data in March 2018.
[14] Canadian Health Policy Institute. *Coverage of new medicines in public versus private drug plans in Canada 2008-2017.*
[15] Based on IQVIA data from 2017. Note: IQVIA data only represents 83.8% of private payer plans in Canada. We have therefore grossed up the numbers to reflect the entire market.

The following table highlights the gaps by province that would result from any program that shifted all those with private coverage onto their respective provincial drug plans (e.g. if Ontario residents only had access to the Ontario Public Drug Formulary).

Province	**Individuals currently using a medication that is not on their public drug formulary (millions of individuals)**	**Percentage of Provincial Population currently using medication that is not on their public drug formulary**
Newfoundland & Labrador	0.10	18.9%
Prince Edward Island	0.02	13.7%
Nova Scotia	0.18	19.1%
New Brunswick	0.14	18.6%
Quebec	1.61	19.6%
Ontario	4.06	29.9%
Manitoba	0.13	10.1%
Saskatchewan	0.12	10.9%
Alberta	0.74	17.8%
British Columbia	0.61	13.2%
Total	**7.71**	**21.2%**

Of these individuals, those with depression, diabetes, cancer and pain issues would be most at risk. The table below shows the top ten diseases in each province where individuals are currently receiving reimbursement for their needed medications through most private plans and where those medications are not offered on the respective provincial government programs.

BC	AB	SK	MB	ON	QC	NB	NS	PE	NL
Diabetes ($32.6M)	ADHD ($19.5M)	Diabetes ($2.7M)	Pain ($2.4M)	Gastrointestinal Conditions ($106.4M)	Depression ($67.5M)	Diabetes ($6.8M)	Gastrointestinal Conditions ($8.8M)	Cancer ($1.3M)	Gastrointestinal Conditions ($5.8M)
Depression ($14M)	Pain ($19.2M)	Insomnia ($2.3M)	Diabetes ($2.1M)	Pain ($80.4M)	Insomnia ($24.1M)	Gastrointestinal Conditions ($5.4M)	Diabetes ($7.7M)	Gastrointestinal Conditions ($1.2M)	Diabetes ($5.2M)
Pain ($12.2M)	Diabetes ($18.7M)	Pain ($2.2M)	RA/Crohn's /Colitis /Psoriasis ($1.4M)	Diabetes ($79.8M)	Cancer ($23.9M)	Cancer ($3.5M)	Pain ($3.1M)	Depression ($1.1M)	Pain ($4.1M)
Cancer ($10.7M)	Gastrointestinal Conditions ($16.2M)	Depression ($1.5M)	Vaccine ($1.4M)	Allergies ($78.4M)	Pain ($20.3M)	Ocular Infections/Condition ($2.0M)	Cancer ($3.0M)	Diabetes ($0.9M)	Cancer ($2.8M)
Asthma and COPD ($9.4M)	Depression ($9.4M)	Allergies ($1.1M)	Allergies ($1.0M)	Depression ($57.6M)	Diabetes ($16.7M)	Pain ($1.9M)	Phenylketonuria (PKU) ($2.3M)	Multiple Sclerosis ($0.7M)	RA/Crohn's/Colitis/ Psoriasis ($1.5M)
Other Hormonal Conditions ($8.3M)	Allergies ($8.1M)	HIV ($1.1M)	Skin Irritations/Conditions ($1.0M)	Cancer ($52.8M)	Skin Irritations/Condition ($15.6M)	Macular Degeneration ($1.8M)	Skin Irritations/Condition ($2.2M)	Pain ($0.7M)	Sexual Disorders ($1.3M)
Allergies ($6.6M)	Vaccine ($6.9M)	Sexual Disorders ($1.0M)	Sexual Disorders ($0.9M)	Migraines ($49.6M)	Allergies ($15.3M)	Allergies ($1.6M)	RA/Crohn's/Colitis /Psoriasis ($2.1M)	Allergies ($0.6M)	Alpha 1 Antitrypsin (AAT) Deficiency ($1.2M)
ADHD ($5.6M)	Skin Irritations/Condition ($6.9M)	Cystic Fibrosis ($1.0M)	Depression ($0.9M)	Vaccine ($41.0M)	Paroxysmal Nocturnal Hemoglobinuria (PNH) ($11.6M)	Depression ($1.6M)	Depression ($2.0M)	RA/Crohn's/Colitis/ Psoriasis ($0.3M)	Depression ($1.0M)
Skin Irritations/Condition ($5.1M)	Cancer ($6.2M)	Vaccine ($0.9M)	Ocular Infections/ Conditions ($0.8M)	Sexual Disorders ($35.2M)	Multiple Sclerosis ($10.1M)	Skin Irritations/ Condition ($1.5M)	Sexual Disorders ($2.0M)	Sexual Disorders ($0.3M)	Paroxysmal Nocturnal Hemoglobinuria (PNH) ($1.0M)
Ocular Infections/Condition ($4.9M)	HIV ($6.0M)	Birth Control ($0.8M)	ADHD ($0.8M)	Skin Irritations/Condition ($33.5M)	Infection ($9.9M)	Sexual Disorders ($1.2M)	HIV ($1.7M)	Ocular Infections/Condition ($0.3M)	Allergies ($1.0M)

*The numbers in brackets above represent the total drug costs for each disease that are not covered under the provincial drug formularies.

Those that would be most heavily impacted are people suffering from depression, cancer, diabetes and pain issues. In total, pushing everyone to public coverage could result in a pullback of over $1 billion of drug costs that are currently being paid for in the system.

The bottom line is that the Government should help those in need but protect and enhance what works under the current system. Employers support this concept, with 93% surveyed saying that government should help those who need help without hurting those already covered by good health insurance plans.[16]

[16] Based on a survey of 356 businesses across Ontario conducted by Abacus Data in March 2018.

Recommendation

Any reform should ensure the continued viability of the health benefits plans that the majority of Canadians have and value today. Putting them in jeopardy will mean delayed access to new, innovative medicines and could put more than 7.7 million Canadians at risk of seeing a change in access to medications they are already using – with those suffering from depression, cancer, diabetes and chronic pain being the most impacted.

DRUG COVERAGE FOR EVERYONE

Address access issues by establishing minimum coverage standards

All Canadians should have access to prescription medicines regardless of where they live across the country. Lack of harmonization on which drugs are covered by different public and private plans, and differences in the amount of out-of-pocket expenses individuals must pay are central problems within the current system in Canada.

To address these issues, a common minimum standard national formulary could be established. The minimum standard formulary would apply to all plans (whether government run or private) and must be comprehensive enough to address coverage of drugs that treat both chronic illnesses and drugs for rare diseases. Drugs provided on the standard national formulary would be evidenced-based to ensure their value and cost-effectiveness. This approach would still allow those provinces, plan sponsors or individuals, who want additional coverage to have it.

As noted above, in order for this approach to be able to address the issue of out-of-pocket costs, governments could consider establishing a plan design framework that would not only include a minimum standard formulary but also set reasonable out-of-pocket limits for Canadians, possibly tied to income, so that any co-payments or deductibles are not a barrier to access.

The plan design framework with both a standard formulary and maximum out-of-pocket expenses tiered to income would apply to both private and public plans across Canada. Currently, the life and health insurance industry does not have the ability to incorporate all these elements but would work with governments to find appropriate solutions.

Finally, it is important to acknowledge that certain regions and employers in Canada have a greater fiscal capacity to cover medications than others. As a result, establishing such a plan design framework with a standard formulary and including maximum out-of-pocket amounts, possibly tied to income, may not be fiscally possible for all regions and/or employers. To ensure that all Canadians can equally benefit from the standard formulary and out-of-pocket limits, some form of national risk sharing model for all payers (both private and public) for high-cost drugs should be included in any solution. There are many ways to achieve this, with pooling, risk sharing or transfer payments to payers being some examples.

Recommendations

The CLHIA recommends that a national evidence based minimum standard formulary be established. It should provide for coverage of both chronic illnesses and drugs for rare diseases and set maximum allowable out-of-pocket amounts, possibly based on income, for all Canadians. We recommend that the government work with the industry to develop a solution.

The government should also work with the industry to establish a national risk-sharing model for high cost drugs to ensure all regions and/or employers in Canada can afford to offer the minimum standard formulary.

AFFORDABILITY FOR CONSUMERS & TAXPAYERS

Bringing prices down for all Canadians

It has been well established that Canadians pay some of the highest prices in the world for their medications. The CLHIA fully supports the work that is already underway to help address this through reforms to the PMPRB. We believe that these reforms will provide for meaningful reductions in prices that would result in immediate and direct savings to employers and individual Canadians.

In addition, Canada should follow the lead of other developed countries that pool its full buying power in order to negotiate lower prices directly with drug manufacturers. As discussed above, the current approach in Canada is that governments work together through the pCPA to negotiate lower prices for the benefit of public plans. This results in multi-tiered pricing for Canadians and almost certainly results in higher aggregate costs than could be achieved if there was collaboration.

We strongly believe that the pCPA should negotiate on behalf of all Canadians – leveraging the full buying power of the Canadian market to get the best prices possible. This can be achieved under the current system. We note that this is already the approach used by the pCPA for generic drugs – as the pCPA sets the maximum price for generic drugs and this price applies to all Canadians equally. Canada's insurers have long called for, and would welcome, an opportunity to leverage the pCPA, so that the pCPA could benefit from the significant buying power the industry brings to the table to negotiate lower prices for everyone.

Recommendations

The CLHIA fully supports the announced reforms to the PMPRB and urges that the new regulations be implemented as soon as possible.

The CLHIA recommends that, in order to achieve lower prescription drug prices for Canadians, the pCPA negotiate lower branded drug prices on behalf of all Canadians and that they leverage the full buying power of both the public and private payers to do this. We would support allowing Canada's insurers to join or leverage the pCPA in the very short term – even in advance of or in the absence of any national pharmacare reform.

Structural reform to help implement the minimum formulary approach

There are a number of different pharmacare models that can achieve the goals outlined above. In fact, there are two models that currently exist in Canada that could be adapted to allow for everyone to be in a drug plan that meets the national standard formulary and maximum out-of-pocket approach described above. Ultimately, we believe that either approach, a combination of the two, or some other such mixed models could be appropriate for a pan-Canadian solution.

Universal coverage through a Quebec-like model

In January 1997, the basic prescription drug insurance plan (Régime général d'assurance médicaments, RGAM) was established with the objective of providing reasonable and fair patient access to drugs in Quebec. As such, it is a proven model that has been in place for close to 30 years now and is working well. However, there are some elements that could certainly be improved – particularly as it relates to the out-of-pocket limit for individuals.

The Régie de l'assurance maladie du Québec (RAMQ) requires all Quebec residents to be covered by prescription drug insurance. The system requires the following:

For individuals:

- If an individual has a workplace benefit plan through their employer, they must enroll in that plan.
- If an individual does not have access to an employer group plan, they must enroll in the public drug program.

For employers:

- Employers that offer any form of benefit plan (e.g. dental, vision, paramedical, etc.) must include drug coverage as part of that plan.

In addition:

- Both public and private plans must meet a certain minimum requirement related to the formulary and must include a maximum out-of-pocket amount.
- Pooling is required for all private plans for excessive drug costs in order to help ensure all plan sponsors can afford to offer the minimum formulary – this includes expensive drugs for rare diseases.

Established rules for group plans are set in legislation and are used to determine those whose private coverage qualifies them to be exempted from joining the public program. The end result is that the Quebec model provides universal drug coverage and seeks to limit out-of-pocket costs.

There is a mistaken belief by some that the RAMQ model has been an expensive one and therefore may be a poor option to consider as a Canadian pharmacare model. The facts do not support this concern. To the extent that costs have been higher in Quebec, this has been due to policy decisions Quebec has taken over the decades, with the overall intention of incenting and retaining pharmaceutical head office jobs in that province, rather than as a result of the RAMQ structure.

Research has shown that there were two policy decisions that have resulted in higher costs in Quebec.[17] Had they not been in place, costs in Quebec would actually have been lower than in the other provinces in Canada.

Key examples include:

1. <u>BAP-15 (Best Available Price after 15 years)</u>

   BAP-15 was introduced in 1994 to attract and retain pharmaceutical research and investment in the province. However, it added to the costs of drugs borne by the government, private plan sponsors, and patients.

   This rule required the Quebec government to continue reimbursing first-to-market brand name drugs at their original prices for a 15-year period from the listing of the drug on the Quebec formulary, even if cheaper generic products become available. In practice, it added up to an

[17] Actegis Consultants Inc. *Understanding Quebec's Pharmacare System.*

additional two to three years of delay for payers to switch patients to cheaper generic products. While the BAP-15 was cancelled in January 2013, research shows that caused costs to be higher in Quebec relative to other provinces.

Quebec's Minister of Economic Development Clément Gignac acknowledged this, estimating that the BAP-15 rule was costing Quebec about $165M per year in 2009. Modeling was performed to reflect the main costs and benefits, which led to the following estimates:

Direct Plan Costs from the Application of the BAP-15 Rule

Additional Costs Associated to BAP-15					
	Calendar Years				
(in M$)	1997-2000	2001-2005	2006-2010	2011-2015	Total 1997-2015
BAP-15 & Do-Not-Substitute – Costs to Public Plan	99,8	229,9	1 157,1	650,1	2 136,9
BAP-15 & Substitution Constraints – Cost to Private Plans	122,1	207,5	971,1	675,8	1 976,6
Gross Total Costs	221,9	437,4	2 128,2	1 325,8	4 113,5

Source: Research provided by ACTEGIS Consultants Inc. on Quebec's Pharmacare System.

The above estimates correlate with other work performed previously. For example, research undertaken for the Finance Minister in 2005 estimated that the application of the BAP-15 rule resulted in additional expenditures of approximately $25 million for Quebec's public plan (MFQ 2005). A further study indicated that these additional costs had reached $193 million in 2011–2012 (Lacoursière, 2012).

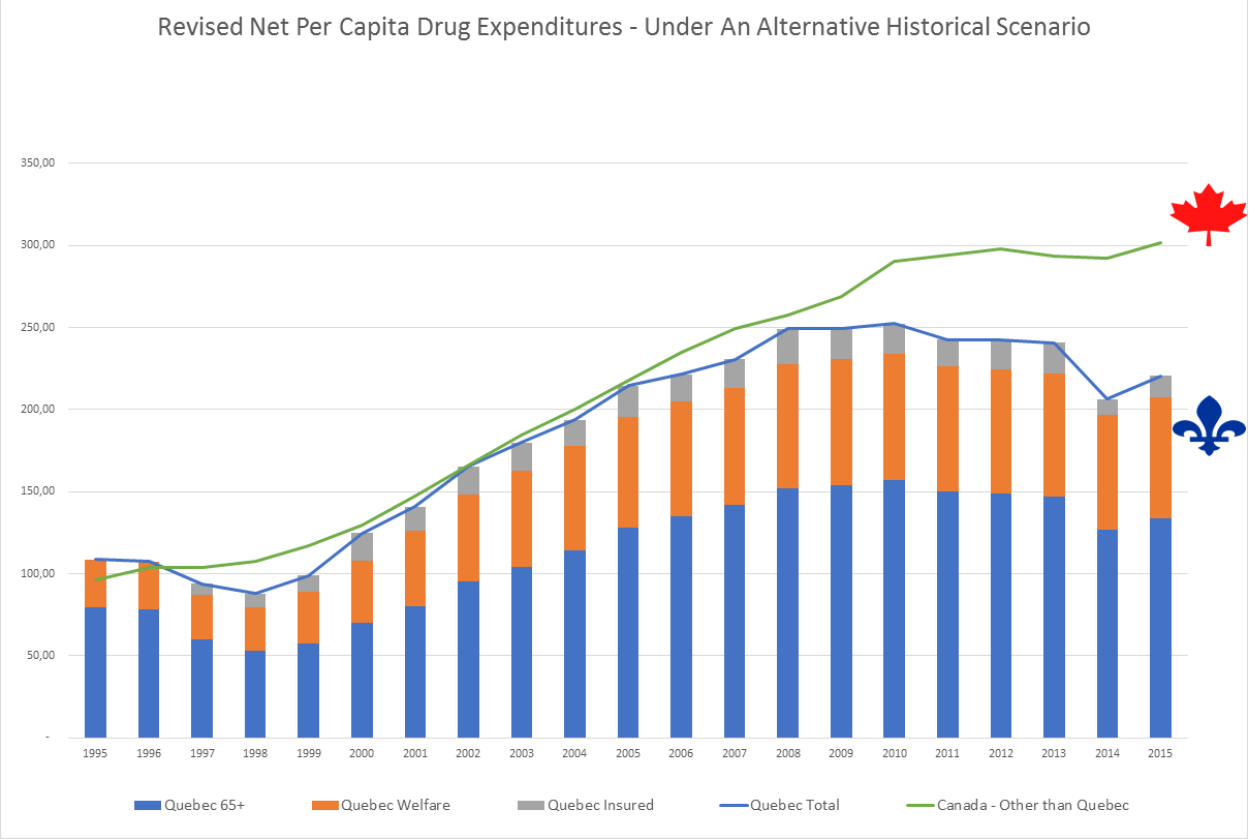
2. Slower to negotiate lower drug prices

Although the Quebec Drug Insurance Act allowed the Minister of Health to enter into Product Listing Agreements (PLAs) beginning in 2002, the government of Quebec was initially reluctant to enter into such agreements (Pelchat 2012). As a result, Quebec continued to pay higher list prices than other provinces in Canada for much of this period. This has changed recently with Quebec joining the other provinces in the pCPA. However, again research shows that if Quebec implemented a PLA program similar to other provinces, it could have saved $2.5 billion between 2007 and 2017. This represents 17.2% of the government's net expenditures in 2015-16.

Net of it all, while the Quebec program has been relatively expensive, the main cost drivers of this were BAP-15 and delays in negotiating prices. Collectively, it is estimated that this may have cost Quebec over $6.5 billion, relative to other provinces.

As illustrated below, had Quebec been able to more readily eliminate its BAP-15 policy and implement PLAs as effectively as other provinces did (in particular, Ontario), it would have had lower expenditure levels. This alternative course of action would have resulted in Quebec achieving lower per capita costs

while providing a much wider range of drug products than any other province, while providing full coverage for all its residents.



Source: Research provided by ACTEGIS Consultants Inc. on Quebec's Pharmacare System.

It is important to note that Quebec has taken steps to eliminate the BAP-15 and the province now fully participates in the pCPA. We support the recent reforms to the RAMQ system. These changes will certainly result in costs in Quebec falling into line with other provinces over time, regardless of any national pharmacare reforms.

Catastrophic costs coverage: British Columbia, Saskatchewan, Manitoba-like model

Currently each of British Columbia, Saskatchewan, and Manitoba have pharmacare models that cap the amount that any individual must pay for their medications before 100% public coverage kicks in. Each province has established a standard formulary for which medications are eligible and then set maximum out-of-pocket limits, tiered by income, before full public coverage kicks in. The deductibles can be paid by insurance and individuals who want access to a broader list of drugs are allowed to access them. As a result, these provinces achieve the overarching goal of standardizing access for their citizens and ensuring that any out-of-pocket amounts are capped at a level that is reasonable at different income levels.

Case Study: British Columbia's Fair Pharmacare Model

Public prescription drug coverage in British Columbia is designed to provide residents coverage to all British Columbians. B.C.'s largest program, Fair PharmaCare, was introduced May 1, 2003. All residents have to enroll in the Medical Services Plan, the mandatory public health insurance in the province. When a resident is enrolled in the Medical Services Plan, they must then enroll in the Fair Pharmacare Program for public drug coverage (their dependents are also enrolled in public drug coverage).

Under the program, once an individual has met the prescribed deductible amount, Fair PharmaCare kicks in to provide full coverage for individuals. Importantly, the deductibles are tiered by income and helps ensure that individuals with low incomes do not pay a higher portion of their prescription drug costs than those with higher incomes.

The following table provides a summary of the BC Fair Pharmacare program's tiered deductible model:

FAIR PHARMACARE PROGRAM			
Net Annual Family Income	**Family Deductible**	**Portion PharmaCare Pays (once deductible reached)**	**Family Maximum (after which 100% of costs are covered)**
Less than $15,000	None - Government assists you with your drug costs immediately	70% of eligible prescription drug costs	Equal to 2% of your net income
Between $15,000 and $30,000	Equal to 2% of your net income	70% of eligible prescription drug costs	Equal to 3% of your net income
Over $30,000	Equal to 3% of your net income	70% of eligible prescription drug costs	Equal to 4% of your net income

In order to contain costs, the province uses reference-based pricing, which means it only reimburses the lowest price drug in a class of drugs that have the same therapeutic effects. As a result, British Columbia spends among the lowest per capita on public prescribed drugs (just under $250 per person in 2017).

Recommendation

Structural reform may be helpful to help ensure Canadians benefit from a national standard formulary and maximum out-of-pocket model that we recommend in the section above. The Advisory Council should examine approaches already in use in Quebec and British Columbia, Saskatchewan and Manitoba as potential models that could be adapted for a pan-Canadian approach.

Fiscal implications of government-run single pharmacare model

A critical element to be considered of a government-run single pharmacare model is the fiscal implications for governments. To assist in this, the Conference Board of Canada undertook an analysis to calculate the full fiscal impacts of two scenarios.

The Conference Board used the following approach to develop the cost estimates below:

- Numbers are based on data from IQVIA, which provides formulary data for each province based on the different provincial models as well as the out-of-pocket expense. The IQVIA data only represents about 83.8% of the private payer plans in Canada. As such, numbers have been scaled to represent 100% of the market.[18]

- Assumed the earliest realistic date for any pharmacare reform is 2020. The data from IQVIA is in 2015 dollars. As such, baseline numbers are grossed up by 3.1% per year. The baseline costs in the system are estimated to be $36 billion (public - $13.0 B; private $16.4 B; out-of-pocket $6.1 B) in 2020.

***Scenario 1*: Federal First-Dollar, First-Payer Pharmacare**

In this scenario, the federal government is first-payer and covers all drugs listed on the Quebec formulary for all Canadians. The scenario assumes no cost-sharing by individual Canadians (e.g. through deductibles or co-payments) as these amounts would be covered by the federal government.

Under this scenario, the day one cost to the federal government would be roughly **$34.4 billion dollars** and would grow from there in future years.[19] In this scenario, the incremental costs to the federal government is due to covering all amounts for drugs on the Quebec formulary currently paid by private insurance, all amounts paid for by each provincial government, and all amounts currently paid out-of-pocket.

As illustrated in the *Protecting & Enhancing Health Benefits* section above, about 20% of Canadians currently using medication would not be covered under this scenario and would still require additional support in the amount of $1.1 billion. The table below illustrates the impact to public, private and out-of-pocket spending under scenario 1.

[18] Note: The Conference Board analysis provides some of the expenditures for extended access program drugs, Cancer Care program drugs, etc. but not all. Therefore, the results may be conservative.

[19] Our estimated total cost to the public sector of a national government-run pharmacare program differs from the analysis by the Parliamentary Budget Officer (PBO) primarily as a result of two assumptions that we adjusted so that the data reflects real world assumptions. First, while the PBO report uses 2015 data, we gross the starting cost numbers up to 2020 which is realistically the earliest start date for any potential pharmacare reform. Second, the PBO report assumes that all drug prices will be reduced by 25% on the first day of any new pharmacare program. The mechanism for this is that governments will bulk purchase drugs and drive prices lower. While this is a potential benefit of bulk purchasing, in reality negotiating lower drug prices takes time (likely several years) and there is no real world methodology that could reduce prices across the board at the outset.

	Current Prescription Drug Spending ($ billions)	Scenario 1 Prescription Drug Spending ($ billions)	Difference ($ billions)
Federal Government[20]	$ 0.0	$34.4	+$34.4
Provincial Governments	$13.0	$ 0.0	-$13.0
Private Sector	$16.4	$ 1.1	-$15.3
Out-of-Pocket	$ 6.1	$ 0.0	-$ 6.1
Total	**$35.5**	**$35.5**	**$ 0.0**

Scenario 2: ***Provincial First-Dollar, First-Payer Pharmacare***

The provincial governments are first-payer and cover all the drugs listed on the Quebec formulary for all citizens in their province. The scenario assumes no cost-sharing by individual Canadians (e.g., through deductibles or co-payments) as these amounts would be covered by each provincial government. The table below illustrates the impact to the public, private and out-of-pocket spending under scenario 2.

	Current Prescription Drug Spending ($ billions)	Scenario 2 Prescription Drug Spending ($ billions)	Difference ($ billions)
Federal Government	$ 0.0	$ 0.0	$ 0.0
Provincial Governments	$13.0	$34.4	+$21.4
Private Sector	$16.4	$ 1.1	-$15.3
Out-of-Pocket	$ 6.1	$ 0.0	-$ 6.1
Total	**$35.5**	**$35.5**	**$ 0.0**

Under this scenario, the additional cost to the public sector is **$21.4 billion**. Similar to scenario 1 above, there would remain 20% of Canadians currently using medication that would not be covered under this scenario. Additional support would be required in the amount of $1.1 billion.

The incremental costs to the provincial governments are due to each province covering all amounts for drugs on the Quebec formulary currently paid by private insurance, those amounts currently paid out-of-pocket, as well as incremental costs in all provinces, other than Quebec, to cover the broader Quebec formulary. Incremental costs by province are shown below.

[20] The federal government provides coverage of prescription drugs for some Canadians (e.g. First Nations, veterans, prisons). However, funding for these costs are administered through private plans and would therefore be included in the "private sector" category.

	Current Prescription Drug Spending ($ millions)	Scenario 2 Prescription Drug Spending ($ millions)	Difference ($ millions)
Newfoundland & Labrador	$139.3	$518.4	$379.1
Nova Scotia	$319.2	$955.5	$636.3
Prince Edward Island	$57.6	$81.1	$23.5
New Brunswick	$223.8	$926.4	$702.6
Quebec	$3,928.3	$10,409.8	$6,481.5
Ontario	$5,229.9	$13,443.6	$8,213.7
Manitoba	$335.1	$873.5	$538.4
Saskatchewan	$402.2	$848.9	$446.7
Alberta	$1,284.0	$3,276.2	$1,992.2
British Columbia	$1,085.7	$3,096.7	$2,011.0
Total	**$13,005.1**	**$34,430.0**	**$21,424.9**

Any reform must not further erode Canada's competitive position

Given the above, a critical consideration for any pharmacare reform must be how any such reforms would be financed. As with any potential new government program, governments will need to identify revenue sources to fund their new commitments and ensure that these new revenue sources are long-term and sustainable. Any scenario where there is a significant additional cost incurred by the public sector would be difficult in Canada's current fiscal position.

Many commentators are already expressing concern with the lack of competitiveness of the Canadian economy. As Jack Mintz and others have noted, foreign direct investment levels in Canada continue to fall and are at their lowest in eight years. In addition, the recent tax reforms in the United States mean that the Canadian tax burden is 10 percent higher on new investments than in the United States. A report by PricewaterhouseCoopers estimates that, as a result of the U.S. tax reforms, $85 billion (4.9% of Canada's GDP) and 635,000 jobs are at risk.[21] This combined with higher energy and labour taxes results in Canada already being at a disadvantage when trying to attract and retain businesses. As a result, most observers are arguing for a lightening of the tax burden on Canadian business and individuals over time to ensure we can continue to attract the needed investment to support Canadians' current standards of living. This suggests that any pharmacare reform should strive to address the access and cost issues with as minimal a fiscal impact as possible so as to avoid worsening an already challenging tax competitiveness environment in Canada.

Complexity of moving to a new system

Another important consideration is the logistics and costs of moving from one program to another. The current system is complex and touches the vast majority of Canadians, in real time, on a regular if not daily basis. The complexity of big changes to this should not be underestimated – both from a cost and patient impact perspective.

[21] PwC report *The Impacts of US Tax Reform on Canada's Economy*, September 2018.

Do not create disincentives for employers to offer health benefit plans

In order to compete for high quality employees, employers in Canada offer health benefit plans. This includes comprehensive coverage for prescription drugs. Employer support for these plans is evidenced by the fact that 96% of employers surveyed indicated that they place quite a bit or a great deal of value on offering group benefits to their employees.[22] As well, 66% of employees indicated that they would probably or definitely leave their place of employment if employers stopped providing coverage for prescription drugs.[23]

The current tax exempt status of employer health benefits in Canada creates a positive incentive for employers to provide health and dental benefits to their employees and their families. The federal government may consider removing the tax exemption on employer health benefits in order to pay for a national government-run pharmacare program. However, removing the tax exemption would only cover a small portion of the overall added expense to the public (approximately $3 billion) and would be counterbalanced by the loss in tax revenue that all levels of government currently realize from the taxes paid by insurers on the health benefits business (approximately $3.6 billion).

Imposing a tax on their employer-provided benefit plans also does not even factor in the increase in CPP contributions that would have to be paid by employees as a result. Taxing employer-paid benefits would require both CPP and EI premiums to be paid on those incremental amounts. The CLHIA estimates this will result in an additional $1 billion of CPP and EI contributions to be paid by employees and their employers. This cost will fall largely on lower and middle-income Canadians who earn between $15,000 and $55,000, and their employers.

Employers contribute, on average, between $3,000 and $3,500 every year to provide comprehensive benefits to each of their employees and their families. The CLHIA estimates that the cost of replacing an employer health plan with an individual private plan coverage[24] would be in excess of $6,000 annually.[25]

Low and middle income earners are generally the least likely to be able to afford to take home less pay each month. Even if an individual is able to deduct part of the expense for purchasing their own plan under the existing Medical Expense Tax Credit, an average family will still have to pay $5,100 out-of-pocket for coverage similar to that of an employer-provided extended health benefits group plan. This accounts for about 9% of a typical family's take-home pay (based on a median family net income of $55,600).

Finally, we know that if the federal government were to tax employer health benefits, a large number of employers would drop coverage. This was the experience in Quebec in 1993 when 20% of employers dropped health benefit plans when employer health benefits were made taxable.[26] This will lead to significantly worse health outcomes for Canadians. In addition, this will have significant impacts to maintaining health care professionals in Canada as many rely on private plans to support their business.

[22] Based on a survey of 356 businesses across Ontario conducted by Abacus Data in March 2018.
[23] Based on a survey of 3,000 individual Canadians conducted by Abacus Data in March 2018.
[24] Note: Group plan coverage is typically cheaper than individual private plan coverage as providers are able to pool risk and administrative costs.
[25] However, this number would be reduced slightly if the government were to introduce a government run single pharmacare program.
[26] Note: the number of employers dropping coverage would be greater should the government also decide to offer a government-run, national pharmacare program.

Recommendations

The CLHIA recommends that any reform must make effective use of taxpayer dollars particularly in the context of the current competitive challenge facing the Canadian economy. As such we recommend a model that leverages the existing system of public and private coverage going forward as it creates the least fiscal drag for governments while still reducing overall costs and meeting the key policy objectives of improving access.

The CLHIA recommends that the tax exempt status of workplace benefit plans be maintained to safeguard the current incentives for employers to offer the needed health benefits to their employees.

CONCLUSION

Working collaboratively, we can meet the objectives of protecting the health benefits that Canadians value, ensuring access to affordable prescription medicines and ensuring affordability for taxpayers and consumers. This can be achieved on a timely and effective basis by moving forward with smart reforms that build on the strengths of the current system to focus resources on those without adequate coverage and ensures no one loses access to coverage for medications they currently have and their health benefits are not put at risk.

Drawing on the analysis and recommendations above, the industry has developed proposed enhancements for reform that will address the three key components for reform: (1) protecting and enhancing existing health benefits; (2) ensuring all Canadians have access to proven and effective prescription medications; and (3) ensuring the enhanced system does not place undue financial hardship on taxpayers. The industry's list of recommendations from the paper are set out below.

Protecting & Enhancing Health Benefits

1. Any reform should ensure the continued viability of the health benefits plans that the majority of Canadians have and value today. Putting them in jeopardy will mean delayed access to new, innovative medicines and could put more than 7.7 million Canadians at risk of seeing a change in access to medications they are already using – with those suffering from depression, cancer, diabetes and chronic pain being the most impacted.

Drug Coverage for Everyone

2. The CLHIA recommends that a national evidence based minimum standard formulary be established. It should provide for coverage of both chronic illnesses and drugs for rare diseases and set maximum allowable out-of-pocket amounts, possibly based on income, for all Canadians. We recommend that the government work with industry to develop a solution.

3. The government should also work with the industry to establish a national risk-sharing model for high cost drugs to ensure all regions and/or employers in Canada can afford to offer the minimum standard formulary.

Affordability for Consumers and Taxpayers

4. The CLHIA fully supports the announced reforms to the PMPRB and urges that the new regulations be implemented as soon as possible.

5. The CLHIA recommends that, in order to achieve lower prescription drug prices for Canadians, the pCPA negotiate lower branded drug prices on behalf of all Canadians and that they leverage the full buying power of both the public and private payers to do this. We would support allowing Canada's insurers to join or leverage the pCPA in the very short term – even in advance of or in the absence of any national pharmacare reform.

6. Structural reform may be helpful to help ensure Canadians benefit from a national standard formulary and maximum out-of-pocket model that we recommend. The Advisory Council should examine the

approaches already in use in Quebec, British Columbia, Saskatchewan and Manitoba as potential models that could be adapted for a pan-Canadian approach.

7. The CLHIA recommends that any reform must make effective use of taxpayer dollars particularly in the context of the current competitive challenge facing the Canadian economy. As such we recommend a model that leverages the existing system of public and private coverage going forward as it creates the least fiscal drag for governments while still reducing overall costs and meeting the key policy objectives of improving access.

8. The CLHIA recommends that the tax exempt status of workplace benefit plans be maintained to safeguard the current incentives for employers to offer the needed health benefits to their employees.

APPENDIX - HOW BENEFIT PLANS WORK

Extended health care plans provided by insurers vary from plan to plan. Most commonly, extended health plans provide coverage for prescription drugs/medicine, vision care, mental health services, short- and long-term disability, dental coverage, and therapy.

A large percentage of extended health care plans are provided through employers. The employer is the plan sponsor, who pays for all or part of the cost of the benefit plan. The group insurance provider is hired by the employer to insure the plan members (employees) and run various aspects of the program, including paying claims.

Private insurers work with advisors and employers to determine the appropriate group benefit plan for each employer, meaning that plans are tailored to organizations of various sizes. As part of this, generally, formularies are:

- Open – formularies that may or may not include over-the-counter medicines;
- Managed – formularies that are designed to control costs while still ensuring the most appropriate therapeutic choices are available;
- Targeted – formularies that have specific objectives that can be targeted to support the needs of the plan sponsor/employer; and
- Provincial mirror.

The percentage of plans that are open vs managed vs targeted or provincial mirror will vary from insurer to insurer based on its plan sponsors. Overall, the most common type of formulary is open, however there are a number that have managed formularies.

The type of plan generally influences the coinsurance. The most common coinsurance is between 0% to 20%. In some cases, sponsors may also choose the option to have a plan design that covers drugs on a managed formulary at a higher coinsurance, the percentage of eligible cost that the plan will pay, and layer it with an open formulary at a lower coinsurance. Where there is 0% coinsurance it is often accompanied by a deductible or annual maximum.

It is important to note that deductibles are increasingly uncommon. Co-payments, deductibles, and annual maximums are plan design features chosen by employers.