Canadian Life & Health Insurance Association
Association canadienne des compagnies d'assurances de personnes

Submission to the

ONTARIO MINISTRY OF FINANCE ON PREFERRED PROVIDER NETWORKS IN DRUG GROUP INSURANCE PLANS

July 28, 2025

EXECUTIVE SUMMARY

CLHIA is pleased to provide its comments on the consultation on Preferred Provider Networks in Drug Group Insurance Plans. We appreciate the government's commitment to collaborate closely with stakeholders as the government considers different policy options to regulate preferred provider networks ("PPNs"). We encourage the government to continue engagement with our sector given our industry's role in supporting drug care and managing drug costs for Ontarians.

The current geopolitical environment and global trade tensions have led to heightened economic uncertainty and affordability concerns for Ontarians and employers. Based on a recent survey, 77% of employers are worried about drug costs, with 44% of employers needing to take direct action on high-cost drugs.[1] To further compound these challenges, the ongoing Section 232 investigation in the United States means there is a real threat of pharmaceutical tariffs, generating serious concerns of increased drug prices and drug shortages. The government's support for Ontarians is critical at this time – ensuring that they do not face further upheaval by disrupting tools used to manage drug costs.

In the midst of the current affordability crisis, nearly 70% of all Canadians, regardless of whether they have health benefits under their employer's plan, place significant importance on paying lowest prices for their prescriptions.[2]

PPNs are important tools for managing drug costs, especially for specialty drugs. Less than two per cent of claimants are for specialty drugs, yet specialty drug spending accounts for over 30 per cent of total private drug spending in 2024[3]. Without PPNs, the cost of comprehensive drug coverage may be unsustainable for employers.

PPNs also elevate care by connecting Ontarians with wraparound health services. These services aim to give patients more support in managing their health beyond just providing medications. This is especially critical for patients with complex, specialty health needs that need coordinated, expert-driven support.

PPNs continue to work well for Ontarians. Patients are well served by PPNs and are overwhelmingly satisfied, as demonstrated through our members' customer surveys that show consistent customer satisfaction rates of over 90%.[4]

It is critical that the government protect the integrity of PPNs and help ensure Ontario businesses, employees and their families do not lose access to the benefits that PPNs bring.

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[1] 2024 Benefits Canada Healthcare Survey
[2] Internal CLHIA polling
[3] 2025 Drug Data Trends & National Benchmarks (Telus Health)
[4] CLHIA members' surveys

While we do not believe that regulating PPNs will improve patient access or experience, if the government regulates PPNs, we recommend that the government adopt the Standardized and Mandatory Exemption ("SME") model.

The SME model preserves the core benefits of PPN models and will continue to support affordable coverage. It minimizes disruption to patients and does not excessively restrict the flexibility insurers need to design PPN options that best meet the needs of employers and their employees.

Canadians will not see the perceived benefits or lower pharmacy fees with the Any Able and Willing Provider ("AAWP") model. The AAWP model would effectively eliminate the closed PPN model by severely limiting insurers' ability to effectively negotiate for lower pharmacy fees. Employers could be faced with the tough decision to reduce coverage in order to reduce drug costs, inadvertently shifting costs to the provincial government. The AAWP model also poses more administrative challenges, adding significant administrative burden on government, regulators and insurers.

As the government considers regulating PPNs, we encourage the government to take a principles-based approach to regulation and to leverage existing processes for regulatory oversight, ensuring that it's not creating duplicative red tape.

KEY RECOMMENDATIONS

Regulating PPNs will not improve patient access or experience. There are extensive checks and balances in place that ensure this is already done. However, if the government regulates PPNs we recommend that the government:

1. **Adopt a Standardized and Mandatory Exemption ("SME") model.**

   The SME model would ensure all insurers operating mandatory PPNs in Ontario apply consistent, transparent exemption criteria that allows patients to access non-network pharmacies in specific circumstances, such as going to a pharmacy where an in-network pharmacy cannot be reached by the individual and mail-order is unavailable due to a geographic restriction.

   The SME model would address the government's policy objectives of affordable coverage, improved health outcomes, and competition, while still permitting mandatory PPNs to exist and protecting consumer access through a principled exemption approach. It preserves the core benefits of PPN models, minimizes disruption to patients and does not excessively restrict the flexibility insurers need to design PPN options that best meet the needs of employers and their employees. Compared to the AAWP model, it is less administratively challenging to implement and results in less administrative burden for government, regulators and insurers.

2. **Do not implement the AAWP model.**

   The AAWP model would restrict insurers' ability to maximize savings and benefits for employers and their employees as it diminishes insurers' ability to negotiate cost savings for plan members and sponsors. It would also create significant administrative and operational challenges. Any AAWP model will increase the cost of drugs for Ontarians as employers, employees and potentially as taxpayers if sponsors drop coverage, and negatively impact their pharmacy care, coverage and experience.

3. **Take a principles-based approach rather than enshrining prescriptive exemptions in regulation.**

   Guiding principles should be included in the regulation to standardize exemptions, rather than prescriptive exemptions and should be developed in concert with our industry, patient groups and other sector stakeholders to ensure they meet patient needs and are not administratively burdensome. Exemptions should be assessed and granted by the individual insurer under the terms agreed to by the plan sponsor. They should also be granted based on clinical need. The following example considerations could be included in regulation:

   - **Geographical considerations:** Patients that cannot reasonably access a pharmacy within network and where delivery is not feasible based on remote location, cold chain requirements, or other unique considerations
   - **Accommodation needs and cultural sensitivities:** Patients with accommodation needs (e.g., cannot travel and where home delivery is not possible due to unique circumstances);

consideration could also made for language or cultural barriers where they cannot be met by existing supports.

It is also worth noting that the Ontario College of Pharmacists ("OCP") has policies on accessibility and the regulations should not duplicate existing OCP requirements.[5]

4. **Leverage existing processes and regulatory bodies for oversight**

Creating new, duplicative processes imposes unnecessary red tape and administrative burden on both the government, regulators and insurers. The government should leverage existing regulatory frameworks and processes for regulatory oversight, complaints and dispute resolution. In particular, the Financial Services Regulatory Authority of Ontario ("FSRA") should continue to have regulatory oversight of insurers, especially if the regulatory regime enacted solely targets insurers.

5. **Ensure that regulations protect the following values that are foundational to PPNs:**

Specialized Care for Complex Conditions

- PPNs help elevate care. Patients who require specialty medications[6] need more than a prescription – these are high touch, highly complex medications which need specialized care by healthcare professionals that have a thorough understanding of the clinical, technical administration, holistic physiological impacts, and that can assist with reimbursement navigation. PPNs ensure that participating pharmacies meet enhanced clinical, operational, and logistical standards.

Cost Savings that Expand Access

- PPNs deliver negotiated savings that directly benefit plan sponsors and their members. These savings are not theoretical – they are real, measurable, and essential to sustaining affordable drug coverage in Ontario.

Patient Satisfaction and Choice

- PPNs demonstrate high satisfaction rates. Patients are not locked in, and exemptions are already provided in appropriate cases. Under the SME model, this process would be standardized and better understood across stakeholders.

6. **Continue to consult and engage our sector once the government has decided on its policy approach.**

It is challenging to comment on the scope of regulations without more details on the policy approach. Additional engagement is necessary to ensure that the regulatory framework allows PPNs to continue to enhance care and manage drug costs.

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[5] https://www.ocpinfo.com/about/accessibility/

[6] 2024 Drug Data Trends & National Benchmarks Report (Telus Health)

PPNS AND THE GOVERNMENT'S POLICY OBJECTIVES

As noted above, PPNs are not unique to the insurance market and are used across the healthcare sector. What is currently being proposed targets insurers. Hospitals, patient support programs run by manufacturers, pharmacy retailers and long-term care facilities also use PPNs. It is unclear what makes PPNs in the drug insurance sector different from other PPNs and why the government is focusing on PPNs administered by insurers. Patients are well serviced by and overwhelmingly satisfied with the existing PPN system, as demonstrated through customer satisfaction rates of over 90%.[7]

It is important that employers and their employees can continue to use PPNs to help manage their drug costs through reduced markups at in-network pharmacies. These networks improve patient access to specialty drugs that may otherwise be too costly for an employer to include in their coverage while at the same time, reducing out-of-pocket costs for patients with a co-pay. These savings are also key to improving patient health by mitigating the risk of patient not adhering to their prescription drugs due to drug costs.

Our industry recognizes that the government's policy objectives are to support consumer choice, maintain drug affordability and coverage, promote health outcomes, and support competition in the pharmacy sector. While our industry does not agree that regulation will improve patient access or experience, we are committed to working towards ensuring PPNs can continue to support these policy objectives.

Policy objective: Drug cost and affordable coverage

Less than 2% of claims are for specialty drugs, and not all specialty drugs are dispensed through a PPN. Despite this, these drugs accounted for over 30%[8] of total private drug spending in 2024, with some drugs costing over $1 million per patient per year. The cost of these drugs has increased significantly over the last decade. To help manage these costs for employers and their employees, many insurers introduced PPN models. PPNs help manage drug costs for specialty drugs but also drugs not considered specialty.

PPN-related cost savings matter to employers as they are highly sensitive to drug plan costs. According to a recent survey by Benefits Canada, drug coverage is the first thing employers will cut when considering reducing or removing benefits.[9] Without PPNs, the cost of full drug coverage is likely unsustainable for many employers, resulting in the imposition of annual maximums, formulary exclusions for high-cost specialty drugs and other plan designs that reduce coverage for employees. When employers don't pay for fulsome drug coverage and employees can't afford these drugs without the coverage, we will see these costs being shifted to the Ontario Trillium Drug Program or lead to

[7] CLHIA members' surveys
[8] 2025 Drug Data Trends & National Benchmarks (Telus Health)
[9] 2024 Benefits Canada Healthcare Survey

higher costs to the public healthcare system if patients are not able to access the treatments they need.

The savings afforded to employers, employees and their families through PPNs also protect the long-term sustainability of health benefit plans.

Additionally, in the first consultation on PPNs, other stakeholders suggested that independent pharmacies offer better pricing than specialty PPN pharmacies for specialty drugs.[10] There is no source for the data and therefore cannot be relied upon. The cost savings claims are questionable at best.

They have also indicated that PPNs benefit insurers and pharmacy benefit managers but not patients.[11] That claim is untrue. Patients using PPN services have a 90% satisfaction rate[12] and have provided testimonials confirming their satisfaction with PPN services.

Finally, we encourage the government to work with our industry and continue engagement to ensure that regulations on PPNs do not result in an economic burden on Ontario employers and employees.

Cystic Fibrosis (CF) is a rare genetic condition that impacts roughly 1 in 3,600 babies born in Ontario each year.

Some specialized symptom management and life-saving medication for cystic fibrosis patients cost over $300,000 per year.

CF patients are an important example of how PPNs help maintain access to lifesaving treatments while easing pressure on the public healthcare system.

Due to the high cost of CF medications, employers often select specialty drug PPN plan designs as economically viable ways to provide coverage to their employees and their families.

Without PPNs, employers may face unaffordable costs, leaving patients to rely on public programs like OHIP+, Trillium, or ODB—shifting the financial burden to both Ontarians and the government.

Policy objective: Health outcomes

As the government considers regulating PPNs, it is important to recognize PPNs as critical tools for delivering patient-centred care. PPNs help patients access health services and programs, such as one-on-one education and adherence support from specially-trained nurses, pharmacists or other healthcare professionals to support patients in managing their conditions and encourage proper drug utilization. These services aim to give patients more support in managing their health beyond just providing medications. Patients with complex, specialty health needs (i.e., those taking certain specialty drugs) may rely on these resources to ensure effective and positive treatment outcomes.

[10] OnPharm Response to the Ministry of Finance Consultation on Preferred Provider Networks (2024)
[11] OnPharm Response to the Ministry of Finance Consultation on Preferred Provider Networks (2024)
[12] CLHIA members' surveys

One of the concerns that the government heard during the initial consultation was that some PPNs may fragment care as an in-network pharmacy used by a patient may not know about other drugs dispensed to the patient at out-of-network pharmacies. However, this is no different than patients getting their prescriptions filled at multiple pharmacies and is something that pharmacies are adept at managing.

In the case of specialty drugs specifically, and because of the complexity of administering these drugs (e.g., via infusion), it is common for patients to receive them from specialty pharmacies even in the absence of an insurer PPN. This is because specialty pharmacies deploy a sophisticated model of care initiation and coordination that is patient-centered and liaises with patient support programs, specialist physicians, and others in a coordinated ecosystem. Patients using multiple pharmacies, particularly where they are taking specialty drugs, is not unique to PPNs.

We also note that in some cases, PPNs require enhanced coordination between the PPN administrator, patient, physician, drug manufacturer's patient support program (where applicable), and pharmacy to actively manage drug utilization to ensure effectiveness of the relevant drug. This coordination reduces the likelihood of fragmented care. PPNs can support uniformity of patient experience and enables a more cohesive and efficient service delivery.

*One insurer reported that patients using their specialty drug PPN had a **nearly 57% lower incident rate** for Short Term Disability (STD) and Long-Term Disability (LTD) compared to those who didn't, for the same drug.*

We encourage the government to collaborate with our industry and continue to engage us to ensure that regulations on PPNs does not restrict the ability of insurers to provide these services, and does not result in poorer health outcomes for Ontarians.

Policy objective: Competition

Evidence indicates that PPNs in Ontario have not hindered pharmacy competitiveness. PPNs require pharmacies to compete on price and service, while maintaining a sufficiently open market for new businesses to thrive in. In fact, the number of community pharmacies is actively growing year over year. The OCP stated in 2024 that the College regulated 5,019 community pharmacies which was a 10% increase over the past five years.[13]

Establishing a PPN involves competition-promoting activities like requests for proposals and negotiations. These activities result in lower prices for things like pharmacy fees and markups and require network pharmacies to provide enhanced services that must meet specific service levels or service level agreements ensuring the protection and care of patients and meeting the expectations of employers.

[13] OCP 2024 Annual Report

Insurers utilizing PPNs are no different than any other organization or industry that chooses vendors that can offer lower prices and enhanced services. Regulating this ability could undermine these arrangements today, resulting in higher prices for employers and employees and less access to life saving medications for Ontarians. Ultimately, this counters the government's other policy objectives of maintaining drug costs and affordable coverage.

We also encourage the government to work with our industry to ensure that regulations on PPNs do not have the effect of lowering the standards that apply to pharmacies looking to join PPNs and allows insurers to be able to engage in arrangements with pharmacies where price and services can be effectively negotiated.

Policy objective: Consumer choice

PPNs in Ontario continue to work well for employers and Ontario families. One of the concerns heard by the government in the first consultation was that PPNs have a role in limiting access to pharmacies, particularly for residents of remote or small communities. However, data supporting these arguments is from the United States.[14] The Canadian and American healthcare markets are vastly different and not comparable. For example, there are material differences in geographic coverage as Canada has 40% more pharmacies per capita than the United States.[15] States that impose an AAWP model likely did so to address considerations unique to the American context, such as the health maintenance organization model and significantly more vertical integration.

For mandatory networks in Canada, the ever-rising cost of drugs and the competitive nature of the Canadian benefits market requires a solution for employers and employees that includes cost management, service level expectations and access. The results of mandatory networks speak for themselves.

*Nearly **70% of Canadians**, regardless of whether they have health benefits under their employer's plan, place a **significant amount of importance on paying lower prices for their prescriptions**.*

Source: Internal CLHIA polling

When patients who have used PPNs in Canada are surveyed on their satisfaction with the program, the results consistently show satisfaction rates of over 90%.[16] Those most impacted by PPNs appreciate the benefits they bring to their health care experience. These are the most vulnerable to drug price increases and in the most need of complicated drug regimes.

We are advocating for a thoughtful SME-principled approach for mandatory networks focused on access and care to affirm that such consumer concerns are being addressed.

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[14] https://www.uspharmacist.com/article/the-impact-of-pharmacy-deserts
[15] https://www.longwoods.com/content/22097/healthcare-policy/geographic-accessibility-of-community-pharmacies-in-ontario
[16] CLHIA members' surveys

BACKGROUND ON POLICY OPTIONS

Scope and definition of policy options

For clarity, our industry's recommendation builds on our understanding of the scope and definition of each policy option, which is as follows:

- AAWP would mandate that any pharmacy PPN be open to any pharmacy operator that is able and willing to meet a PPN's terms. The AAWP model would effectively eliminate the closed PPN model (mandatory and voluntary), which would raise drug costs and jeopardize higher qualities of care.
- SME would standardize the mandatory exemptions to pharmacy PPNs so that patients can access pharmacies outside their network if required.

Applying either the SME or AAWP model to any network effectively puts the government in the position of negotiating commercial deals for all pharmacies and removing a tool for managing drug costs for Ontarians.

RESPONSES TO CONSULTATION QUESTIONS

To provide the best coverage of drugs for consumers, life and health insurers work with pharmacies to deliver the best value and support for plan sponsors (employers) and their employees and their families.

As such, life and health insurers are in a unique position to provide responses to the consultation questions as they engage with all employers, pharmacies and pharmacists, and patients on a regular basis. We have provided responses to each of the questions below.
Note, however, it is challenging to comment on the scope of the regulations and on the questions without more detail on the government's policy approach. Additional engagement is necessary to ensure that the regulatory framework addresses the government's policy objectives. We encourage the government to engage stakeholders once a policy approach has been decided.

GENERAL QUESTIONS

1. Should PPNs be expressly restricted to specialty medication? If so, what is the appropriate definition for speciality medication?

There is no standard definition for specialty drugs, but the term is often used to refer to drugs that are high-cost (e.g., $10,000 or more per year and per person) and are used to treat complex, chronic or rare medical conditions. These drugs often require special handling, storage or administration. They may also require frequent dosing adjustments, intensive patient training and compliance assistance.

It is challenging to comment on the scope of regulations without more detail on the government's policy approach. We expect it will be an ongoing and collaborative process with the government and FSRA to ensure that the regulatory framework addresses the government's policy objectives. We

encourage the government and FSRA to engage our industry on the scope of regulations and definitions once a policy approach has been decided.

However, it should be noted that insurers should have the flexibility to select these drugs in a way that lets them maximize the savings for employers and employees and promote the best patient health outcomes.

2. Which of the two potential regulatory options – Any Able and Willing Provider (AAWP) or Standardized Mandatory Exemption (SME) – would best promote:

Insurers across Canada have a responsibility to help protect the long-term sustainability of drug plans so that Ontarians can continue to access the life-saving drugs they need. Any regulation that is imposed will impact the current drug coverage Ontarians receive. Therefore, we do not believe that regulating PPNs will improve patient access or experience. However, if the government moves forward with regulation, we recommend the SME model as being the least disruptive to the patients and plan sponsors and the best option for promoting health outcomes, affordable coverage of specialty drugs and consumer choice. See below for more details on each.

a) Improved health outcomes (including continuity of care)?

The SME model supports health needs and improved health outcomes by allowing those that meet the exemption requirements to receive their drugs from any pharmacy, while also enabling the vast majority to continue to receive health supports offered from in-network pharmacies. Insurers that utilize PPNs generally provide exemptions in appropriate cases.

An AAWP model may undermine access to wraparound health supports as it will inhibit insurers' ability to hold pharmacies in network to standards (as broad expansion can be challenging and costly to administer).

b) Affordable coverage of specialty medication?

The SME model will continue to support affordable coverage compared to an AAWP model. The SME model allows insurers to continue to negotiate with pharmacies for costs to generate savings for employers and Ontarians.

Whereas an AAWP model would severely curtail carriers' negotiating leverage to put downward pressure on pharmacy fees. This could result in employers reducing drug coverage to reduce their plan costs, and this could lead to drug costs being inadvertently shifted to provincial drug programs or lead to higher costs to the public healthcare system if patients are not able to access the treatments they need.

c) Consumer choice?

It is important to note that currently, most PPNs enable multiple pharmacy options and many already offer exemptions.

The SME model would allow consumer access and care while the AAWP focuses exclusively on pharmacies rather than on patients. If a plan member prefers to get their prescription filled at an alternative pharmacy and they meet the exemption requirements, they can choose to do so.

The primary benefit of an AAWP model is that it provides more business opportunities to more pharmacies compared to the SME option. However, an AAWP model pays for those business opportunities through patients and employers being subjected to potentially higher drug prices.

3. Should the two options be seen as mutually exclusive or complementary?

We recommend that both policy options continue to be seen as mutually exclusive. Implementing one regulatory model will already reduce the ability for insurers to customize their PPNs in a way that maximizes their ability to generate savings for employers and employees. Implementing both policy options risks a highly restrictive regulatory environment that would prevent insurers from having the flexibility needed to design and utilize PPNs in a way that maximizes benefits to Ontarians.

Insurers and employers consider plan members experience when establishing PPNs. Flexibility is needed to design PPN models that best meet the needs of the employers and their employees, without an overly complex regulatory framework that may need to be amended in the future.

4. Which policy option would be most appropriate for Ontario? Is there another alternative which may better balance the key policy objectives?

PPNs operating under Ontario's current approach have satisfaction rates of over 90%, as reported by several CLHIA member companies.[17] Given this, it does not appear that regulation is needed if the goal is to benefit Ontario patients.

Additionally, drug plan sustainability and the impact of inflation are employers' top challenges affecting their health benefits plans with 44% of employers needing to take direct action on high-cost drugs.[18] Regulation restricting PPNs do not appear to be the answer to maintaining affordable drug coverage for employers and their employees.

However, if regulation is deemed necessary, our industry is recommending the SME model as it is least disruptive to the market and the best option for promoting health outcomes, affordable coverage of specialty drugs and consumer choice.

5. During the initial consultation, some PPN operators indicated that certain pharmacy categories should be included in all pharmacy PPNs by default (such as

[17] CLHIA members' surveys
[18] 2024 Benefits Canada Healthcare Survey

those within Oncology Centres of Excellence and pharmacies located on hospital premises).

a. Is this an appropriate approach?

b. If so, what categories of pharmacies should be included?

We do not believe that this is an appropriate approach.

The category exemptions would create an additional exemption group that is not based on patient need, care or affordability. Insurers include pharmacies in PPNs because of their ability to provide, among other factors, high-quality care, cost-effectiveness, enhanced services, and operational excellence – not on their pharmacy category. It is not clear how requiring PPNs to include certain pharmacy categories is connected to patient care or affordability.

For example, exemptions for physicians to direct patients with complex needs to an on-site pharmacy would be of significant concern. College of Physicians & Surgeons of Ontario (CPSO) policies on prescribing drugs state that "Physicians must respect the patient's choice of pharmacy," and "must not attempt to influence the patient's choice of pharmacy unless doing so is in the patient's best interest and does not create a conflict of interest for the physician".[19] The idea of an "on-site pharmacy" automatically creates conflict of interest concerns.

Including certain categories of pharmacies by default also reduces competition, which would lead to increased cost and reduction of enhanced services for patients.

This approach would also restrict insurers' ability to customize PPNs and could negatively impact the ability for PPNs to provide affordable access to drugs. If the government is trying to promote patient care and access, this default inclusion would address neither issue.

ANY ABLE AND WILLING PROVIDER (AAWP)

6. Should insurers be required to demonstrate the reasonableness of terms in a PPN? If so, how?

No. Reasonableness is subjective and too difficult to define. There is nothing inherently different between a PPN agreement and other types of contracts between customers and suppliers of goods that necessitates additional regulation. Ultimately, insurers are accountable to their plan sponsors and their members to deliver benefit plan designs (which may or may not include PPNs) that appropriately balance robustness of drug coverage and costs. It should be up to the parties to the agreement (e.g., insurers and pharmacy) to assess whether the terms of a PPN are reasonable.

As with any other business arrangement, the parties to an agreement can decide either to enter into the agreement or to walk away (e.g., if a pharmacy decides that it cannot or does not want to meet the terms of a PPN agreement). The government should not require a business to accept certain terms

[19] https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Prescribing-Drugs

and conditions from a supplier, especially when there is insufficient data showing patient harm arising from the current competitive market approach.

Additionally, insurers are required to treat customers fairly, in accordance with the FSRA Fair Treatment of Customers Guidance. These regulatory expectations for insurers to treat customers fairly are met even as insurers determine the terms of a PPN.

Insurers are also incentivized to prioritize patient needs as customer service is a key differentiator between insurers. In fact, insurers periodically review these agreements to ensure that their PPN arrangements continue to meet the needs of employers and their employees. Insurers compete for the business of Ontario businesses, and PPN design is one differentiator that factors into this competition. Regulating a standard approach across the sector reduces this facet of competition to the detriment of Ontario businesses.

7. How should a pharmacy operator's ability to meet terms in a pharmacy PPN (e.g., terms relating to safety, quality of care, or value-added services) be determined and by whom?

In terms of minimum standards for safety and quality of care, under the current regulatory framework, the Ontario College of Pharmacists ("OCP") ensures that all licensed pharmacists meet the minimum standards of practice, and existing pharmacy regulations provide a mandatory framework within which pharmacies must operate.[20] Remaining consistent with these standards while part of a PPN is paramount and there is no reason to believe PPNs cause pharmacists or pharmacies to deviate from OCP and regulatory obligations, particularly without complaint or disciplinary data to support such contentions. Ontarians should continue to be assured of the quality of care they receive from pharmacists, whether the pharmacy belongs or doesn't belong to a PPN.

However, it is critical to leave insurers with sufficient agency and discretion to hold pharmacists to a higher service standard in order to be a member pharmacy in a network. With respect to PPNs, insurers determine and establish the criteria for pharmacies based on meeting the needs of employers and their employees across their block of business, which may include measurable success and service standards. Insurers compete with each other to deliver competitive solutions to employers and their employees. They are incentivized to design PPN solutions to meet their needs.

Insurers must continue to have the ability to set their criteria. They need sufficient flexibility to customize and administer PPNs to ensure these needs continue to be met. In the absence of this, employers may find that PPNs are not a suitable option for their drug benefit plans. Similarly, insurers should retain the right to administer their PPNs as they determine appropriate.

It should also be noted that life and health insurers work closely with employers, pharmacies and patients on a regular basis. As such, insurers are best positioned to set the terms of inclusion for their pharmacy PPNs. There is nothing unique about this kind of supplier agreement that necessitates government intervention or that impedes the parties' ability to freely contract.

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[20] https://www.ocpinfo.com/regulations-standards/standards-practice/

Insurers are not forcing pharmacies to accept unfavorable terms. They are evaluating their customers' needs and selecting vendors that best meet those needs. Vendors that do not meet those needs should not be given a regulated advantage when they cannot otherwise compete.

8. How should disputes between insurers and pharmacy operators, and complaints by plan members or sponsors, be resolved?

As with any competitive negotiations, insurers and pharmacy operators should continue to have the ability to decide whether to agree to the terms and enter the agreement or walk away.

In cases where insurers and pharmacy operators already have a PPN agreement, disputes between these parties should be resolved using the mechanisms set out in the applicable contract, within the confines of existing legislative and regulatory schemes. Contract law already provides robust remedies in case of disputes.

Outside of the mechanisms within a PPN agreement, there are existing complaints processes available to plan members. Complaints are first directed towards the relevant insurer. If those complaints are unresolved, they can be directed to OmbudService for Life & Health Insurance ("OLHI"), which provides free, fast, independent and impartial dispute resolution services for Canadians.

If the complaint remains unresolved, the complaint should be directed to FSRA. They have an established protocol for consumers to send complaints when there are concerns of non-compliance with the regulations they oversee, including the handling of claims and fair treatment of customers. They also have broad investigative powers to ensure compliance with financial services regulations and protection of consumers.

Additionally, it is important to note that there are OCP requirements around the treatment of and communication with patients. If someone is concerned about their pharmacist's ability to provide appropriate service or properly communicate with the patients they serve, they can file a complaint to OCP.

The existing mechanisms are effective in addressing any issues or complaints. As noted above, PPNs operating under Ontario's current approach have satisfaction rates of over 90%. Adding yet another dispute-resolution body to adjudicate complaints and disputes would be duplicative, result in unnecessary red tape, could risk creating conflicting oversight protocols between various governmental bodies and add significant administrative burden on insurers, the government and regulators.

9. Should there be restrictions on the types of terms insurers may set for PPNs under AAWP? If so, what types of restrictions would be appropriate?

Insurers need the flexibility to develop terms of inclusion for pharmacies that best meet the needs of employers and their employees. Legislated restrictions would negatively impact insurers' ability to generate cost savings for employers and their employees. This is not an activity where government

regulation is needed to prevent a public harm. Patients are well serviced by and are overwhelmingly satisfied with the existing PPN system.

STANDARDIZED AND MANDATORY EXEMPTIONS (SME)

10. How should standardized exemptions be set, and by whom? (e.g., by one or more regulators, by an independent body, by statute or regulation enacted by the government)?

We recommend taking a principles-based approach instead of enshrining prescriptive exemptions in regulation. Specific exemptions should be evaluated on a case-by-case basis and clinically driven with the insurer and plan sponsor having ultimate decision-making authority pursuant to the terms of the agreement between the insurer and plan sponsor.

The following example considerations could be included in regulation:

- **Geographical considerations:** Patients that cannot reasonably access a pharmacy within network and where delivery is not feasible based on the remoteness of their location, cold chain requirements, or other unique considerations

- **Accommodation needs:** Patients with accommodation needs who cannot travel and where home delivery cannot be leveraged due to unique circumstances; consideration could be made for language or cultural barriers where the relationship with a particular pharmacy is fundamental to the patient receiving good care. Given the ethical and practice-related requirements the OCP imposes on pharmacies on issues like non-discrimination and patient service, this kind of exemption should be rare as all Ontario pharmacies are able to serve the vast majority of Ontario patients.

11. How should complaints relating to standardized exemptions be handled? Specifically:

a. Who should be able to file complaints (e.g., plan members, pharmacy operators, prescribing physicians, plan sponsors)?

Since coverage decisions affect plan sponsors and plan members, they are the right parties to make or file complaints. Other health professionals, such psychologists or opticians, have no special complaint mechanism related to coverage decisions because those decisions impact patients and plan sponsors. Insurers already have an escalation process for handling a plan sponsor complaint, which may also be part of their contractual arrangement with the plan sponsor. OLHI and FSRA already have robust complaints processes meant to address the concerns of plan sponsors and members. A new complaints process would merely be duplicative and add unnecessary red tape.

For individual pharmacies, complaints and disputes can be managed through contract law and within the existing dispute resolution mechanisms established in the PPN agreement. It should also be noted that patient and plan sponsor complaints about PPN requirements are exceedingly rare, despite a handful of high-profile media stories with anecdotal examples.

Government should be wary of creating a complaints mechanism that can be leveraged as a tool to hinder competition by enabling competitor driven complaints, ultimately, creating an expensive burden on the system that can undermine the policy objectives stated by the government.

b. Who should address such complaints (e.g., FSRA, OLHI, OCP, or other entities)?

As mentioned above, there are existing complaint resolution processes. Creating new, duplicative processes imposes unnecessary red tape and administrative burden on both the government, regulators and insurers. The government should leverage existing regulatory frameworks and processes for regulatory oversight, complaints and dispute resolution.

It is critical that if the regulatory regime enacted solely targets insurers, it is appropriate that an insurer regulatory entity address the complaints (i.e., FSRA). If the government considers a regulatory regime that applies to hospitals, pharmaceuticals, government agencies, patient care programs, etc. which also operate PPNs in Ontario, then another regulatory governing body could be appropriate. That said, FSRA should be consulted first before recommendations are made.

12. During the initial consultation, stakeholders indicated that certain exemptions are considered best practice for PPNs. Which types of exemptions should be instituted and for what reasons? Examples the government was made aware of during the initial consultation include:

a. Exemptions for individuals with specific linguistic or cultural needs

b. Exemptions for physicians to direct patients with complex needs to an on-site pharmacy

It is important to recognize that insurers already provide exemptions that help avoid causing undue hardship for patients and alleviate issues around ease of access. Insurers enter business arrangements with providers (e.g., pharmacies) with these considerations in mind and impose contractual expectations on providers to require that they offer services in a way that accommodates the needs of plan members. Additionally, existing human rights protections prohibit all businesses, including pharmacies and insurers, from discriminating based on grounds like race, ethnicity, disability, and more.

With that said, if the government were to standardize mandatory exemptions, it should not establish specific exemption requirements. As noted above, we recommend the government take a principles-based approach instead of enshrining prescriptive exemptions in regulation. PPNs are tailored to the drug benefit plans to which they are associated and the needs of employers and their employees, and the plan design process includes consideration of patient situations that may require an exemption. Including specific exemptions would be disadvantageously prescriptive and should not be included in legislation.

Specific exemptions to allow physicians to direct patients with complex needs to on-site pharmacies would be of significant concern. The College of Physicians and Surgeons' policies on prescribing drugs state that "physicians must respect the patient's choice of pharmacy," and "must not attempt to

influence the patient's choice of pharmacy unless doing so is in the patient's best interest and does not create a conflict of interest for the physician." The idea of directing patients to an "on-site pharmacy" automatically creates conflict of interest concerns.

TARGETED QUESTIONS

For Insurers, Pharmacy Operators, and Intermediaries:
13. What type of additional value-added services are pharmacy operators required to offer in order to dispense specialty medicine?

It is important to keep in mind that each PPN and drug benefit plan is different. Many support services are not provided by pharmacists under the terms of a PPN, but are provided in the community by health professionals such as a nurse or nurse practitioner. Many PPN models fund those supports. Some examples of value-added services could include, but are not limited to:

- Adherence programs;
- Chronic disease and wellness coaching;
- Coaching and counselling requirements by specialized clinicians;
- Collaborating and following up with the prescriber, other professionals and PSPs;
- Collecting information from the prescriber, as needed;
- Consultations for specialty drugs;
- Delivery timeline guarantees;
- Disease specific community referrals;
- Infusion services including coordination with infusion clinics;
- Initial consultations on the drug and the condition its treating;
- Mental health referrals;
- Patient experience guarantees;
- Patient injection training;
- Regular patient follow-ups to monitor side-effects and to ensure treatment adherence; and
- Reimbursement navigation (coordinating reimbursement sources between public, private and Patient Support Programs).

For Insurers, Pharmacy Operators, and Intermediaries:
14. What challenges could you face in implementing AAWP or SME?

Under either model, if PPN network administrators are not able to engage in differentiated offerings between pharmacies, it will severely impact the ability to generate cost savings and will create an anti-competitive environment. This could lead to a reduction in coverage for Ontarians as employers, faced with increased costs, reconsider the amount of coverage for their members. Ultimately, insurers may discontinue their PPNs, along with their related patient health services, if they are unable to generate sufficient savings for employers and employees to justify the administrative burdens.

Some PPNs also help coordinate with all payers (including government funded programs and manufacturer-sponsored patient support programs). A challenge could be ensuring that pharmacies

outside the PPN network become familiar with these coordination processes and exhaust all sources of financial support to ensure patients have consistent access to their drugs.

Additionally, the challenges and implications for parties currently in PPN arrangements, and the potential need to open existing agreements, should be considered. Even where PPNs are maintained, changes to the regulatory environment may result in these arrangements needing to be renegotiated, and such negotiations are complex and take significant time. These changes impact not only insurers and pharmacy operators, but every plan sponsor currently using a PPN.

Specific challenges associated with the AAWP model include:

- Difficulty ensuring each pharmacy's ability to meet the criteria on an ongoing basis;
- The process and mechanism for removing a pharmacy from the network if the pharmacy is deemed "not able" after the initial assessment;
- Communicating program changes with a vast network;
- Operational feasibility of a fully open network;
- Adjudication and administration of AAWP;
- Communicating to plan members to ensure accurate services, as AAWP list could be evolving and it may be difficult to direct plan members to AAWP pharmacies;
- Managing opt-in and opt-out process of pharmacies. This could affect the continuity of care if a pharmacy decides to opt out of the PPN;
- Managing monitoring and ongoing reporting; and
- Managing the ongoing escalations and operational matters of all the pharmacy locations.

Challenges associated with the AAWP model may not be unique to just insurers. Depending on the final regulatory model, some of these responsibilities (e.g., ensuring pharmacy's ability to meet criteria, ongoing monitoring and reporting, etc.) may fall onto the regulator and/or government.

The implementation of this new regulatory regime will be a significant undertaking, as with any new regulatory regime. For example, new policies, certifications and benefit explanation materials will need to be created to ensure members understand the impact to their coverage. We recommend that any new regulation in this space, whether it be the SME or AAWP model, come with a long transition and coming into force (at minimum 24 months) period to reduce disruption to patients.

For Regulators, Insurers, Intermediaries, and Pharmacy Operators:
15. How should responsibility (e.g., oversight, enforcement) be allocated between provincial regulators under either option? Would the powers or mandate of one or both provincial regulators (i.e., OCP and FSRA) need to be revised?

FSRA should continue to have oversight of insurers, while the OCP should continue to have oversight of pharmacists, patient safety and quality of care with respect to pharmacies.

For Rural/Northern Ontarians:

16. Which, if any, of the proposed options would best improve their ability to access care?

Insurers' PPNs already consider the access needs of rural patients.

If regulation is deemed necessary, the SME model is the best policy option to alleviate burdens for Ontarians living in rural or northern communities as it is tailored to consider unique patient needs.

For Ontarians with Disabilities and Ontarians Age 55+:
17. Which, if any, of the proposed options would best alleviate the burdens (e.g., using specific pharmacies, delivery-only) on account of age or disability?

Insurers' PPNs already consider the accessibility needs of patients when designing their PPNs.

If regulation is deemed necessary, the SME model is the best policy option to alleviate burdens for Ontarians with disabilities or those over age 55, as it is tailored to consider unique patient needs.

While AAWP may force insurers to allow additional pharmacies into their network based on minimum threshold requirements, it does not address inequity for unique patient populations.

For Indigenous Communities and Linguistic or Cultural Minorities:
18. Which, if any, of the proposed options would eliminate barriers that PPNs may pose in accessing culturally-appropriate care and/or care in a preferred language (including French, ASL, LSQ, Indigenous languages)?

The SME model is the best policy option to alleviate burdens for Indigenous communities and linguistic or cultural minorities, as it is tailored to consider unique patient needs.

CONCLUSION

We greatly appreciate the opportunity to provide comments on PPNs and the continued engagement on this issue. Should you have any questions, please contact Sarah Hobbs, Vice President, Policy at shobbs@clhia.ca.

WHO WE ARE

The Canadian Life and Health Insurance Association ("CLHIA") is the national trade association for life and health insurers in Canada. Our members account for 99 per cent of Canada's life and health insurance business.

The life and health insurance industry is a key contributor to the health and well being of Canadians and the healthcare system through the provision of health insurance to 27 million Canadians. In 2023, our industry paid nearly $37 billion in claims for health, drugs and dental care. Prescription drug costs continue to account for the largest share of health benefits at $15 billion – this accounts for over 35% of drug spending in Canada.

Protecting **11.1 million Ontarians**

10.4 million
with drug, dental and other health benefits

8.5 million
with life insurance averaging $273,000 per insured

5 million
with disability income protection

$56.7 billion in payments to Ontarians

$19.7 billion
in health and disability claims

$7.5 billion
in life insurance claims paid

$29.5 billion
in annuities

$3.7 billion in provincial tax contributions

$424 million
in corporate income tax

$452 million
in payroll and other taxes

$746 million
in premium tax

$2.09 billion
in retail sales tax collected

Investing in Ontario

$378 billion
in total invested assets

97%
held in long-term investments

Canadian Life & Health Insurance Association

Association canadienne des compagnies d'assurances de personnes