Canadian Life
and Health Insurance
Association Inc.

Association canadienne
des compagnies d'assurances
de personnes inc.

Frank Swedlove
President

September 2, 2014

Ms. Linda Silas
President
Canadian Federation of Nurses Unions
2841 Riverside Drive
Ottawa, Ontario
K1V 8X7

Dear Ms. Silas:

I'm writing you to outline our concerns with the Canadian Federation of Nurses Unions' (CFNU) recently published report "**A Roadmap to a Rational Pharmacare Policy in Canada**." It contains a number of errors that ultimately result in inaccurate conclusions about the benefits of nationalising Canada's prescription drug coverage market.

The author bases his analysis on data for the entire supplemental group benefits market in Canada. This market includes a disparate set of businesses that is much broader than simply prescription drugs. In addition, in a number of areas, the author mischaracterises the current system of private prescription drug coverage in Canada. The net result is that the conclusions about the benefits of nationalizing the drug coverage system in Canada are not supported by fact. We outline our specific concerns in the attached Appendix for your review and consideration.

The Canadian life and health insurance industry acknowledges that major reform is required if the pharmacare system is to be made more sustainable, although we firmly believe there are better and more constructive approaches. As this report notes, the CLHIA released a policy

paper in June 2013 where we identify a number of actionable and achievable ways that this could be done. We would be pleased to meet with you to discuss these ideas in more detail and to identify areas of common ground.

Sincerely,

Original signed by

Frank Swedlove

c. Mr. Marc-Andre Gagnon, Assistant Professor, Carlton University
Mr. Steve Morgan, Director, Centre for Health Services and Policy Research
Professor, School of Population and Public Health, UBC
Mr. Michael McBane, National Coordinator: Canadian Health Coalition

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Appendix: Comments on CFNU report

"A Roadmap to a Rational Pharmacare Policy in Canada"

This report uses data related to the supplementary health benefits market to draw conclusions about the economics and trends around prescription drug coverage. The supplemental benefits business includes a number of disparate services, including coverage for prescription drugs, dental services, paramedical (physiotherapy, chiropractor, massage therapy etc), vision care, hospital accommodation, short term disability and long term disability. It may also include other forms of life protection, critical illness and long-term care coverage.

Each of these businesses has different margins, drivers and trends over time. Some are heavily impacted by interest rate movements and others are not. Using this aggregate data to draw conclusions about an underlying service leads to incorrect conclusions.

Specific feedback:

- *On page 26, author takes issue with the CLHIA proposal for a national minimum formulary and questions "under which principle private insurers can continue to reimburse drugs when their therapeutic value does not justify the costs."*

Employers pay the costs of their benefits and are able to make choices as to what level of coverage they offer their employees. They do so within the context of their entire benefits package and their desire to attract and retain employees as well as to promote a healthy workplace.

All insurers in Canada have plan design options for employers that include mimicking the provincial formulary, leveraging the insurer's own evidence based formulary or that provide more comprehensive access to drugs. Employers and other plan sponsors, in consultation with their advisors, chose the option that works best for their particular needs.

It is frankly curious as to why the author criticizes a situation where an employer chooses to offer to their employees and pay for prescription drugs over and above the provincial formularies.

- *On page 26, author states that "If private insurers ask provinces to lead the way and encourage greater collaboration to contain drug costs, they must also contribute to the collective effort, rather than undermining those efforts by setting unnecessarily high prices for some medicines".*

This statement is not supported by the discussion in the paper and it's unclear what the author is commenting on. Private insurers do not set prices for drugs and agreeing to purchase a prescription medication does not inflate prices for prescription drugs on provincial formularies in any way.

Indeed, through our most recent policy paper and advocacy we are aggressively encouraging governments to find ways to reduce the price of prescription drugs for both public and private sector plans. The author also fails to note the recent initiatives by private insurers to introduce solutions for clients to address drug prices including implementing pharmacy benefit agreements, introducing case management processes for high cost drug claimants etc.

- *On page 27 in Section 4.2.1 section related to "skimming" is incorrect in its characterisation of the Canadian market.*

B.C., Saskatchewan, Manitoba and most recently PEI all have income based deductible drug plans that cover all citizens equally regardless of whether they are employed or not. The state, therefore, does not have "bad" risks as the paper contends. Rather these provinces have 100% of the risks for all citizens above their established deductible limits (which are income based). They cover this liability through general revenues which are funded through their existing progressive tax system.

For the remaining provinces, we would note that the public plans are also funded from general revenues and so the risk of the public plans are in fact spread over the entire population through the existing progressive tax systems that are in place.

- *There are significant errors throughout Section 4.2.4 related to "Administrative Costs ".*

    - *Data issues:*

    We note that the research quoted in the report ultimately relies on CIHI data to estimate the administrative costs for public and private plans.

    The CIHI data for public plans does not include administration costs for administering drug programs under "Administration"; rather they are included in the category data for "drugs". This has been confirmed to us by CIHI and is also clearly highlighted in CIHI's Methodological Notes:

    > **"Administration—**expenditures related to the cost of providing health insurance programs by the government and private health insurance companies and all costs for the infrastructure to operate health departments. The administrative costs of operating hospitals, drug programs, long-term care programs and other non-insured health services are not included under the category of administration, but rather are included under the category of service, for example, hospitals, other institutions and drugs."

    As a result, the 1.8% that CIHI notes for administration is not a fully loaded cost and cannot be used as the benchmark for the costs of administering a public drug program. All that can be concluded is that the administrative costs for public plans are higher than 1.8%.

    With respect to estimates for private administrative costs, the paper incorrectly adjusts CIHI's numbers for administrative costs which results in inflated estimates for private payers. Section 3.6 of CIHI's National Health Expenditures Trends indicates that the administrative cost ratio for private insurers is 6.2%. Despite this, the author appears to

have adjusted the CIHI figures to remove the out-of-pocket costs from the calculation of the administrative cost ratio. A majority (maybe even the vast majority) of the "out of pocket" costs for drugs, dental, vision care, hospital, etc. relate to co-payments and deductibles on private plans. They are appropriately included in the calculation of administrative ratios. (To remove them begs the question of who is administering these costs? If not private payers, then who?)

The paper also references a recent publication by Prof Law et. al. in the Canadian Medical Association Journal. This paper is incorrect in its conclusions and should not be sourced in any way going forward. We outline the errors in this report in some detail on our public letter to the CMAJ and the authors. You can find a copy of this letter at:

https://www.clhia.ca/domino/html/clhia/clhia_lp4w_lnd_webstation.nsf/page/3A5E795E2F46716A85257CBD004BC933

- *Assumptions on degree of cost savings*

Regardless of the levels of administrative costs assumed by the author, the paper incorrectly assumes that removing prescription drug coverage from the suite of supplemental benefits will result in a proportionate decrease in total administrative costs. This is not the case.

Administration cost estimates are calculated for Supplemental Health business - not drug coverage. The marketing, sales and distribution costs (agents, brokers), regulatory oversight, negotiating agreements, system development etc imbedded in the administration costs are in support of all the service offerings and many are relatively fixed. Removing drug coverage from the list of services under a supplemental plan would not result in a proportionate decrease in these costs. We know from a recent survey by the CMA for example that, even if Canada transitioned drug coverage to the public sector, 85% of employers would still offer supplemental benefits to their employees. So there certainly would be a resizing of the business, but in the end insurers would still be selling and marketing supplemental health with all the attendant regulatory and distribution costs that this brings. As a result, the money freed up from removing

drugs from supplemental coverage should be really thought of as more of a haircut off of the existing cost base and not a proportionate decrease.

- *Page 31, the statement "Private health insurance plans are not only costly and inefficient, their mere existence prevents an effective coordination of pharmaceutical policy…" is unsubstantiated and clearly incorrect. Coordination between private and public plans is entirely feasible and is improving in Canada.*

- *Page 34,the section around dispensing fees is incorrect*

  The assumption that there is significant time and cost at the pharmacy level seems to rely on an analysis of the market in Canada that is approaching 20 years old and no longer reflects the reality in the pharmacy. The vast majority of prescription drug claims are now processed electronically and the pharmacy adjudication systems can administer an individual's claims in real time. For any plan member that may be on a reimbursement plan (paper), they are simply charged the full cost of the drug by the pharmacist to submit to their insurer. Any adjudication of the claim with respect to co-payments, coordination of benefits etc is done by the insurer when processing the reimbursement request.

  Accordingly, there is likely no savings to pharmacy from a dispensing perspective if private insurance were no longer on the market. The author should assume $0 savings.

- *Section 5.3 - the discussion about the Quebec system's fiscal situation is incorrect*

The paper asserts that premiums for participants in the public plan in Quebec are determined in such a way as to cover all the expenses of the plan. In fact, the Quebec drug program runs an annual deficit of $2.47 billion dollars (paying out $3.364 B in 2013 and collecting only $0.884 B in premiums). This is outlined in the "Fonds général du fonds consolidé" annual report.

This operating deficit highlights the risk in the untested assumptions about the efficiency and financial probity of government programs that underlie much of the advocacy around the benefits of nationalising Canada's drug coverage system.