UNDERSTANDING QUEBEC'S PHARMACARE SYSTEM

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Abstract

As the discussion around National Pharmacare reform is picking up its momentum, one model that may be a good option to consider for Canada is the approach developed for the 'Régime général d'assurance medicaments' (RGAM) in Quebec.

Many questions still arise and are debated about the actual performance and benefits of the RGAM. One issue that is often raised is whether pharmaceutical costs in Quebec are higher due to the adoption of the RGAM model, and thus would be costly to implement in other Canadian provinces. This paper intends to review the underlying logics, policy choices, metrics and other evidence for the Quebec public drug program to appear more or less expensive than programs in other provinces, and to provide some reasonable explanations for the differences in any comparison. Also, we intend on using those findings to simulate the results the RGAM would have experienced had the latest policy improvements been in place since the inception of RGAM.

Based on our analysis, an enhanced RGAM would have yielded lower per capita costs than what's typically encountered in other Canadian provinces, while providing 1st dollar drug coverage for all its citizens.

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Overview

According to most recent statistics, 42% of the Quebec population is covered by one of the 3 segments of its public drug program – the rest of the population being all covered by comprehensive private drug plans.

So, Quebec provides first dollar drug coverage for everyone, but at what cost? Could this model provide the panacea that Canadians are looking for to implement a National Pharmacare strategy?

Total costs of prescription drugs in Quebec will be nearly $10.6B in 2018 (both public and private) which represents close to 20% of all healthcare expenses in the province – somewhat more than the proportion spent in Canada i.e. at close to 16.3%. Also, public expenses for drugs in 2016 represented 11.5% of Quebec's total public health budget - compared to 8.4% for Canada.

There are different ways to compare drug expenditures across Canada (costs per capita, percent of GDP) and each one has its strengths and weaknesses. The Canadian Institute for Health Information (CIHI) and the Régie de l'assurance maladie du Québec (RAMQ), among others, have regularly been providing extensive statistics on drug costs for Canadians for decades. CIHI's National Health Expenditure Trends reports (NHEX) have provided annual updates and analysis on key healthcare expenditures, including drugs. In Appendix D3 of its most recent NHEX report, CIHI shows that drug expenditures per capita in Quebec were at par with Ontario before the RGAM was established, but now have grown to more than 20% higher than Ontario's (the last figures published by CIHI showed per capita drug expenditures for 2014 were 20.7% higher in Quebec than in Ontario, and my estimates for 2016 show it has likely grown to be almost 25% higher).

Clearly, these metrics show total and public drug expenditures appear to be noticeably higher in Quebec than for the rest of Canada.

Similarly, the projected estimates for public drug expenditures in Quebec represented close to 1% of GDP – while the other provinces were merely allocating 0.6% of GDP to public drug expenditures.

One of the reasons often invoked for this is that Quebec has developed a very generous public drug program with a much more comprehensive drug formulary (e.g. over 8000 DINs vs 4400 in Ontario). Some will argue that Quebec's health authorities may not have been as diligent as they should have with reviewing older drugs on their public formulary or in monitoring special authorizations for exception drugs (or special authorization drugs) or patients. Lately, it has also been argued that Quebec has not been as diligent as the rest of Canada in negotiating Product Listing Agreements, and hence, has not always benefited from the best prices available, as it assumed it did. As a result, there have been a myriad of bills passed in the last few years to help promote pharmacare reforms and rein in costs within Quebec.[1]

As in any similar stories, there may be more than one angle to look at in order to understand the underlying factors at play and identify the appropriate comparable performance measures. This report is meant to shed more light and share some insights into the Quebec government and business logic at play.

[1] For example, see Morgan S. & Smolina K. (2014) where it is argued that Quebec has the highest total spending per capita on prescription drugs – 35% higher than the rest of Canada.

Mandate

This report is meant to provide some valuable insights in order to better understand the differences in the logic behind Quebec's and other provinces' pharmacare systems based on publicly available data at the time the report was prepared. More evidence could possibly be brought to light if we had undertaken to access more detailed information from the various key health authorities or private data services. However, this would have added more delays and challenges. Given the short timeline for this project and the high likelihood that more data may not be needed, it was decided that we would review our position once the final version of the report became available and determine what aspects may be worthwhile to explore further with additional or more specialized data.

Section I: Initial Context and Objectives

First, let's provide a brief overview of Quebec's current public drug plan and how it evolved to become what it is today.

Some Historical Perspective

Pre-1997

Since the early 1970s, various measures have been deployed by the Quebec and other Canadian governments to provide access to drug treatments mostly to its low-income citizens and to its senior population (65+). In 1996, just before the launch of the current Universal Drug Insurance Program[2] (abbreviated to RGAM to use the same acronym as in French, various distinct pharmacare programs co-existed :

- The main public programs provided drug coverage without any copay or any charge to social assistance recipients, and seniors aged 65 and over and their spouses aged 60 to 64 when eligible for income supplements. However, seniors aged 65 and over who were not eligible to receive the maximum GIS benefits were required to pay a $2 deductible per prescription, up to an annual maximum of $100;
- To support public health strategies, other specific drug treatments were provided for free to treat STDs as well as certain vaccines;
- Drug benefits were provided to those indemnified or covered by Workers' Compensation or Auto Insurance programs, or for prisoners, and multiple Federal program participants (First Nations, veterans, and federal penitentiaries);
- In addition, drug benefits were provided by various public institutions, including under the out-patient assistance program 'Circulaire malades sur pied' (a Ministry's instruction set for 'patients on the go'), designed to cover unmet needs associated with specific diseases (e.g. for organ transplants, dialysis, growth hormones, AIDS, etc.) after a simple $2 deductible was met;
- In-patients received all medically necessary drugs during their stay at the hospital;
- In addition, in 1996, close to 4.5 million Quebecers were covered for drugs under their group insurance programs sponsored by a work-related organization. These private plans also provided coverage to their spouse and children.

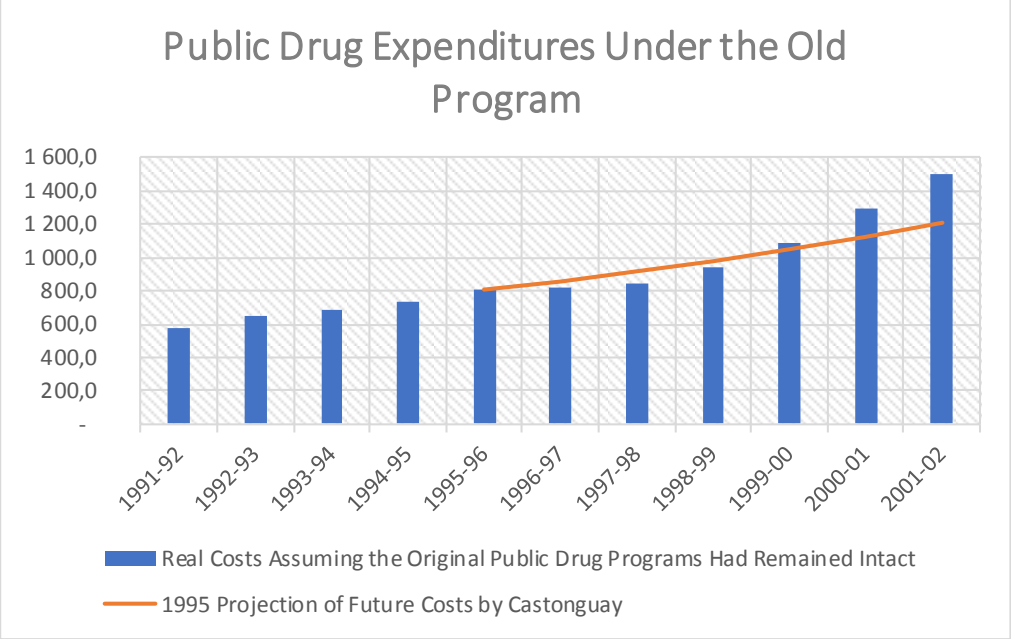
[2] Actually, the English version of the Act refers to a "basic prescription drug insurance plan". But, often the program is commonly referred to as a 'Universal Drug Program' to re-affirm the main goal of the legislation i.e. to eliminate any accessibility issue.

Yet, 1.1 million persons had no drug coverage. They were mainly contract, seasonal or other temporary workers, the self-employed, or SME employees, unemployed, or older students who were no longer eligible to be covered under their parent's health insurance plan. Hence, even with public expenses that neared $1B per year, many individuals had no access to medically necessary drug therapies. This situation was not only inequitable but also was perceived as discriminatory since public assistance for drugs was mainly provided based on age or on the source of revenue (GIS).

Further, the financial context was providing a compelling argument to create the RGAM. The Castonguay report was forecasting 7% annual growth rates in average per capita drug costs over the next 5 years, and some changes would be welcome to manage costs more effectively.

As the graphic 1 shows, the expected growth in public drug costs alluded to in the Castonguay report would ultimately have proved to end up even higher, had the original public drug program been maintained intact:

Graphic 1: Projected vs. Actual Public Drug Expenditures, Quebec



After numerous commissions and studies (Demers, Gagnon and Castonguay), legislation was developed to propose the Universal Drug Insurance Program (RGAM) to be adopted by the legislature. The Act was sanctioned in June 1996 and implemented in two quick steps, on July 1, 1996 and on January 1, 1997. It mainly meant to:

- eliminate inequitably partial, or limited or non-uniform drug coverage that was occasionally provided by public and private plan sponsors;

- reduce the often significant differences in drug coverage available on an in-patient or out-patient basis;
- support an ambulatory care strategy.

Objectives Pursued Initially

In January 1997, the Universal Drug Insurance Program (RGAM) was fully deployed with the objective of providing reasonable and fair patient access to drugs in Quebec. Beyond the broad objectives of enhanced coherence and equity, the project was targeting many more ancillary objectives and benefits (in no particular order):

1. Ensure universal coverage and eliminate the uninsured segment – 1M uninsured - to avoid personal catastrophic expenses for medically required drug treatments;
2. Build-in cost controls within the public drug program, with a long-term view: co-pays, deductibles and premium contributions could evolve over time, and would be able to fund future cost increases, if they were introduced early as part of the plan's design;
3. Meet general expectations by providing reasonable access to innovative drug treatments: Surveys were consistently indicating that most Quebecers (and Canadians) would rather make additional contributions needed to support their drug plans rather than being restricted to a plan that doesn't cover innovative and often the most effective pharmaceutical products;
4. In the long run, reduce or eliminate the inherent financial assistance built-in the public drug programs (a fixed amount of deductible) for individuals who have adequate income;
5. Reduce the leverage that lobbying groups had with government, when it came to extend coverage to new innovative treatments: the trend was for interest groups to lobby to create unique programs to access emerging drug treatments (AIDS, MS, cancer, etc.). This could only get worse and there was frankly no reason to support treatments for certain health conditions and not for others;
6. Eliminate the gap in drug coverage for the low-income working population who by and large do not have access to group plan protection;
7. Limit if not eliminate the reliance on public plans just to support the costlier treatments: there was and there still is a perception that private programs look after the better and healthier risks and do not hesitate to let them go to the public programs when they become more seriously ill. The advantages to the insurance industry of introducing mandatory participation could more easily be traded with an obligation for all private programs to maintain comprehensive coverage for all members of the selected population segment eligible for coverage;
8. Attract and retain pharmaceutical research for innovative drug products by developing incentives for the pharmaceutical industry to introduce new innovative drugs sooner to the market: pharmaceutical R&D was clearly in a worldwide expansion mode, and a significant level of economic and intellectual activity could be generated and retained in the country rather than move to the US or Europe;
9. Eliminate the pressure on hospitals who were required; at times, for obvious compassionate reasons, to provide or maintain adequate drug treatments for patients who could be more quickly released;
10. Provide coverage for children with minimal financial constraints;

11. Support most optimal medical practices and reduce total healthcare costs by utilizing cheaper pharmaceutical treatments that are increasingly more effective in reducing or eliminating traditional medical and surgical procedures;
12. Support out-patient healthcare strategies, hence eliminating part of the hospital stays that may only be needed to administer less common drug treatments (eg. drug infusion) while also shifting some of the hospitals' drug budget over to the patients.

In addition, the main features of the RGAM were to become the minimum statutory standards for all private plans:

1. With a few minor exceptions (federal employees, First Nations), all citizens have an obligation to maintain drug coverage with their designated group (through their group health plan at work or the public plan);
2. 8,000 drugs listed on the prescribed formulary (split between regular and exceptional drug lists) were to be covered by all, with no annual or lifetime limit;
3. A minimum coinsurance level and a maximum annual out-of-pocket (for all co-pays and deductibles) were imposed – see the Appendix for historical values set for these RGAM parameters;
4. An annual premium was to be paid by all adults covered by the public plan – there are no direct constraints on what private plans may charge, other than the indirect pressure from the comparative levels of the public program's premium and the direct market pressures from a competitive market;
5. Any employment-related benefit plan that includes any type of Accident & Sickness benefits (income replacement, extended health, hospital, travel etc.) to their employees or members triggers the legal obligation for the plan sponsor to also provide drug coverage that meets the minimum statutory standards – the underlying logic being that employers or unions that value their ability to attract and retain workers by providing any type of health protection must also own the responsibility to provide adequate drug coverage without relying on the publicly funded program;
6. A public pool for substandard risks was to be created and now must be maintained to ease individual mobility as well as protect the ability of any group plan to be able to secure and maintain affordable drug coverage from a competitive market – the Health minister being ultimately responsible to the legislature; has so far chosen to rely on the industry's ability to administer the industry pooling mechanism, the 'Société de compensation d'assurance medicament du Québec' (SCAMQ) – somewhat the equivalent of what CDIPC (the 'Canadian Drug Insurance Protection Corporation') now does for the entire Canadian market;
7. Initially, all drugs listed were to be covered at the RAMQ guaranteed price: we will see later that this policy was dropped. However, initially, all first-to-market innovator drugs (single source) were to be covered at that initial price for 15 years, even after a cheaper generic equivalent was introduced (the BAP-15 rule);
8. A Drug Advisory Board (le 'Conseil du médicament', later replaced by INESSS – 'l'Institut national d'excellence en santé et services sociaux') is responsible for reviewing proposals for additions or deletions to the drug formulary and making recommendations to the Health Minister.

Finally, the following features were introduced in the RGAM design, without impacting private plans:

1. Social assistance recipients were provided drug coverage without any co-pay, deductible or premiums;
2. Premium contributions required from all public plan members are collected by the public Revenue agency were income-tested – they are not to exceed 10.33% of an individual's income;
3. The deductible and the maximum out-of-pocket amount are applied monthly, so that an unusually large expenditure made in one or a few months would not generate an unduly large burden.

Section II: Policy Setting and its Impacts on Drug Costs

In this section, we undertake to provide an analysis of the key policies that have impacted prescription drug expenditures:

- **Mixed funding**: to avoid requiring the government to fund all benefits for all its residents, we should consider leveraging the fact that a significant portion of the population is already covered under private group plans. Also, some **cost-sharing** may be contemplated for those who are to be publicly insured and have the financial resources to do so;
- **Universal and mandated drug coverage**: eliminates program multiplicity, mandated participation while providing financial assistance to low-income individuals;
- **Mandated minimum standards and limitations** of the potential anti-selection between private and public plans;
- The RAMQ **BAP-15 rule**[3] and the support of the industrial policy;
- Increased use and support of the reliance on drugs for medical therapies, to generate medical and hospital savings from a global perspective, by expanding the number of drugs listed on the minimum mandated drug formulary (at least, relative to other jurisdictions);
- Quebec's approach to **Product Listing Agreements (PLAs)** or other forms of negotiated lower drug prices over time; ; and
- Quebec's approach to **pharmacy dispensing fees** relative to other jurisdictions.

The intent is to conclude this section with an estimate of the incremental and cumulative impacts of all these policies on drug prices / costs in the province.

A. Mixed funding

Introducing a universal Pharmacare plan brings unique challenges when it comes to funding for coverage of a large previously uninsured population. Before the RGAM was created, Quebec was providing coverage to seniors and welfare recipients, and hence had 1.1M individuals uninsured and 4.0M individuals insured through various private insurance, mostly employment related group plans.

[33] Best Available Price for 15 Years: BAP-15 is a RAMQ policy that protected (for 15 years from the date they are listed on the RAMQ formulary), 50 brand name drugs. For Quebec residents, these 50 select brand name drugs are eligible for reimbursement even when generics are available. To be compliant, if a Quebec member chooses to have the brand drug, private payers reimburse at the brand drug cost. This was implemented in 1994 and withdrawn in 2014

Quebec adopted a mixed system in order to simply provide funding for the uninsured population, and thus avoided having to also fund for drugs for the sizeable insured privately. Since mandatory coverage would inevitably raise the issue of affordability for some of the uninsured population, income tested subsidies were to be considered. At the same time, a stronger discipline was needed to maintain adequate and reasonably consistent drug coverage from all the possible private group plans designs. Those two policies saved the government from having to levy more income taxes to support the addition of coverage for both the uninsured and the privately insured population, in addition to having to compensate for the loss of premium and retail sales taxes levied on private plan premiums, as well as a material loss of economic activities associated with disbanding a significant part of the insurance industry.

B. Cost-sharing and maximum out of pocket

Cost sharing refers to what patients spend "out of pocket" for their health care at the time of service. Plan design features like deductibles, co-payments, and coinsurance are considered elements of cost sharing. As employers, insurers, and policy makers look to control health care spending, cost sharing has increased and patients are routinely paying more out-of-pocket for their health care and prescription drugs.

Most private and all public drug plans now include provisions requiring plan members to share the costs of core drug benefit expenses, except at times for specific evidence-based preventive health services or for financially assisted individuals. At times, incentive-based cost-sharing features may adjust cost sharing to encourage plan members to use lower-cost medications.

Cost-sharing features act as both a funding vehicle and an individual incentive to carefully use the plan's resources. Even though most prescriptions are established for valid medical reasons, there are numerous valid reasons to rely on cost-sharing to control expenditure levels. Yet, financial barriers should not prevent valid treatments from being administered due to limited financial means.

For these reasons, all provinces have generous plans for social assistance beneficiaries that leave patients with no or minimal out-of-pocket expenditures.[4]

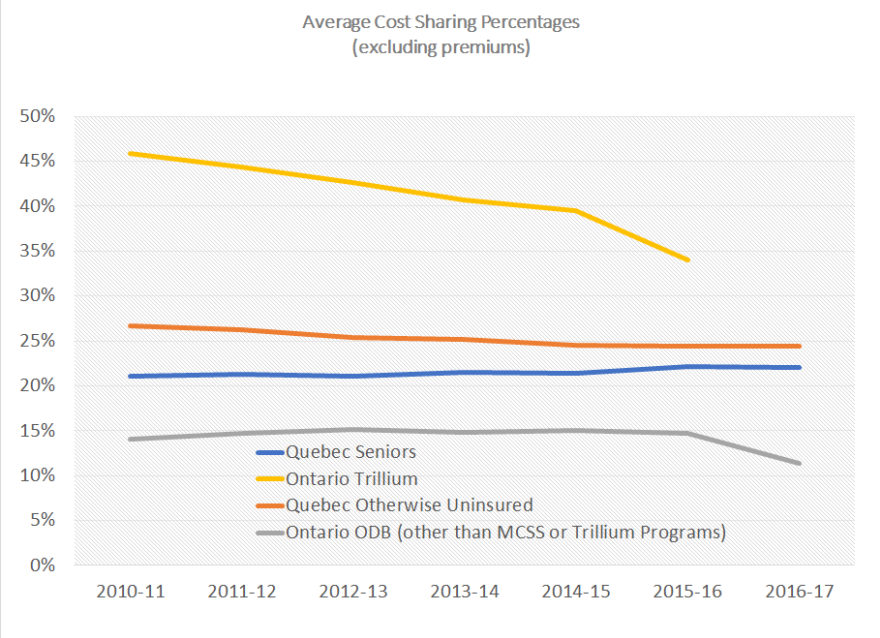
Otherwise, cost-sharing features vary widely within and between provincial plans[5]. All provinces have generic payment rules that generally state that the provincial payer will pay only the amount for generic equivalents, where available. All of the provinces have different plans for those aged less than 65 years and those aged 65 years or more except Quebec, Manitoba and BC. Some provinces rely on premium-based systems, whereas others use some mix of copayments and deductibles to cost-share with beneficiaries. In general, the amount of out-of-pocket expenditures paid by Canadians varies by medication burden and/or income level except within Alberta.

[4] Also see Esmail & Barua (2015) for a detailed review of drug coverage for low income families in Canada and lessons learned from Switzerland and the Netherlands

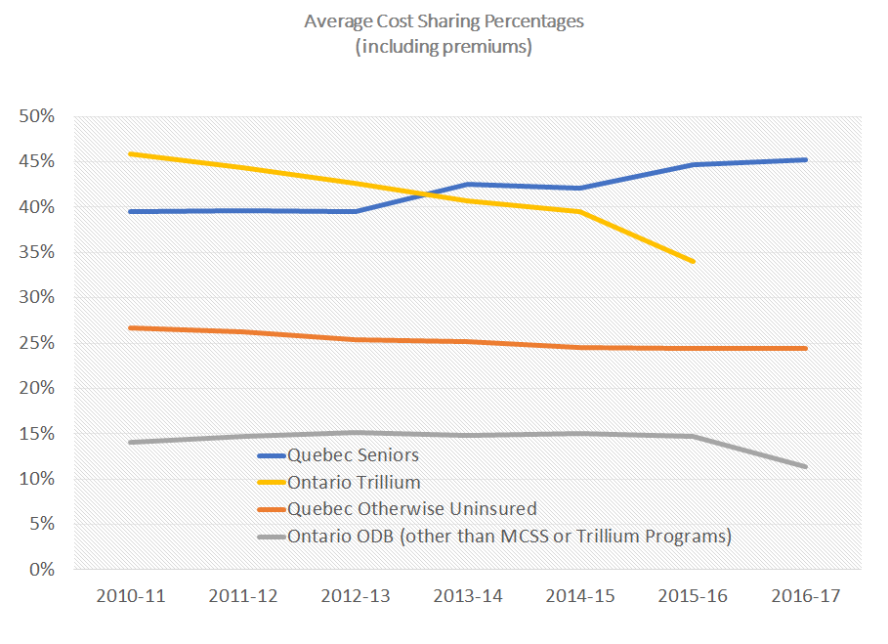
[5] This section relies heavily on Campbell & al. "Comparison of Canadian public medication insurance plans and the impact on out-of-pocket costs", December 2017

With the exception of Quebec, all provinces use multiple medication insurance plans (up to 27, in P.E.I.), which makes comparison of cost-sharing levels more difficult[6]. A quick comparison of the trend in the

Graphic 2a : Cost-Sharing – Excluding Premium Contributions



Graphic 2b: Cost-Sharing – Including Premium Contributions



[6] See Appendix 1, Tables 2 and 3 for a recent and complete review of most cost-sharing features for all Canadian public plans.

level of cost sharing was derived (excluding expenditures for social assistance recipients) based on data released by Ontario and Quebec health agencies[7] and are illustrated in Graphics 2a and 2b.

The following comments are drawn from these two graphs:

- Before considerations for maximum out-of-pocket, Quebec coinsurance levels averaged 32%, which with a $200 deductible should have lead to a 50% cost-sharing. Yet, after reflecting the monthly application of deductibles and out-of-pocket maximums, cost-sharing for seniors and public insureds average 22%-24%, which compares easily with other Canadian non-catastrophic plans' cost-sharing level (see Appendix 2 for summaries of cost-sharing features for all Canadian drug plans);
- What distinguishes Quebec's approach to cost-sharing of its public drug plan expenditures is the material impact of its income tested premium requirement. Premiums are not a benefit-based cost-sharing feature and are often viewed as indirect taxation, and hence are not reflected in the cost-sharing measures.
- Ontario seniors appear to support a lower share of their drug benefits, likely lower than would be expected in other public drug programs;
- Ontario residents who rely on Trillium to cover their drug expenditure appear to have a lower than average family income than average Canadian families; despite the recent increase of younger claimants under Trillium (with likely higher income), it continues to be the case that the program is predominantly used by those in groups with lower deductibles (92.0% in 2015)[8];
- If we were to include premiums in the cost-sharing calculation, then Quebec seniors would appear by far to support the highest proportion of their drug costs.

In retrospect, there appears no be no clear or fix logic to set the cost-sharing level, other than:

- Low income and financially assisted population segment are typically waived from having to make any significant contribution to fund their own drug expenditures, otherwise they will forgo medically necessary treatments that will add more to healthcare costs than the costs borne by waiving their financial contribution to the plan;
- Specific population segments may be required to contribute more or less than others simply based on historical levels and each plan's philosophy;
- High claimants' cost-sharing rates are typically capped – reflecting the true shelter these plans normally provide against catastrophic losses.

In the end, the level of cost sharing may end up becoming the balancing item to relieve public finances from the impact of ever increasing drug prices.

C. Impact on Utilization

In addition to helping to support drug program's expenditures, cost sharing may impact the level of utilization. Price elasticity is known to be low for medically necessary prescription drug. Yet, cost-sharing does impact drug consumption. For example, a US Study on Medicare beneficiaries with employer-sponsored retiree showed that higher cost-sharing in tiered drug plans reduced overall expenditures and

[7] The level of deductible for the Ontario Trillium program was based on information reported by Welds, K. in 'Shifting The Drug Cost Burden in Ontario', stating that, according to the ministry, "average net household income of Trillium beneficiaries is $35,000".
[8] See Tadrous & al., 2018

the number of prescriptions purchased. The estimated price elasticity of demand for prescription drug expenditures was -0.23. Unsurprisingly, beneficiaries were less responsive to cost sharing incentives when using drugs to treat chronic conditions, with members in three-tiered plans having 11.5 % fewer prescriptions filled for maintenance medications used for the long-term treatment of chronic conditions -compared to 14.6 % overall.[9]

D. Universal and mandatory participation

The current RGAM is unique in Canada because it requires all Quebec residents to be covered by a prescription drug insurance plan that meets minimum statutory requirements.[10] In addition, individuals who were mostly uninsured before and now are required to join the public drug program are compelled to join a public program that is structured as an insurance plan: participation is mandatory, premiums are required from each participant (except for welfare recipients and children), and drug claim expenditures must be shared with the plan (up to a maximum out-of-pocket level).

To allow for public and private insurance to effectively coexist, rules had to be introduced to prevent individuals to arbitrarily elect between private and public coverage solely based on their own economic advantages – and usually to detriment of the public plan. It would be typical for a competing private market to compete to attract the lower cost risk profiles. Therefore, private insurers naturally would typically try to attract the lower risks to maintain an edge by generating the lowest premium rates. It was decided that the only population that could and had to maintain private drug coverage were workers who would be provided with any type of group accident & sickness benefits (mostly income replacement).

Rules were then needed to protect the public program's experience by setting criterias for "pre-determined groups" to be required to maintain minimum statutory coverage under a private plan, while all others to have to be compelled to join the public plan. Depending on whether you qualify for either public or private coverage, then you HAVE TO maintain coverage that meets the minimum statutory standards with your designated primary insurance provider – and support the premiums and copayments requirements of that plan.

Under RGAM, the legislation was set so that only a certain segment of the working population would not have to join the public plan – or have to maintain private coverage of all mandated drugs, depending on how you want to look at it. The trigger used in the legislation to distinguish between having to maintain private coverage or to join the public program is for any "pre-determined groups of workers" to elect to provide or receive any types of group accident and sickness benefits (typically income replacement and complementary health protection): if they are eligible to any group accident and sickness benefits, they must maintain private drug coverage, otherwise they must join the public drug plan.

By keeping that protective wall between private and public plans, unit costs for drug expenditures are expected to trend without an adverse anti-selection effect. Finding the right measures to compare expenditure trend between provinces then become challenging: if effective, the protecting rules would keep public expenditures costs at similar levels or even better than for other provinces.

[9] Gilman & Kautter, 2008

[10] An approach shared with typical Workers' Compensation schemes in Canada and in the US, as well as Obamacare.

Per capita drug expenditures are most often used as comparative measures: per capita cost do reflect the different number of individuals in each province, but do not adjust to reflect the effects of a difference in the age structure or in the prevalence of public coverage. As we shall show later in this section, measures of overall costs using 'per capita costs' may easily be misleading in this context.

Per capita costs published by CIHI may have lead many to believe that public drug expenditures in Quebec have dramatically increased by 58% from 1996 ($105.95 before the launch) to 1999 (then $167.23), while it was only increasing by 26% in the "Rest-of-Canada "during that same period[11]. The reality with the program change is that the number of claiming individuals jumped from 1.2M in 1996 to 2.1M, a 75% increase, as a result of the extension of public drug coverage to 1.5M low income workers, unemployed residents, or simply uninsured workers[12]. However, this new segment came in with a premium contribution that meant that the net costs to government represented only $65M (RAMQ, 1998), or just 10% of total net expenditures (after accounting for premium contributions). Most of the misunderstanding in the differences in per capita costs of public drug expenditures between Quebec and the Rest-of-Canada stems from mishandling of the public support for the newly insured population and of the premium contribution.

In fact, what resulted from the introduction of the new RGAM provisions meant:

1. That there was little or no change to the costs and support for welfare recipients[13];
2. Except for a relatively small income assistance component, the newly publicly insured group essentially paid for its means through income-tested premium contributions collected annually through the income tax filing process;
3. Most public drug plan expenditures i.e. drug costs for seniors, were financially stabilized through an implicitly indexed premium contribution;

All this while a rather comprehensive drug formulary was made available for all residents, and the pharmaceutical industry was being incented to bring new pharmaceutical innovations to the Quebec market – to benefit from the privileged BAP-15 position.

Because the impacts of the newly-added segment were comingled by CIHI with other 'traditional' public drug expenditures, and probably some confusing terminology used by CIHI[14], this translated into a common misunderstanding in the actual financial impacts of the new program. To blur things even more, CIHI reported the premium contribution in a separate set of tables, which further exacerbated the trends.

The following two graphs, Graphic 3 and 4, are meant to show how the three population segments made up the per capita measures reported by CIHI during the introductory period.

[11] See CIHI National Health Expenditures Appendix D3

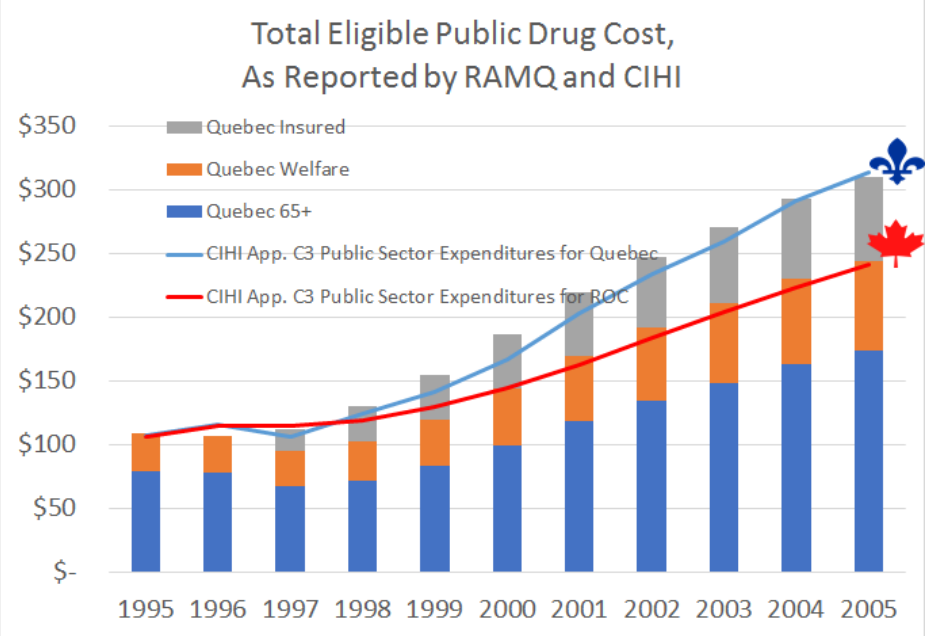
[12] In total, 1.5M new insured were added, bringing 0.9M new claimants - RAMQ calling the latter 'participants', a somewhat counter-intuitive name tag for those who are used to the different meaning in a group insurance context.

[13] Initially, welfare recipients were required to support the same copays as all other participants, but this was later reverted on January 1, 2005 to the original position after the Tamblyn report indicated that this situation created unreasonable social and medical issues.

[14] CIHI NHEX reports provide total eligible drug costs in Appendix C3 as 'Public Sector Expenditures', while eligible drug costs netted against premium contributions collected are reported in Appendix C4 as 'Government Expenditures'.

First, consider total eligible drug costs borne by public drug programs in Quebec vs. ROC, as reported by CIHI:

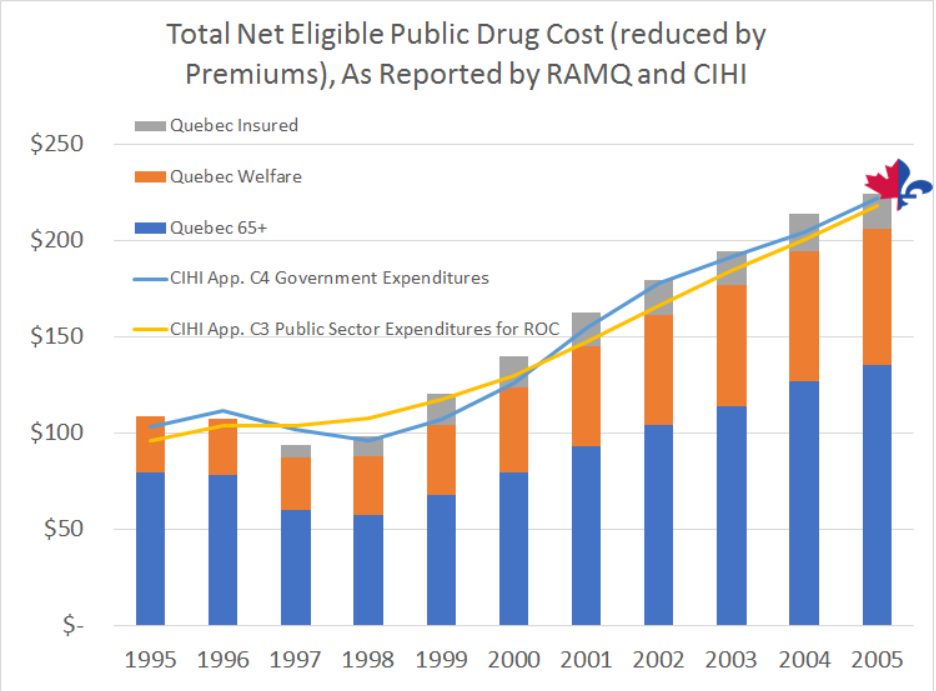
Graphic 3: Public Drug Expenditure Trend In Quebec and Canada, Per Capita



The divergence between the 2 lines for Quebec (blue) and ROC (red) per capita costs are too often interpreted as showing a growing gap between the costs borne in Quebec vs. the ROC, while the main difference between the two is mostly the result of the addition of first-dollar drug coverage for the uninsured working population segment (shown by the grey bars).

As mentioned earlier, the ambiguity in the treatment of required premium contributions by the newly insured population segment is not accounted for in the previous per capita cost comparisons. Next, Graphic 4 shows how per capita public drug expenditures compare between Quebec and ROC, once premiums are accounted for and properly allocated:

Graphic 4 : Public Drug Expenditure Trend In Quebec and Canada, Per Capita

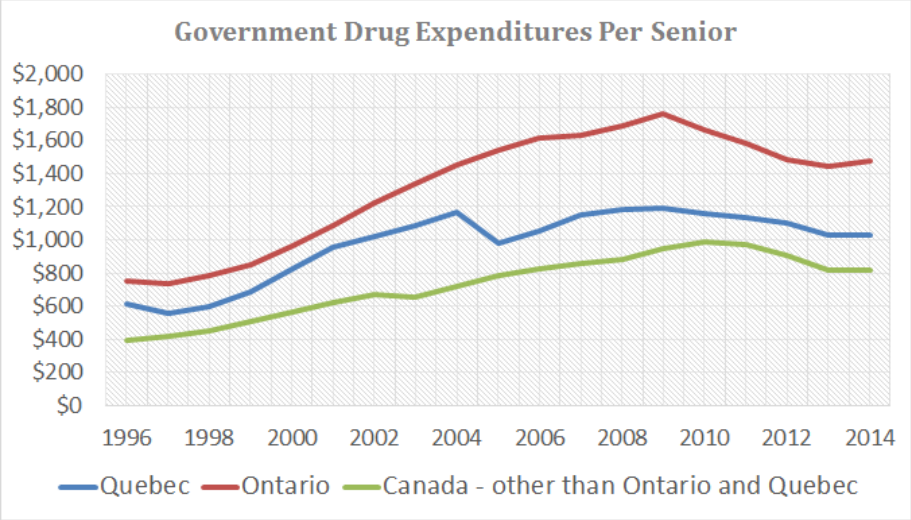


Graphic 4 depicts clearly how per capita costs were trending similarly in Quebec and Canada, with the newly public insured population (shown with grey bars) only marginally adding to public costs.

Also, we may gain some additional valuable insights by focussing on the cost trend for the government to provide coverage to its main segment - seniors. It is again often mentioned that Quebec's expansion of drug coverage to seniors with such a wide-ranging drug formulary was unnecessarily adding costs to its public program. It should be noted that per capita cost measures may again be misleading in that it is also distorted by the demographic structure of the compared populations.

CIHI NHEX Appendix E provides drug and other healthcare costs by age groups. This appendix re-allocates by age and sex the results published in Appendix C4 (Government) expenditures, i.e., expenditures reduced by the premium contributions required. Graphic 5 depicts how the new RGAM costs structure, when expressed per individual senior covered, not only did not add costs to government following the introduction of the RGAM, but in fact provided a lower and much more stable cost structure (even in constant dollar terms) in Quebec than in other provinces

Graphic 5: Average Drug Expenditures for Canadian Seniors



In essence, it appears that Ontario would save the most by implementing a public program to its seniors population that replicates some of the RGAM features, while all other provinces would likely have to support an average of 25% increase in costs for its seniors – before we consider other potential savings that will be discussed later in this report. True seniors are required to contribute more money, but they get more benefits in return, as a carefully designed expanded formulary is known to result in reduced medical and hospitalization costs; - another way of saying just better health[15].

E. The impacts of BAP-15 and other industrial development policies

BAP-15 is the acronym for Best Available Price after 15 years (PPB-15 in French, for 'Prix le Plus Bas"). It is a Quebec policy which the Quebec government used to continue to reimburse first-to-market brand name drugs at its original price for a 15-year period from the listing of the drug on the Quebec formulary, even if after cheaper generic products became available. In other words, "BAP-15 drugs" are the innovating brand name drugs which were awarded "price protection" by RAMQ on its covered drug list (i.e. RAMQ does not cutback to generic pricing) for a 15-year period for bringing new innovative and cost saving drug treatments to its drug formulary. On average, this adds up to an additional two to three more years of sales without having to cut back its price after cheaper generic products became available.

BAP-15 was introduced in 1994 (thus before the RGAM started) to attract and retain pharmaceutical research and investment in the province. It undoubtedly added to the costs of drugs borne both by the government, private plan sponsors, and patients. In fact, it shifted the costs of an industrial strategy to those who provided the funding basis for drug coverage i.e. public and private drug plans. On the other hand, it could probably be argued that they all benefited from lower taxes resulting from the

[15] A US research performed on US Medicare showed that US$2.06 were saved in Medicare hospital and medical costs for a dollar spent on prescription drugs (Shang & Goldman, 2007)

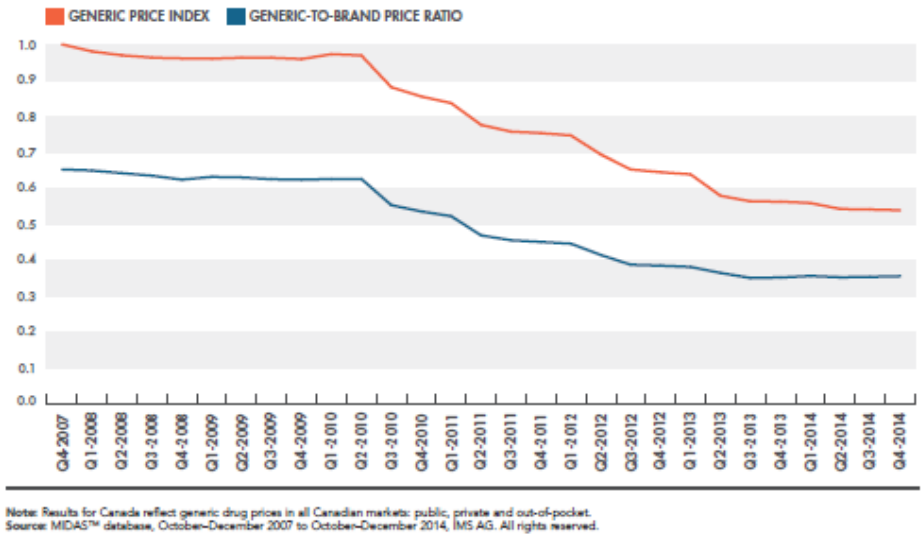
positive impacts the RGAM had on the provinces healthcare budgets and increased economic activity generated by the pharmaceutical industry.

Initially, net costs for the BAP-15 policy were thought to be minimal since only a small number of innovating drugs qualified for the special status while the costs for generic products were generally still high – 60-70% of the equivalent brand product. Later, the market for generics literally took off in the US following the introduction of US Pharmacare (Medicare Part D, promulgated in 2003 and effective Jan. 1, 2006) and hence US generic drug prices started to decline sharply, while Canadian generic prices initially lagged, until 2010.

Generic drug prices sharply declined following the introduction of Medicare Part D—the voluntary outpatient prescription drug program administered by the Centers for Medicare & Medicaid Services within the Department of Health and Human Services (HHS). More specifically, generic drug prices fell 59 % from the first quarter of 2010 through the second quarter of 2015.

Canadian generic prices have been relatively high historically compared to international and US levels. Through the implementation of more proactive generic pricing policies, the provinces have been able to reduce that pricing gap for all Canadians, generating important cost savings. While these policies had narrowed the gap in generic prices between Canadian and international markets, prices in other countries continued to be lowered. Canadian generic prices fell by an average of 48% during the 2010-2015 period, exceeding the generic price reductions in all other foreign markets analyzed. The largest declines (65%) were realized for the 18 commonly used generic drugs whose prices were reduced to 18% of their equivalent brand-name products through the pan-Canadian Pharmaceutical Alliance

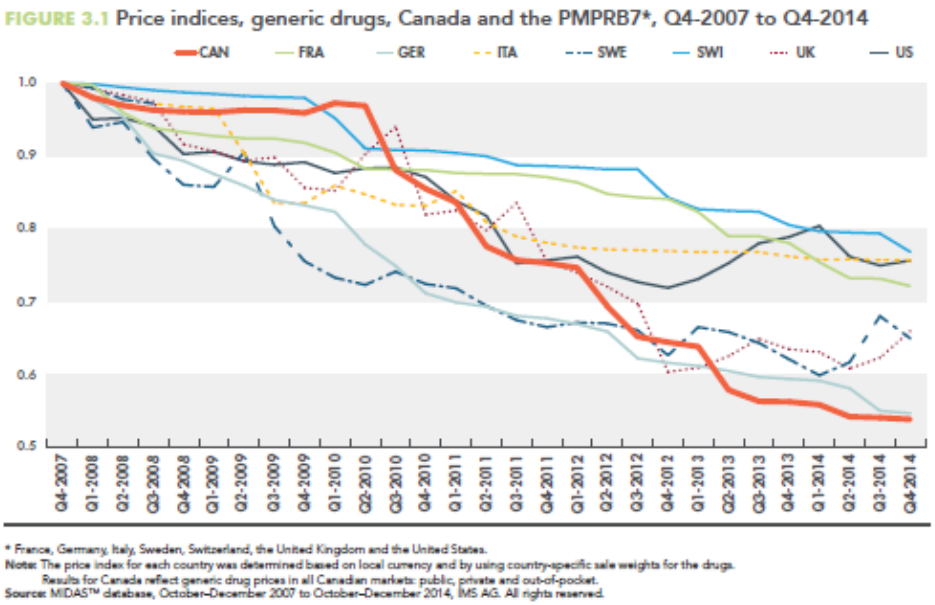
Graphic 6: Generic Pricing In Canada



Source : Figure reproduced with permission from PMPRB's 2014 'Generic 360' report, p. 6

(pCPA). Relative to their brand-name counterparts, average generic prices in Canada declined from 63% to 35% of its equivalent brand during that same period (as depicted in Graphic 6 and 7).

Graphic 7 : International Comparisons of Generic Pricing In Canada



Source : Figure reproduced with permission from PMPRB's 2014 'Generic 360' report, p. 12

Declining generic drug prices provided for more opportunity for arbitrage, so generic manufacturers could pay more for the pharmacists to perform the extra work to substitute the more costly brand drugs by their generic products. Yet, higher prices were still being borne by most Canadian public and private drug plans until 2011. Even so, the proportion of total costs directed at generic drugs was consistently lower in Quebec than in the rest of Canada – due to higher spending on branded products and a lower substitution rate of multiple-source drugs. From that moment, the costs of maintaining the BAP-15 program became more onerous; while at the same time, investments in pharmaceutical R&D was gradually moving outside of Quebec and Canada, to the US and Europe.

BAP-15 was terminated on January 1, 2013. Despite this change, doctors could still request that a prescription for a multiple-source brand not be substituted. The option to impose a substitutable brand was eliminated in April 2015.

It is difficult to precisely measure the net financial impacts of the BAP-15 rule on drug expenditures or government finances:

1. It has different impacts on public and private plans;

2. It varies from one branded product to another based on the time the generic entered the market, the price differential, the number of generics and the timing of product entry for each of them, as well as plans cost management strategies;
3. Economic benefits should be reflected to account for the tax revenues and economic multiplier effects resulting from R&D expenditures that would have otherwise been made elsewhere. In addition, the Quebec government was providing the pharmaceutical industry with tax credits worth 25% of total R&D spent in the province.

Nevertheless, the Quebec's Minister of Economic Development at the time reluctantly acknowledged that the BAP-15 rule was costing Quebec more than it benefited the province, about $165M per year by 2009, but that he had no data to evaluate the cost and the benefits of the BAP-15 rule for subsequent years. It wasn't clear whether he alluded to the costs to the Quebec public drug plan only or that his estimate also included the costs borne by private plans as well. Simple modeling performed to reflect the main costs and benefits led to the following estimates:

Table 1: 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

The above estimates seem to correlate reasonably well with other work performed previously. Earlier research performed for the Finance Minister estimated the additional drug expenditures resulting from the application of the BAP-15 rule were approximately $25 million annually for the Quebec's public plan in 2005 (see MFQ 2005) while another one study indicated that it had reached $193 million per year in 2011–2012 (see Lacoursière, 2012).

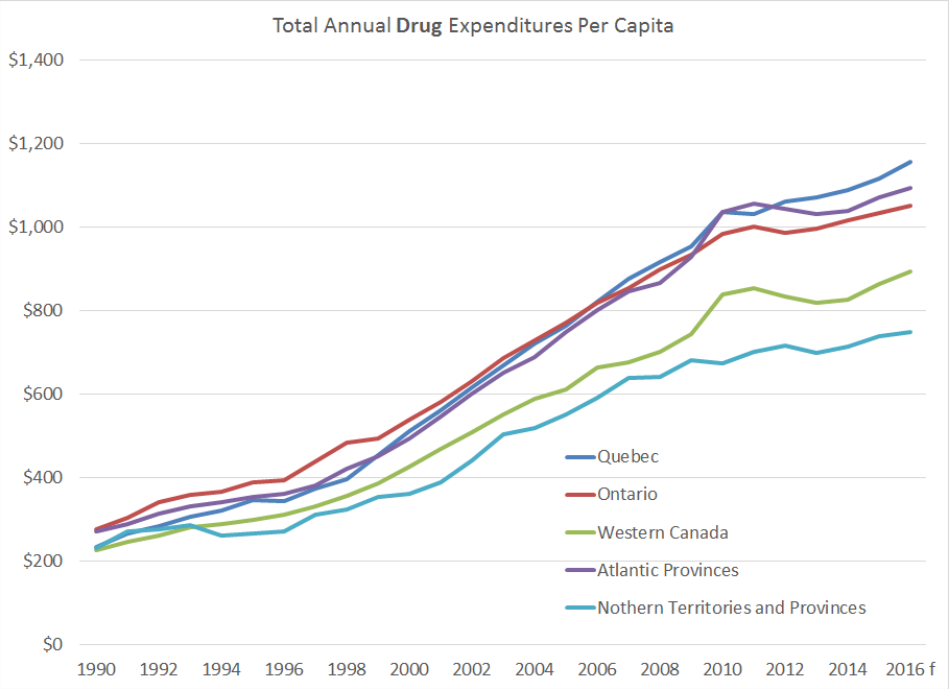
F. Increased use and support of the reliance on drugs for medical therapies

The effect of mandating unlimited coverage of an apparently more generous drug formulary may have supported the perceptions that Quebec's drug utilization is overwhelmingly costly. Although it is difficult to compare the ultimate impacts of the RGAM requirements on public and private expenditures made on drugs, CIHI has provided annual estimates by province for all costs borne for drugs, including public and private expenditures, premiums and co-payments, as well as personal expenditure made for any uninsured medication. The measures are, of course, imperfect since they are not adjusted for the impact

of the varying demographic profiles (CIHI reports net government expenditures by age and sex, but not total expenditures from all sources), differences in the level of access, or regional differences in medical practices or supplies of certain drugs. Graphics 8 and 9 show that although Quebec definitely spent more for drugs than ever before, this was more than compensated by much larger differences in total per capita expenditures made for all healthcare services, as anticipated.

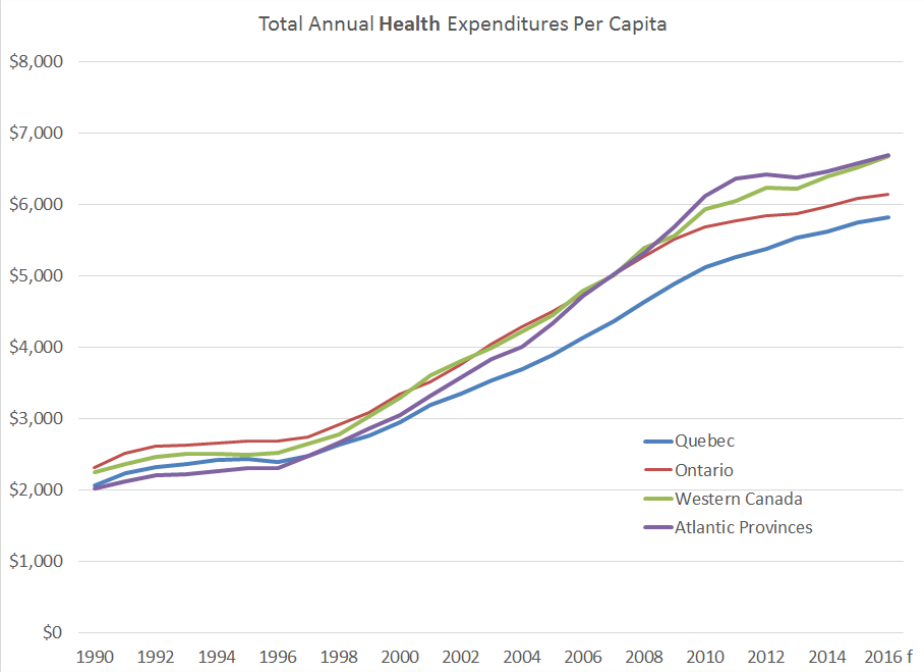
In other words, although Quebec ranked in the middle of the pack in terms of total amounts spent on drugs when RGAM was introduced, and now ranks first in terms of total drug expenditure per capita,

Graphic 8: Provincial Comparisons for Total Drug Expenditures



statistics available for up until the end of 2016 showed that the impact since the introduction of RGAM could not be more than 10% i.e. approx. $100 per year per capita. On the other hand, Quebec's global health strategies seem to have allowed to support a 10% overall reduction in total health expenditures i.e. approx. a $1,000 per year per capita saving.

Graphic 9: Provincial Comparisons for Public Healthcare Expenditures



G. Indirect Savings From A Comprehensive Coverage of Prescription Drugs[16]

This should not come as a surprise as this is echoed by other studies in Canada and in other countries as well. For example, a US study on Medicare participants showed that a $1 increase in prescription drug expenditures reduced Medicare expenses by $2.06 in 2000 (Shang & Goldman, 2007). An older research, also about the US experience, estimated that an increase of 100 prescriptions reduced average length of stay at hospitals by 16.3 days. Consequently, a $1 increase in prescription drug expenditures reduced hospital costs by US$3.65 while increasing the costs of ambulatory care by US$1.54 (1991), hence a net saving of US$2.11 (Lichtenberg, 1996). In Canada, similar results are observed : for every $1 spent on prescription drugs, we witnessed a reduction in healthcare expenses other than drugs and medical consultations of $1.48 for men and $1.05 for women, without impacting expected life expectancy (Crémieux, Ouellette, & Petit, 2007).

Finally, other studies have shown that Quebec is able to support smaller per capita healthcare costs largely because it spends more on prescription drugs (+15%) than elsewhere in Canada: lower number of hospitalized days, more doctors, but in the end lower costs while health indicators are comparable or superior (total healthcare costs are lower, more doctors per capita, lower death rates at birth, lower prevalence of arthritis and diabetes).

[16] This section draws on a summary included in CIRANO's report "Les risques liés à la création de PHARMA-QUEBEC" (Montmarquette, Boulenger, Castonguay, 2014)

H. The number of drugs listed on the Quebec formulary relative to other jurisdictions

As we all recognize, the delivery of pharmaceutical insurance in Canada is currently a patchwork, with each province having separate drug insurance plans and limited or no requirements for private plans to meet. With the exception of Quebec, all provinces use multiple medication insurance plans, ranging from 3 (Ontario) to 17 (Prince Edward Island) (see Table 2). Many provinces also have a variety of specialized programs that support patients with exceptional needs such as palliative care and high-cost medications infectious diseases, or cancer.

Table 2: Summary of Provincial & Territorial Drug Plans

Province	No. of programs	Universal Coverage	Seniors	Social Assistance
British Columbia	10	Yes, for catastrophic drug expenses or with specific health conditions only	Covered by the universal program – except for families with at least one family member born before 1940	Yes
Alberta	11	Yes, but with restrictions and contributions required for residents aged less than 65	65 and older and their eligible dependants	Yes
Saskatchewan	10	Yes, for catastrophic drug expenses only	Different programs sor Seniors, 65+, based on income	Yes
Manitoba	4	Yes, for catastrophic drug expenses only	Only for residents of personal care homes	Yes
Ontario	3	Yes, for catastrophic drug expenses only	Different programs for 65+, based on income and esidence	Yes
Quebec	1	Yes, within a mixed system, and requiring contributions	Covered by the universal program – except for 65+ with low income	Yes
New Brunswick	10	Yes, within a mixed system, and requiring contributions	Yes, 65+ with contributions varying based on income	Yes
Nova Scotia	5	Yes, for catastrophic drug expenses only	Yes, 65+ with contributions varying based on income	Yes
Prince Edward Island	17	For specific health conditions only	Yes, 65+	Yes
Newfoundland & Labrador	5	Yes, for catastrophic drug expenses only	Covered by the universal catastrophic program – except for 65+ with low income	Yes
Northwest Territories	4	Resident, non-native or Métis who have a specified disease condition	Resident and nonnative Residents who are 60 and older	Yes
Yukon	3	For children or adults with chronic disease or a serious functional disability	Yes, 65+	Yes
Nunavut	2	For residents with chronic disease or a serious functional disability	Yes, 65+	Yes

The number of programs is based on one of the plan classifications used in the Canadian Health Institute for Health report on prescribed drug spending.

All provinces have different plans for those aged less than 65 years and those aged 65 years or more, except Quebec, Manitoba and British Columbia. Some provinces fund their programs with premiums, whereas others use a mix of copayments and deductibles to cost-share with beneficiaries. In general, the amount of out-of-pocket expenditures paid by Canadians varies by medication burden and/or income level except for Alberta.

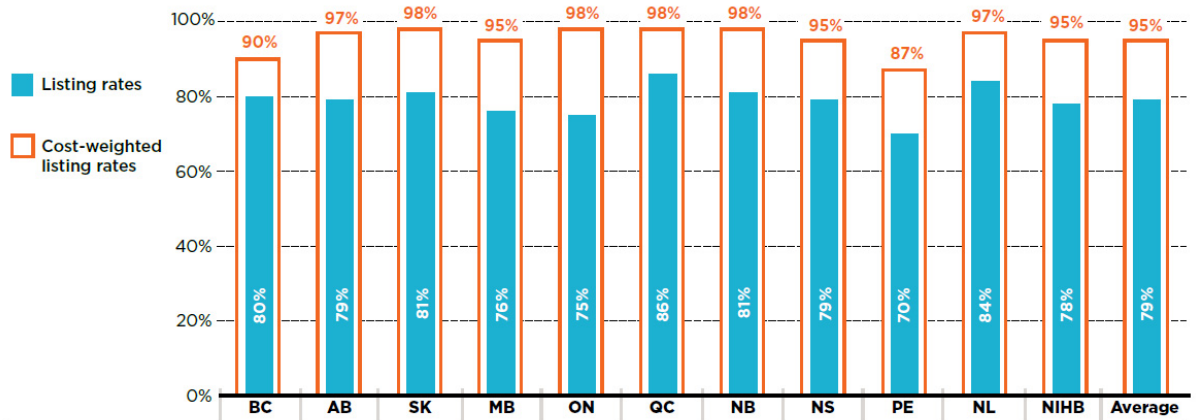
The Ontario Drug Benefit (ODB) program is one of the more generous drug benefit programs in Canada, providing coverage for over 4,400 drug products (DINs), including nutrition products and diabetic testing agents. Drugs that are not listed in the ODB Formulary/Comparative Drug Index (Formulary) are also considered for coverage through the Ministry's Exceptional Access Program on a case-by-case basis. In comparison, Quebec's RGAM covers over 8 000 drug products (DINs) which are listed on the List of Medications, published periodically by the Régie.

It is not simple to compare the extent and implications for the differences in scope of these various drug formularies. The impact of including one particular drug, or not, would vary based on

1. Provincial variations in its utilization rate and average annual costs; and
2. Alternative therapeutic treatments (for multiple-source drugs), dosage, and forms.

Yet, research published in 2017 by the PMPRB[17] found that there is a reasonably high degree of alignment among provincial drug plan formularies in Canada. Of the 1,456 drugs commonly listed on Canadian public formularies in 2015, 729 were selected for analysis, including 262 single-source brand-name products and 467 multi-source products. The research compared coverage for these 729 selected drugs that accounted for 82% of all public drug costs in 2015 (all of Canada except Quebec). Most of the 729 drugs selected for this analysis were listed on the provincial drug plan formularies, ranging from 70% in Prince Edward Island to 86% in Quebec, with an average of 79% across all the plans analyzed.

Graphic 10: Common Drugs Listing Coverage



	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	NIHB	Average
Number of drugs	585	578	592	557	549	628	592	577	509	612	566	n=729
Drug costs†	$1,235M	$638M	$360M	$404M	$3,237M	N/A	$137M	$140M	$23M	$86M	$295M	$6,555M

Source : Figure reproduced with permission from PMPRB's 2017 report "Alignment Among Public Formularies in Canada", p. 9

[17] PMPRB "Alignment Among Public Formularies in Canada" (2017)

When related drug costs are weighted in, the formulary listing rates accounts for an average rate of 95% of total plan costs - ranging from 87% in Prince Edward Island to 98% in several public plans - suggesting that drugs not covered by the plans only account for a small fraction of total costs.

A direct comparison of listing decisions between pairs of plans reinforces this result – demonstrating that while variations exist, overall there is a general consensus among plans. Different products may simply originate from the different manufacturers or be provided under different dosage or in slightly different forms, without much consequences in providing access to the needed active ingredients. For example, despite the significant differences in the number of products covered by ODB and RAMQ, both included enough of the 729 drugs selected to recoup 98% of all drug costs (see Graphic 10).

Graphic 11 shows that these high listing rates are similar for both single and multi source drugs.

Graphic 11: Single vs. Multiple Source Drugs Listing Coverage

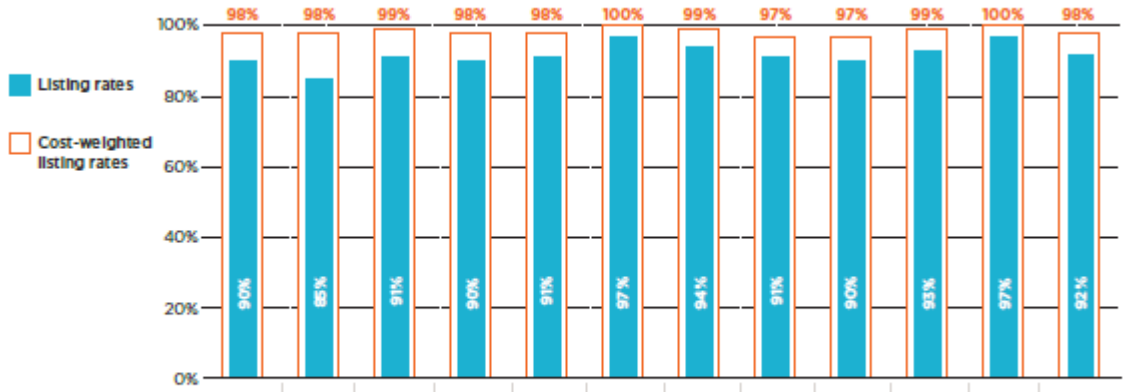
	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	NIHB	Avg.	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	NIHB	Avg.
Number of drugs	169	172	194	157	184	210	184	172	133	184	167	n=262	416	406	398	400	365	418	408	405	376	428	399	n=467
Drug costs† (millions)	$614	$361	$165	$173	$1,704	N/A	$57	$63	$10	$27	$122	$3,298	$621	$276	$194	$231	$1,533	N/A	$80	$77	$14	$59	$173	$3,257

Source : Figure reproduced with permission from PMPRB's 2017 report "Alignment Among Public Formularies in Canada", p. 15

The PMPRB study also validated the proportion of essential drugs covered by each provincial drug plan, in number of drugs and proportion of total costs. The list of 125 drugs used for this analysis was based on the CLEAN Meds Project list of essential medicines for primary health care in Canada and includes both single- and multi-source drugs (16 and 109 drugs, respectively). Two of the single-source drugs are high-cost drugs, as defined previously (adalimumab and emtricitabine/tenofovir disoproxil/efavirenz). All plans ranked fairly high, with Quebec being the only plan covering the cost of all 125 essential drugs' (see Graphic 12).

Graphic 12: Essential Drugs Listing Coverage

FIGURE 3.1 Formulary listing rates in public drug plans, essential medicines*, 2015



	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	NIHB	Average
Number of drugs	113	106	114	113	114	121	117	114	112	116	121	n=125
Drug costs†	$428M	$200M	$123M	$130M	$1,003M	N/A	$50M	$50M	$11M	$32M	$124M	$2,150M

Source : Figure reproduced with permission from PMPRB's 2017 report "Alignment Among Public Formularies in Canada", p. 21

Another approach may be based on the Common Drug Review that CADTH regularly prepares to guide listing decisions for 18 participating drug plans. A comparison of the non-mandatory recommendations from the Common Drug Review in Canada with the listing decisions of provincial payers may be performed to assess the level of provincial alignment in their product listing decisions. Allen & al. identified the recommendations issued by the Common Drug Review from Jan. 1, 2009, to Jan. 1, 2015, and compared these with the listing decisions of 3 provincial public payers (Alberta, British Columbia and Ontario) that participate in the Common Drug Review and the recommendations from Quebec. [18] Of the174 medicine–indication pairs issued in CADTH Common Drug Review reports from Jan. 1, 2009, to Jan. 1, 2015, 110 of these met the inclusion criterion. Among the 110 medicine–indication pairs, listing decisions were favorable for 95 in Alberta, 102 in Quebec, 104 in Ontario and 106 in BC. Again, there was little evidence found in this latest review, that the amounts of drugs covered materially differs in Quebec from the other plans – despite the differences in the number of drug products covered.

Finally, although drug supply disruptions are rare, they are may increasingly become part of our reality. Its causes are multifactorial and difficult to assess exactly. Due to the significant impacts drug supply disruptions have on patients' lives, proactive strategies are required to help prevent, minimize, and/or manage their impacts, and maintaining an healthy and competitive drug market is certainly a key element.[19]

In conclusion, based on the above analysis, additional costs borne by the Quebec plan that may be attributable to the number of drug products covered is not material, when compared with the Ontario plan, and may cost slightly less than 5% of total drug expenditures when compared to the Canadian average. However, there may be strategic risk management benefits in maintaining more than a single

[18] See Allen & al. (2016)
[19] See CADTH 'Drug Supply Disruptions' (2011) for a brief overview

provider in the market. Hence, we conclude that no net costs may be associated with Quebec's level of drug formulary extensiveness.

I. Program Listing Agreements (PLAs) or other forms of negotiated lower drug prices

There are many types of PLAs that may be implemented. Each type creates its own opportunities and challenges. Interestingly, unlike most Canadian provinces at the time – and although various sections of the Quebec Drug Insurance Act allow the Health Minister to enter into PLAs since 2002 – the government of Quebec has, until 2006, been reluctant to enter into such agreements (Pelchat 2012). One reason may be that the types that are clinically-based agreements are difficult to implement (Neumann et al. 2011). Other reasons may include the fact that financial PLAs are confidential, and that private insurers, and consequently the individuals they insure, do not benefit from the discount granted by the manufacturer to the government (actually, they are expected to be paying more to compensate for the lower costs to the public plans).

Unlike other provincial public plan managers, the Quebec legislation requires RAMQ to disclose any such agreement in its annual report to the public. Since 2005, RAMQ has acknowledged entering into minor types of PLAs (to cancel the annual price indexation allowed). Initially, these agreements had minor financial implications. However, in the Fall of 2014, the Provincial/Territorial Health Ministers announced the intentions for Quebec's participation in the Federation's Health Care Innovation Working Group (HCIWG). Quebec effectively started to participate in brand and generic initiatives in October

Table 3: Estimated Impacts from Product Listing Agreements

	Ontario's PLA Savings As a % of Total Expenditures	As a % of Net Expenditures	Quebec Potential Savings Missed (in M$)
2016-17	16,5%	18,6%	
2015-16	15,2%	17,2%	351,8
2014-15	11,1%	12,7%	468,0
2013-14	11,6%	13,2%	470,2
2012-13	8,3%	9,5%	342,9
2011-12	6,4%	7,3%	254,4
2010-11	6,6%	7,4%	261,0
2009-10	4,2%	4,7%	163,0
2008-09	4,5%	5,1%	165,6
2007-08	2,4%	2,7%	81,5
2006-07	0,0%	0,0%	-

2015 and joined many then completed pCPA negotiations.

It may be difficult to evaluate exactly how much could have been saved by undertaking to implement a PLA program just like the other provinces did. As a guide, Ontario was able to save a total of $4.6B from 2007 to 2017, representing 16.5% of total drug expenditures in the year 2016-17, or 18.6% of government's net expenditures[20]. Had Quebec implemented the same PLAs during that period, and assuming Quebec had little or no delay in implementing those PLAs as of October 1, 2015, we could extrapolate that Quebec would have missed $2.6B in savings, as provided in Table 3.

J. Quebec's approach to pharmacy dispensing fees relative to other jurisdictions

There are generally distinct dispensing fee structures and agreements for the public program of every provinces as well as for private payers.

Dispensing fees for the public program in Quebec are negotiated between RAMQ and the pharmacists' association, the 'Association Québécoise des pharmaciens-propriétaires' (AQPP). The agreement has mainly been maintained on a fixed fee for most prescriptions:

- The pharmacist is expected to provide supplies for a 30-day period;
- Some provisions were made to adjust the dispensing fee when the number of days the drug is provided for exceeds 90 days;
- Additional fees were allowed for specialized medicines requiring additional handling – refrigeration, mixtures, syringes preparation, re-packaging, etc.
- Specific margins were set to allow for wholesellers' distribution costs and margins

Table 4: Historical rates for dispensing fees for a 30-day script in Quebec vs. OHIP

	Quebec, June 2015-March 2018	**Ontario ODB**
Pharmacies with 48.5k transactions per year	Most scripts are paid at the following rates: - New Script, 7<Days<90 - $8.74 - Renewal scripts are paid $8.37	Since April 01, 2014, the dispensing fee payable to most pharmacies is $8.83 for each ODB prescription filled.
	Scripts for 7 days or less are paid: - New: $4.37 - Renewal: $4.19	
Professional Services	$19.79	

[20] Office of the Auditor General of Ontario, 2017. "2017 Annual Report", Volume 1

- A wholesaler's markup of typically 6.5% already built-into the drug prices, so no further margin is provided for.

As a comparison, ODB will reimburse the lesser of a pharmacy's posted usual and customary fee or the ODP Dispensing fee.

There may be multiple factors to justify paying more or less for dispensing drugs through the community pharmacies:

- Geographic distribution and concentration;
- Urban vs rural location costs;
- Actual costs and the impact of shifting costs to the private sector.

Table 5 shows the wide range in average dispensing fees supported by the various provincial drug plans in Canada.

Table 5: Provincial Comparisons for Public Coverage of Pharmacy Dispensing Fees

Jurisdiction	Maximum Dispensing Fee
Ontario	$8.83, $9.93, $12.14 or $13.25 depending on geographic location
British Columbia	$10.00
Alberta	$12.30
Saskatchewan	$11.40
Manitoba	The professional fee for Pharmacare is equal to the amount regularly charged by a pharmacist to persons who are responsible for paying the fee without reimbursement. The Employment and Income Assistance Program has a maximum professional fee of $6.95.
New Brunswick	$11.00*
Nova Scotia	$11.65
Prince Edward Island	$12.36
Newfoundland and Labrador	The professional fees for the Foundation Plan, Access Plan and Assurance Plan are: • $11.96 for drug costs between $0 and $49.99 • $23.93 for drug costs between $50 and $249.99 • $50 for drug costs of $250+ The professional fees for the 65Plus Plan are: • $12 for drug costs between $0 and $249.99 • $40 for drug costs of $250+
Yukon Territory	$8.75

* The dispensing fee is $9.50 for drugs for opioid dependence.

Source : Reproduced from Ontario's Auditor General 2017 Annual Report, Volume 1

In the end, we found no evidence to justify considering adjustments to public drug costs to reflect a policy that is different in Quebec than what is commonly applied in other Canadian provinces.

K. Cumulative impacts

In summary, we have been able to draw the following overall conclusions

- **Mixed funding**: by imposing a premium-based public drug plan to the insured segment, Quebec was able to provide, at virtually no cost to the government's general funds, a universal and wide-ranging therapeutic drug coverage to a segment of its population that would otherwise not have access to affordable drug coverage;

- **Universal and mandated drug coverage**: it has simplified public coverage and ensured consistent access to all medically needed drug therapies to support more efficient global healthcare strategies, likely generating healthcare savings, overall;
- **Mandated minimum standards and limitations**: Quebec was able to impose discipline on private plan sponsors to reduce if not almost eliminate anti-selection against public funds for high cost drug treatments;
- **BAP-15** : RAMQ's BAP 15 rules may initially have been a worthwhile policy to support an industrial policy attracting investments in R&D at little costs, yet it became so expensive that it may have cost its public drug program over $2.1B until it was discontinued in 2013;
- **Product Listing Agreements (PLAs) and generic substitution:** Increased use and reliance on drug therapies for medical treatments may have led to 10%-15% more expenditure on drugs and costing Quebec's public drug program close to $2.6B overall until it was discontinued in 2015;
- **Dispensing Fees**: Quebec's policy to pharmacy dispensing fees was found to be reasonably similar to what was implemented in other jurisdictions, and thus was deemed to be neutral.

These direct costs are summarized and applied against historical drug cost in Table 6 – indirect savings from better global healthcare outcomes are ignored for now. Overall, 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 achieved a lower drug expenditure trend.

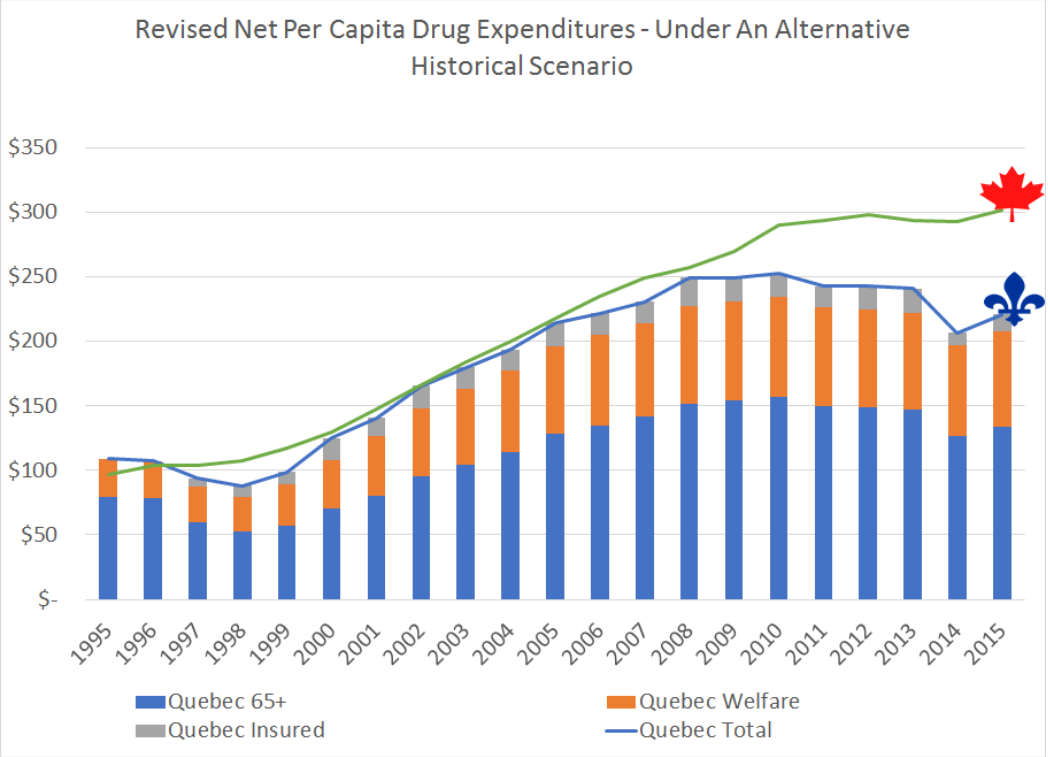
Table 6: Adjusted Net Drug Expenditures

		Additions to Gross Public Drug Expenditures			Corrections to Net Public Drug Expenditures		
	(in M$)	BAP-15	PLAs	Total Costs	Corrections to Public Expenditures	Actual Net Public Expenditures	Revised Net Public Expenditures
Budget Years	1997-1999	58,8	-	58,8	44,9	2 321,1	2 276,2
	2000-2002	93,9	-	93,9	76,0	3 675,1	3 599,0
	2003-2005	134,7	-	134,7	109,0	4 864,6	4 755,6
	2006-2008	497,8	247,1	744,8	608,5	6 221,1	5 612,6
	2009-2011	765,0	678,4	1 443,4	1 175,5	7 020,8	5 845,3
	2012-2014	894,0	1 281,2	2 175,2	1 773,8	7 213,9	5 440,1
	2015-2017	40,0	351,8	391,8	318,4	4 883,6	4 565,2
	Total	2 484,1	2 558,5	5 042,6	4 106,2	36 200,2	32 094,0

This alternative course of action would have resulted in Quebec achieving lower per capita drug expenditures while providing a much wider range of drug products than any other Canadian provinces, and providing full coverage for all its residents.

Average per capita net expenditures and trends are depicted on Graphic 13.

Graphic 13: Provincial Trends in Adjusted Net Drug Expenditures



In light of all of this, other Canadian provinces considering to extend universal coverage in the National Pharmacare discussion should probably adjust their impact assessments to reflect the differences in historical perspectives with the ones in which they will be evolving if they were to implement a model similar to Quebec's RGAM.

Section III: Conclusions

While the Quebec RGAM may appear to be more expensive than other provincial drug programs based on historical data, an adjusted historical cost base that reflects the impacts of most recent policy changes on the proper cost measurements indicates that the RGAM would likely have been showing lower per capita net costs than most other public programs in Canada while providing first dollar coverage to all its population.

REFERENCES

1. Allen, N. Walker, S., Liberti, L. Sehgal, C., Salek, S., 'Evaluating alignment between Canadian Common Drug Review reimbursement recommendations and provincial drug plan listing decisions: an exploratory study', CMAJ, 2016 http://cmajopen.ca/content/4/4/E674.full
2. Barnes, R., "Supreme Court upholds Obama's health-care law". USA, The Washington Post, June 28, 2012. https://www.washingtonpost.com/politics/supreme-court-to-rule-thursday-on-health-care-law/2012/06/28/gJQAarRm8V_story.html?utm_term=.5ab16c60b6e5
3. Bourassa Forcier, M. & Noël, F. "Product Listing Agreements (PLAs): A New Tool for Reaching Quebec's Pharmaceutical Policy Objectives?". Sherbrooke; Healthcare Policy Vol.9 No.1, 2013 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3999551/
4. Babad, M. 2012 (February 2). "R&D in Quebec Pharma Industry Continues to Erode." The Globe and Mail. Retrieved June 5, 2013. http://www.theglobeandmail.com/report-on-business/top-business-stories/rd-in-quebec-pharma-industry-continues-to-erode/article2323848/
5. Baic, D., 'To avoid open bidding, generic-drug makers cut prices outside Quebec', Globe & Mail, 2018 https://www.theglobeandmail.com/news/national/to-avoid-open-bidding-generic-drug-makers-cut-prices-outside-quebec/article37783920/
6. Benefits Canada, 'Ontario Trillium program sees rise in young users, spend on high-cost drugs', 2018 https://www.benefitscanada.com/news/ontarios-trillium-program-sees-rise-in-young-users-spend-on-high-cost-drugs-study-112531
7. CADTH, 'Drug Supply Disruptions', 2011, https://www.cadth.ca/drug-supply-disruptions
8. Castonguay, C., 'L'assurance médicaments – Des voies de solution', MSSS, 1996, 198 p. http://www.santecom.qc.ca/Bibliothequevirtuelle/santecom/35567000025590.pdf
9. Clement, F., Soril, L., Emery, H., Campbell, D., Manns, B.,. "Canadian Publicly Funded Prescription Drug Plans, Expenditures and an Overview of Patient Impacts" U. of Calgary School of Public Policy, 2016. http://www.health.alberta.ca/documents/Health-Spending-PubliclyFundedDrugPlans-2016.pdf
10. CIHI, "National Health Expenditures" (NHEX), Reports and data published over multiple years
11. CIHI, "Prescribed Drug Spending in Canada, 2016: A Focus on Public Drug Programs", 2016. https://secure.cihi.ca/free_products/Prescribed%20Drug%20Spending%20in%20Canada_2016_EN_web.pdf
12. Competition Bureau of Canada, 'Canadian Generic Drug Sector Study', 2007 http://www.competitionbureau.gc.ca/eic/site/cb-bc.nsf/eng/02495.html
13. David J.T. Campbell, MD, PhD, Braden J. Manns, MSc, Lesley J.J. Soril, MSc, Fiona Clement, PhD. "Comparison of Canadian public medication insurance plans and the impact on out-of-pocket costs". Canada: CMAJ November 27, 2017 vol. 5 no. 4 E808-E813. http://cmajopen.ca/content/5/4/E808.full
14. Demers, J. et al., 'De l'assistance à l'assurance', MSSS, 1994, 50 p.
15. Félix, G., 'Implantation du régime général d'assurance médicaments québécois - 1994-2005', Mémoire de maitrise à l'UQAM, Québec, 2017, https://archipel.uqam.ca/4751/
16. Government Accountability Office, Generic Drugs Under Medicare, United States, 2016, https://www.gao.gov/assets/680/679022.pdf

17. Gagnon, R. & al., «Mise en place d'un régime universel de base d'assurance médicaments au Québec – Analyse de la faisabilité», MSSS, 1995, 156 p. http://uniondesconsommateurs.ca/docu/sante/1995-Assurance-Med-rapportGagnon.pdf
18. Gilman & Kautter, 2008. "Impact of Multitiered Copayments on the Use and Cost of Prescription Drugs among Medicare Beneficiaries", Health Research and Educational Trust
19. Goedken AM , Urmie JM, Farris KB, Doucette WR., 'Impact of cost sharing on prescription drugs used by Medicare beneficiaries., NCBI, 2010, https://www.ncbi.nlm.nih.gov/pubmed/20511109
20. Hollis, A., 'Generic Drug Pricing and Procurement: A Policy for Alberta', University of Calgary, Alberta, 2009 https://www.policyschool.ca/publications/generic-drug-pricing-and-procurement-policy-alberta/
21. Kratzer, J., McGrail, K., Strumpf, E., Law, M., "Cost-Control Mechanisms in Canadian Private Drug Plans - Cost-Control Mechanisms in Canadian Private Drug Plans", Healthcare Policy volume 9, No. 1; 2013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3999546/pdf/policy-09-035.pdf
22. Keelaghan D., 2016. "Quebec government move to bring pharmacy fees in line". Life & Health Professionals. https://www.lifehealthpro.ca/news/quebec-government-move-to-bring-pharmacy-fees-in-line-216980.aspx
23. Lacoursière, A. 2012 (January 18). "Remboursement des médicaments: fini la règle des 15 ans." La Presse. http://www.lapresse.ca/actualites/sante/201201/17/01-4486859-remboursement-des-medicaments-fini-la-regle-des-15-ans.php
24. Law, M. Cheng L., Worthington H., Mamdani M., McGrail K., Chan F., Majumdar S., 'Impact of income-based deductibles on drug use and health care utilization among older adults'. 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5433870/pdf/189e690.pdf
25. Ministère des finances du Québec (MFQ). 2005. "Les Impacts économiques de la « règle des 15 ans » appliquée au remboursement des médicaments innovateurs au Québec." Travaux de recherche 2005-002. Retrieved June 5, 2013. http://www.finances.gouv.qc.ca/documents/feuille/fr/2005_002.pdf
26. Ministry of Health & Long-Term Care, Annual Reports, Ontario, http://www.health.gov.on.ca/en/pro/programs/drugs/pub_drugs.aspx
27. Montmarquette, Boulenger & Castonguay, 'Les risques liés à la création de PHARMA-QUEBEC', 2014, CIRANO, https://cirano.qc.ca/pdf/publication/2014RP-05.pdf
28. Morgan, S. & al., 'Evaluating the effects of Quebec's private–public drug insurance system', CMAJ, 2017 http://www.cmaj.ca/content/189/40/E1259
29. Morgan S. & Smolina K. 2014. "The Drivers of Overspending on Prescription Drugs in Quebec". Health Policy vol10 no2, https://www.ncbi.nlm.nih.gov/pubmed/25617512
30. Ministère de la Santé et des Services sociaux du Québec (MSSSQ), "Évaluation du régime général d'assurance médicaments", Québec, 1999 http://publications.msss.gouv.qc.ca/msss/fichiers/1999/99-756.pdf
31. Ministère de la Santé et des Services sociaux du Québec (MSSSQ), Montmarquette & al.. 'Pour un régime d'assurance médicaments équitable et viable : Rapport préparé par le Comité sur la pertinence et la faisabilité d'un régime universel public d'assurance médicaments au Québec', Décembre 2001. http://publications.msss.gouv.qc.ca/msss/fichiers/2001/01-montmarquette.pdf

32. Ministère de la Santé et des Services sociaux du Québec (MSSSQ), 'Comptes de la santé', http://publications.msss.gouv.qc.ca/msss/recherche/?txt=comptes+de+la+sant%C3%A9&rechercher=Lancer+la+recherche&msss_valpub=
33. Neumann, J., J.D. Chambers, F. Simon and L.M. Meckley. 2011. "Risk Sharing Agreements that Link Payment to Outcomes Are Proving Hard to Implement." Health Affairs 30(12): 23–29.
34. Office of the Auditor General of Ontario, 2017. "2017 Annual Report", Volume 1
35. Pelchat, P. 2012 (October 4). "Médicaments anticancer: Hébert veut une réponse rapide." Le Soleil. Retrieved June 5, 2013. http://www.lapresse.ca/le-soleil/actualites/sante/201210/04/01-4580408-medicaments-anticancer-hebert-veut-une-reponse-rapide.php
36. Patented Medicine Prices Review Board (PMPRB) 'Annual Reports', Canada, http://www.pmprb-cepmb.gc.ca/reporting/annual-reports
37. Patented Medicine Prices Review Board (PMPRB) "Generics360, Generic Drugs In Canada, 2014"
38. Patented Medicine Prices Review Board (PMPRB). "Dispensing Fee Policies in Public Drug Plans, 2015/16". 2017. http://www.pmprb-cepmb.gc.ca/view.asp?ccid=1308
39. Patented Medicine Prices Review Board (PMPRB) "Alignment Among Public Formularies in Canada Part 1: General Overview"; October 2017. http://www.pmprb-cepmb.gc.ca/view.asp?ccid=1327
40. Pfizer, 'Patient Out-of-Pocket Costs', 2015, Global Policy & International Public Affairs, https://www.pfizer.com/files/about/Position-Patient-Out-of-Pocket-Costs.pdf
41. Picard, A., 'Use of 'catastrophic' drug plan surges in Ontario, study says', Globe & Mail, 2018 https://www.theglobeandmail.com/canada/article-use-of-catastrophic-drug-plan-surges-in-ontario-study-says/
42. Quebec Legislation, 'An Act Respecting Prescription Drug Insurance'. http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/A-29.01
43. Régie de l'assurance-maladie du Québec (RAMQ), 'Annual Reports', http://www.ramq.gouv.qc.ca/fr/publications/citoyens/Pages/rapports.aspx
44. Régie de l'assurance-maladie du Québec (RAMQ), 'outil de recherche de l'information statistique (ORIS)', https://www4.prod.ramq.gouv.qc.ca/IST/CD/CDF_DifsnInfoStats/CDF1_CnsulInfoStatsCNC_iut/DifsnInfoStats.aspx?ETAPE_COUR=2&LANGUE=fr-CA
45. Tadrous, M., Greaves, S. Martins, D., Mamdani, M., Juurlink, D., Gomes, T.. 'Catastrophic drug coverage: utilization insights from the Ontario Trillium Drug Program'; March 2018, Vol. 6 no. 1. http://cmajopen.ca/content/6/1/E132.full.pdf+html
46. Tamblyn, R. & al., 1999. «Rapport d'évaluation de l'impact du régime général d'assurance médicaments » : résumé. Montréal : Université McGill/Université de Montréal/Université McMaster (CHEPA), USAGE, 28 p
47. Tatelman S., 2016. "Quebec move to boost pharmacy transparency could save plan sponsors money". Benefits Canada https://www.benefitscanada.com/news/boosting-pharmacy-transparency-could-save-quebec-plan-sponsors-money-90159
48. Welds, K. , 'Shifting The Drug Cost Burden In Ontario', 2017
49. Yeadon N., "Demystifying Quebec's Healthcare Reform for Pharmaceutical Manufacturers". 2017, Impetus. https://www.impetusdigital.com/2017/06/23/demystifiying-quebecs-healthcare-reform-for-pharmaceutical-manufacturers/

APPENDICES

Appendix 1: Key Historical Milestones

This timeline relies on material collected from multiple sources, including from Yeadon (2017)

1996

The new Universal drug plan is deployed to all seniors and welfare recipients only as of August 1, 2016

1997

The new Universal drug plan is deployed to all other eligible citizens on January 1
On July 1, changes introduced through bill 142 changes the application of the deductible and the maximum out-of-pocket from a quarterly to a monthly basis

1999

The first Review of RGAM

Released in March 1999, the Tamblyn report highlights the issue that individuals who reduced their utilization of essential drugs the most following the introduction of the RGAM are those who utilized them most before i.e. welfare recipients and low-income seniors. Adopted June 17, 1999, Bill 69 reinstated full coverage to welfare recipients and their spouse.

Announced on December 15, 1999, the Health Ministry released on February 2, 2000, a strategic review report, inviting all stakeholders to participate in finalizing the initial phase by setting drug policies for the next decade based on the early experience. Among others, 7 financial scenarios were presented to solidify its funding in a world of increasing high-cost trends.

2000

Bill 117 Amends the QDIA

Following the strategic review, and the publication of a White Paper 'Les pistes de révisions du régime général d'assurance médicaments', bill 117 introduces the following changes through the legislature:

- The premium rate was significantly increased from $175 to $350 per year per adult (note that children under 18 or students aged 18-25, welfare or unemployment benefit recipients, as well as very low income individuals - under $10,860 per year - are not required to pay premiums)

The government hires a group of expert to assess the sustainability of the RGAM, 'Comité sur la pertinence et la faisabilité d'un régime universel public d'assurance médicaments'

2001

The Montmarquette Report

Created in February 2001, the Montmarquette committee had the mandate to evaluate the merits of a mixed public-private strategy, and the consequences of adopting an

entirely public plan. The committee was chaired by economist Claude Montmarquette and composed of 8 more members representing various sectors.

It recommended retaining the current public-private mix, mandatory participation, and the copay structure. It also recommended:

1. Greater accountability and transparency on RGAM's financial;
2. Better controls on the list of drugs covered;
3. Closer monitoring of drug utilization and cost drivers; and
4. Consider building strategic partnership with other provinces.

In a report assessing the overall funding and organization of healthcare services, the Clair Commission identifies drug expenditures as the leading cause of healthcare cost growth and recommends to explores control mechanisms.

The Auditor General's report requests further controls on drug expenditures.

2002

Bill 98 is introduced to

- increase funding sources to cope with rapidly increasing drug costs;
- create the 'Conseil du médicament', to manage the drug list
- allow the minister to enter into PLAs

2004

A symposium is held to define optimal drug utilization strategies as well as to develop a drug policy

2005

Adoption of a Drug Policy

In November 2005, Philippe Couillard, the Quebec Minister of Health at the time, introduced the Quebec Drug Policy to the province. In February 2007, bill 130 came into full effect with the intent to meet the following key objectives:

1. Ensure equitable patient access to pharmaceutical drugs.

2. Establish fair and reasonable prices for drugs.

3. Promote optimal use of drugs.

4. Maintain a dynamic pharmaceutical industry in Quebec.

The new Drug Policy allowed an annual indexing of drug prices. This new policy brought an end to the "price-freeze" policy that had been in place since 1994 (MSSS 2007: 7). At the same time, in order to limit the negative impact of annual price increases on the sustainability of Quebec's public plan, the government began to enter into confidential compensatory agreements with manufacturers.

2008

First major legislative review

2011

INESSS replaces the Conseil du médicament

In January 2011, INESSS and AETMIS were created (Conseil du Médicament and the Agence d'Évaluation des Technologies et des Modes d'Interventions en Santé). INESSS was established to work as an independent advisor to the Ministry of Health and had been set up as a Health Technology Assessment (HTA) organization. They work separately from the RAMQ which also reports directly to the Minister of Health and functions similarly to the pan- Canadian Pharmaceutical Association (pCPA). INESSS' role is to establish drug therapeutic value, set fair pricing, evaluate drug cost effectiveness, evaluate impact of drugs on the healthcare system as a whole as well as to make recommendations for listing on the public drug formulary.

2013: Eliminate BAP-15

In 2015, restrictions were added on conditions for the use of "no substitutions" and Quebec joined the pCPA in order that they too benefit from the PLA negotiations with manufacturers (looking for 18-25% reductions in branded drug costs). Quebec has aligned with the pCPA's policy on biosimiliars and will preferentially restrict reimbursement for branded biologics.

2013

The BAP-15 policy is terminated on January 1, 2013

2014

The Provincial/Territorial Health Ministers announced the intentions for Quebec's participation in the Federation's Health Care Innovation Working Group (HCIWG)

2015

Bill 28 Eliminates Minimum Reimbursement Constraints

Passed in April 2015, the Quebec Act pertaining to Prescription Drug Insurance was amended. The first change was the elimination of the minimum reimbursement clause (set to 66% since July 2015) affecting private drug insurance companies. Private plans could now limit the reimbursement of drugs to what is considered eligible under the contract (most often the generic equivalent) and any excess (out of pocket costs) may be billed to patients directly. This bill, in effect, opens the possibility to enforce generic substitution and limits reimbursement to the Reasonable and Customary (R&C) fees paid to pharmacists.

The new Pharmacists Act has entitled pharmacists to offer seven new pharmaceutical services, four of which are billable acts for private plans:

1. extending physician prescriptions by 30 days,
2. scheduling patient follow ups,
3. prescribing medications for minor conditions and

4. prescribing medication when no diagnosis is needed such as smoking cessation.

Minister Gaetan Barrette's third controversial bill was passed in Nov 2015. The new law ended the coverage of IVF and replaced it with a system of tax credits based on family income.

Quebec effectively started to participate in brand and generic initiatives in October 2015 and joined many then completed pCPA negotiations.

2016

Bill 81 Introduces a public tender process for drugs

Passed in June 2016, this bill introduced a tender process into the mix for drugs and distributors. The first proposal suggests that manufacturers bid on tenders. This will allow the Health Minister to adjudicate contracts to include up to three manufacturers per contract where each would be assigned a specific allowable "market share". The second type would be fixed price tenders, again, set by the Health Minister. All eligible manufacturers who comply with the set price caps could be included in the contracts made available in the formulary. Similar tender suggestions are also being considered for wholesalers although it is still not clear if exclusive distribution will be allowed by single wholesalers or not.

Bill 92 limits certain commercial practices

The bill proposes that no manufacturer may enter into an exclusive procurement agreement with a wholesaler or intermediary for any drug listed on the public formulary. It also suggests that no manufacturer, wholesaler or intermediary may a) pay or reimburse the price of a drug, in whole or in part; b) limit supply of drugs to a few pharmacy owners; c) require that a pharmacy owner buy drugs directly from the manufacturer or wholesaler or; d) directly of indirectly encourage or force a pharmacy owner to sell a particular brand of listed drugs or provide them with incentives to sell a particular drug. In addition, the bill allows RAMQ to set the conditions for the reimbursement of drugs listed on the Quebec public formulary and for INESSS to recommend how each drug should be used optimally. They will also be able to make recommendations should a manufacturer's drug be delisted or suspended if they do not meet the required RAMQ pricing and there is a generic substitute available in the market. All of these changes will have a significant impact on the future of patient assistance programs, co-pay cards, private infusion clinics, formulary de-listings and pharmacist professional fees (pharmacists must now provide detailed invoices to payers).

2017

Amendment of Regulations to require pricing disclosures for private plans

2018

The premium contribution rate required by the public program is reduced for the first time

Appendix 2: RGAM Parameters

The following parameters were implemented since the inception of RGAM:

Year	Annual Premium	Coinsurance Level	Annual Deductible	Maximum Annual Out-Of-Pocket
1997-1998	175 $	25,0%	100 $	750 $
1998-1999	175 $	25,0%	100 $	750 $
1999-2000	175 $	25,0%	100 $	750 $
2000-2001	175 $	25,0%	100 $	750 $
2001-2002	175 $	25,0%	100 $	750 $
2002-2003	422 $	27,4%	110 $	822 $
2003-2004	460 $	28,0%	115 $	839 $
2004-2005	494 $	28,5%	123 $	857 $
2005-2006	534 $	29,0%	130 $	874 $
2006-2007	538 $	29,0%	145 $	881 $
2007-2008	557 $	30,0%	169 $	904 $
2008-2009	570 $	31,0%	172 $	927 $
2009-2010	585 $	32,0%	179 $	954 $
2010-2011	600 $	32,0%	192 $	963 $
2011-2012	563 $	32,0%	192 $	963 $
2012-2013	579 $	32,0%	195 $	992 $
2013-2014	607 $	32,0%	195 $	992 $
2014-2015	611 $	32,5%	200 $	1 006 $
2015-2016	640 $	34,0%	216 $	1 029 $
2016-2017	660 $	34,5%	226 $	1 046 $
2017-2018	667 $	34,8%	233 $	1 066 $
2018-2019	616 $	34,9%	239 $	1 087 $

Appendix 3: The RGAM from 1997 to 2018

As alluded to, throughout this report, the RGAM has evolved from its initial format in 1997 to what it is today, more than 20 years later. To help visualize the extent of those changes, we present the following summary table:

Features	Initially in 1997	Today, in 2018
List of Covered Drugs		The current list is probably just a extensive, but with a higher proportion of new drugs now being treated as exception drug (the equivalent of Exceptional Access or Limited Use drugs or special authorization). Since 2015, it now also includes certain pharmaceutical services covered by the government – prescription renewals, etc.
Premium Requirements	$175 per year, max. 10.4% of individual income (children, functionally impaired individuals, social assistance and GIS recipients are exempted)	$616
Coinsurance Level	25% (children, functionally impaired individuals, social assistance and GIS recipients are exempted)	34.9%
Deductible	$100 per year, applied quarterly (children, functionally impaired individuals, social assistance and GIS recipients are exempted)	$239 per year applied monthly
Maximum Annual Out-Of-Pocket	$750 per year, applied quarterly	$1,087 per year, applied monthly
Generic Substitution	Not part of the initial plan	Maximum ingredient price eligible under the public program is set by regulation for each DIN based on the lowest price for its equivalent product.
Drug Prices	The submitted price for the ingredient had to be used as the basis for the settlement.	Any excess of the submitted price over the RGAM price is excludable from the total disbursement used for the application of the maximum out-of-pocket provisions. Since September 2017, pharmacists must detail the components of the price charged: ingredient, (professional) dispensing fee, and wholesaler's margin.
Instances Where the Public Program Is Expected to Provide Drug Coverage	• Individuals aged 65+ who are not covered under a group plan (the group plan is allowed to charge a different premium rates from members who are 65 or more) • Individuals or families eligible for last resort financial assistance • All individuals not required to be covered under a private group plan i.e. not an eligible member of a designated group, as set under the Drug Insurance Act	Unchanged
Instances Where Mandated Drug Coverage Must Minimally Be Provided Under a Private Plan	Designated group plans are those that provide any type of Accident & Sickness to eligible members of - Employment based group - A professional order - A professional association for one or more professional order - An association of workers of a similar trade or occupation - A union or association of employees	NO change to the definition of designated groups, except for the following exception that was added: - Now drug coverage must be provided under individual A&S plans that are underwritten and priced like group plans.

	All family members of an eligible worker (children aged up to 18, or 25 if full-time students, or if functionally impaired) and share the same domicile.	
Special Requirements Imposed on Private Plans	Cannot restrict eligibility to drug coverage for members of an eligible group based on **age (except for individuals aged 65 and over who elect to)**, sex or state of health of the person, the person's spouse or child, or a person suffering from a functional impairment who is domiciled with the person. Industry pooling of substandard risks Employer must enroll and collect premiums for all those who have to join mandated private drug coverage. Minimum 30 days' notice before termination of a plan, including in cases of lockout, strike or work stoppage.	Cannot refrain their member's freedom to elect for the pharmacy of their choice
Special Requirements Imposed on Pharmacists, Drug Manufacturers, or Wholesalers		- No exclusive or preferential agreement, except where allowed by the legislation - No limitation on supply - Limits on benefit, discount or profit margin

Appendix 4: Cost-Sharing Features by Canadian Public Drug Plans

The following tables are reproduced with permission from Clement & al. "Canadian Publicly Funded Prescription Drug Plans, Expenditures and an Overview of Patient Impacts"

Table 1. Overview of Characteristics of Publicly Funded Drug Plans across Canadian Provinces/Territories

Province and Territory	Number of Plans	Common target populations for publicly funded drug plans (✓) and whether coverage is subject to a premium			Generic Payment Rules	Least Cost Alternative	Reference Pricing	Government First Payer
		General Population	Seniors[1]	Social Assistance/Low Income				
Alberta	10	Premiums	✓	✓	✓	✓	×	✓
British Columbia	10	✓	Born before 1939	✓	✓	✓	✓	✓
Saskatchewan	11	✓	✓	✓	✓	✓	✓	✓
Manitoba	5	✓	Same as general population	✓	✓	✓	?	×
Ontario	7	✓	✓	✓	✓	✓	?	✓
Quebec [2]	1	Premiums	Premiums	✓	✓	✓	?	✓
Newfoundland and Labrador	5	✓	✓	✓	✓	✓	×	×
Nova Scotia	5	✓	Premiums	✓	✓	✓	✓	×
New Brunswick	10	Premiums	Low income only	✓	✓	✓	×	×
Prince Edward Island	27	Combination of plans[3]	✓	✓	✓	?	?	?
Yukon	3	Chronic disease plan	✓	×	✓	✓	?	×
Northwest Territories	3	Specified disease conditions	Over 60 yrs.	×	✓	✓	?	×
Nunavut	5	Chronic disease plan	✓	×	✓	✓	?	×

✓ = yes; × = no; ? = unclear

[1] Over 65 years of age unless otherwise denoted.

[2] All persons are mandated to have insurance (private or public).

[3] Prince Edward Island has a variety of disease- and drug-based plans for those under 65 years of age.

Table 2. Characteristics of Publicly Funded Drug Plans for those on Social Assistance/Low Income

	Name of Plan	Premium	Fixed Copayment	Co-Insurance	Deductible	Maximum Out-of-Pocket
Alberta	Alberta Adult Health Benefit (AAHB)	×	×	×	×	N/A
British Columbia	PharmaCare Plan C	×	×	×	×	N/A
Saskatchewan	Supplementary Health Program – Prescription Drugs	×	Up to $2 per prescription dispensed for adults	×	×	×
Manitoba	Employment and Income Assistance (EIA) – Prescription Drugs Assistance for Participants	×	×	×	×	N/A
Ontario	Ontario Drug Benefit (ODB) Program	×	$2 per prescription dispensed	×	×	×
Quebec	Public Prescription Drug Insurance Plan	×	×	×	×	×
Newfoundland and Labrador	Foundation Plan (income support recipients)	×	×	×	×	N/A
	Access Plan (low income families and individuals)	×	×	20% - 70% of total prescription costs, varies with income	×	×
Nova Scotia	Pharmacare Benefit	×	$5 per prescription dispensed	×	×	×
New Brunswick	Plan E (Adults in Licensed Residential Facilities)	?	$4 per prescription dispensed	×	?	$250 annually
	Plan F (Social Development Clients)	?	$4 per prescription dispensed for adults (> 18 yrs.) and $2 for children (< 18 yrs.)	×	?	$250 per family unit annually
	Plan G (Special needs children and children in care of the Minister of Social Development)	×	×	×	×	N/A
Prince Edward Island	Financial Assistance Drug Program	×	×	×	×	N/A
Yukon	--	--	--	--	--	--
Northwest Territories	--	--	--	--	--	--
Nunavut	--	--	--	--	--	--

× = no; N/A = not applicable; -- = not covered; ? = unclear

Table 3. Characteristics of Publicly Funded Drug Plans for Seniors

	Name of Plan	Premium	Fixed Copayment	Co-Insurance	Deductible	Maximum Out-of-Pocket
Alberta (Over age of 65)	Coverage for Seniors	×	×	30% of the cost of the prescription dispensed.	×	$25 maximum per prescription dispensed
British Columbia (Born before 1939)	Fair Pharmacare	×	×	After deductible, 25% of the cost of the prescription dispensed	Annually 0-2% of net income, varies with income	Annually 1.25-3% of net income, varies with income
Saskatchewan (Over age of 65)	Seniors' Drug Plan	×	Maximum $20 per prescription drug dispensed	×	× (Unless GIS recipient, Seniors Income Plan [SIP], or supplemented with Special Support Program)	N/A
Manitoba	Same as general population. No age-based plan					
Ontario (Over age of 65)	Ontario Drug Benefit (ODB) Program	×	$2 per prescription dispensed if income <$16,018 (single), <$24,175 (couple) Maximum $6.11 per prescription dispensed otherwise	×	$0 if income <$16,018 (single), <$24,175 (couple) $100 otherwise	N/A
Quebec (Over age of 65, not eligible for private insurance)	Public Prescription Drug Insurance Plan	Annually $0 - $607, varies with income	×	After deductible, 34% of the cost of the prescription dispensed	$18 monthly	Monthly: $85.75 Annual: $1029
Newfoundland and Labrador (Over age of 65 and receiving Old Age Security Benefits and Guaranteed Income Supplement)	65Plus Plan	×	Maximum $6 of dispensing fee per prescription	×	×	×
Nova Scotia (Over age of 65)	Senior's Pharmacare	Annually $0-$424, varies with income	×	30% of the cost of the prescription dispensed	×	Annual limit including premium and copayments $382-$806, varies with income
New Brunswick	New Brunswick	×	GIS recipients:	×	×	Annual for GIS

	Name of Plan	Premium	Fixed Copayment	Co-Insurance	Deductible	Maximum Out-of-Pocket
	Seniors Plan A (Over 65 yrs. and receiving Guaranteed Income Supplement (GIS) or are low income)		Maximum $9.05 per prescription dispensed $15 per prescription dispensed otherwise			recipients: $500 No maximum otherwise
	Medavie Blue Cross Seniors Prescription Drug Program (over 65 yrs. of age)	$115 monthly	Up to $15 per prescription dispensed	×	×	×
Prince Edward Island (Over age of 65)	Seniors' Drug Cost Assistance Program	×	Maximum $8.25 per prescription dispensed plus pharmacy professional fee up to $7.69	×	×	×
Yukon (Over age of 65 or over 60 and married to someone over 65)	Pharmacare	×	×	×	×	N/A
Northwest Territories (Over age of 60)	Extended Health Benefits Seniors' Program	×	×	×	×	N/A
Nunavut (Over age of 65)	Seniors Full Coverage Plan	?	×	×	?	?
	Seniors Additional Assistance Plan	?	×	×	?	?

× = no; N/A = not applicable; -- = not covered; ? = unclear

Table 4. Characteristics of Publicly Funded Drug Plans for the General Population Under Age 65

	Name of Plan	Premium	Fixed Copayment	Co-Insurance	Deductible	Maximum Out-of-Pocket
Alberta (AB resident, under 65 yrs. of age)	Non-Group Coverage	Monthly premium Single = $63.50 Family = $ 118 Billed quarterly	×	30% of the cost of the prescription dispensed	× (deductible applies to other health benefits, excludes drugs)	$25 maximum per prescription dispensed
British Columbia (BC resident)	Fair Pharmacare	×	×	After deductible, 30% of the cost of the prescription dispensed	Annually 0-3% of net family income, varies with income	Annually 2-4% of net family income, varies with income
Saskatchewan (Sask. resident)	Special Support Program	×	×	Before deductible, varies with income and monthly drug expenditures After deductible, 35% of prescription dispensed	3.4% of net family income Paid semi-annually	×
Manitoba (MB resident)	Pharmacare Program	×	×	×	Annually 2.97-6.73% of net income, varies by income, minimum of $100	N/A
Ontario (ON resident, no or limited private insurance)	Trillium Drug Program	×	After deductible, maximum $2 per prescription dispensed	×	Annually ~4% of net income Paid quarterly.	×
Quebec (those not eligible for private insurance)	Public Prescription Drug Insurance Plan	Annual premium $0 - $660, varies with income	×	After deductible, 34% of the cost of the prescription dispensed	$18 monthly	Monthly: $85.75 Annual: $1029
Newfoundland and Labrador (NFLD resident, experience high drug costs)	Assurance Plan	×	×	Rate= (family income*cap rate)/total drug expenditure of family	×	Annually 5-10% of net income, varies with income
Nova Scotia (NS resident)	Family Pharmacare	×	×	20% of the cost of the prescription dispensed	Annually 1-20% of net income, varies by income	Annually 6-35% of net income, varies by income
New Brunswick (NB resident, no or	New Brunswick Drug Plan	Annual premium $200-$2,000,	×	30% of the cost to a maximum of $5-$30 per	×	×

	Name of Plan	Premium	Fixed Copayment	Co-Insurance	Deductible	Maximum Out-of-Pocket
limited private insurance)		varies with income		prescription dispensed, varies with income		
Prince Edward Island (PEI residents, no private insurance)	Generic Drug Program, 8 disease-based drug plans, 4 drug-specific plans and 2 high-cost drug plans. Limited details of coverage available.					
Yukon (Yukon resident with a chronic disease or serious functional disability)	Chronic disease program	?	?	?	?	?
Northwest Territories (NWT resident and under the care of physician/nurse practitioner for a specified list of diseases)	Extended Health Benefits for Specified Disease Conditions	×	×	×	×	N/A
Nunavut (Nunavut resident with a chronic disease)	Extended Health Benefit (Chronic Illness Plan)	×	×	×	×	N/A

× = no; N/A = not applicable; -- = not covered; ? = unclear

Appendix 5: Generic Drug Pricing Policies During the 2010-2015 Period

The following table was reproduced with permission from PMPRB's 2014 'Generics 360' report, p. 25

TABLE C1 Provincial generic pricing policies, generic price as a percentage of the brand-name price

	2010	2011	2012	2013	2014	2015
pCPA[a] 18% molecules				April 1: **18%** for sixt of the most common generic drugs (the Council of the Federation)	April 1: **18%** for ten of the most common generic drugs (the Council of the Federation)	April 1: **18%** for fourteen of the most common generic drugs (the Council of the Federation)
pCPA[a] Tiered Pricing Framework					**Tier 1** (single source) – one generic: 85% of brand reference price if a Product Listing Agreement (PLA) does not exist for the brand product; 75% if there is a PLA **Tier 2** (dual source) – two generics: 50% of brand reference price **Tier 3** (multi source) – three or more generics: 25% of brand reference price for oral solids; 35% for non-oral solids	
British Columbia	October 15: **50%** existing generics **42%** new generics	July 4: **40%** all generics	April 2: **35%** all generics	April 1: **25%** most generics	April 1: **20%** most generics	
Alberta	April 1: **56%** existing generics **45%** new generics		July 1: **35%** all generics	May 1: **18%**	April 1: Lowest available price for existing generics; tiered pricing for new generics: **70%** one generic **50%** two generics **25%** three generics **18%** four or more generics	
Saskatchewan		April 1: **40%** new generics May 1 and June 1: **45%** existing generics April 1 and October 1: **35%** generics in former Standing Offer Contract categories	April 1: **35%**			April 1: **25%**
Manitoba	Generic drug pricing is subject to utilization management agreements with the manufacturers, which declare that the price of a generic is equal to that of other select provinces.					
Ontario	July 1: **25%**[d] public **50%** private & out-of-pocket	April 1: **25%**[d] public **35%** private & out-of-pocket	April 1: **25%**[d] public, private & out-of-pocket			May 15: Tiered pricing for generics[e]
Quebec	Quebec requires that generic manufacturers provide the province with the lowest price available in other provinces.					
New Brunswick			June 1: **40%** December 1: **35%**	June 1: **25%**		
Nova Scotia		July 1: **45%**	January 1: **40%** July 1: **35%**		November 12: **25%**	
Prince Edward Island			July 1: **35%**	December 1: **25%**		
Newfoundland & Labrador			April 1: **45%** October 1: **40%**	April 1: **35%** July 1: **25%**		

Note: Generic pricing policies apply to oral solid forms; all others are 35%.

[a] pan-Canadian Pharmaceutical Alliance: http://www.pmprovincesterritoires.ca/en/initiatives/358-pan-canadian-pharmaceutical-alliance. After April 1, 2013, the general provincial generic pricing policies no longer apply to the drugs subject to the 18% pricing policy as per the Council of the Federation. Quebec did not participate in the pan-Canadian Pharmaceutical Alliance (pCPA) for generic drugs at this time, but benefited from it because of the lowest price policy.

[d] Drugs under the 18% rule by date of implementation:
April 1, 2013: atorvastatin, ramipril, venlafaxine, amlodipine, omeprazole and rabeprazole.
April 1, 2014: rosuvastatin, pantoprazole, citalopram, and simvastatin.
April 1, 2015: clopidogrel, gabapentin, metformin, and olanzapine.

[e] Changes to regulations applicable to generics listed on the Ontario Drug Benefit (ODB) Formulary on or after April 1, 2013.

Appendix 6: Quebec PLAs As Reported In RAMQ's Annual Report

The following were reported in RAMQ's Annual Reports:

<table>
<tr><td></td><td></td></tr>
<tr><td>Year</td><td>Disclosures</td></tr>
<tr><td>2005-2006</td><td>No such agreement has been entered yet.</td></tr>
<tr><td>2006-2007</td><td>Au 31 mars 2007, 36 fabricants ont adhéré à une entente. Ces ententes prendront effet en 2007-2008 et ultérieurement. Ainsi, aucune somme n'a été versée par les fabricants en vertu de ces ententes en 2006-2007.</td></tr>
<tr><td>2007-2008</td><td>de l'article 52.1 de la Loi sur l'assurance médicaments. La plupart de ces ententes ont pris effet en 2007-2008, et une somme de 2,04 M$ a été versée par les fabricants durant cet exercice conformément à ces ententes. Cette somme représente une mesure compensatoire visant la hausse de prix de 766 produits innovateurs durant la même période.</td></tr>
<tr><td>2008-2009</td><td></td></tr>
<tr><td>2009-2010</td><td>Au 31 mars 2010, 21 ententes étaient en vigueur et couvraient 65 fabricants.
ENTENTES AVEC LES FABRICANTS PHARMACEUTIQUES
<table><tr><th></th><th>2009-2010</th><th>2008-2009</th></tr><tr><td>Nombre d'ententes</td><td>21</td><td>21</td></tr><tr><td>Nombre de fabricants visés par les ententes</td><td>65</td><td>65</td></tr><tr><td>Nombre de produits concernés</td><td>1 281</td><td>896</td></tr><tr><td>Sommes versées en application des ententes</td><td>8,6 M$</td><td>2,4 M$</td></tr></table></td></tr>
<tr><td>2010-2011</td><td>Au 31 mars 2011, 60 ententes étaient en vigueur et couvraient 59 fabricants.
ENTENTES AVEC LES FABRICANTS PHARMACEUTIQUES
<table><tr><th></th><th>2010-2011</th></tr><tr><td>Nombre d'ententes</td><td>60</td></tr><tr><td>Nombre de fabricants visés par les ententes</td><td>59</td></tr><tr><td>Nombre de produits concernés</td><td>648</td></tr><tr><td>Sommes versées en application des ententes</td><td>12,5 M$</td></tr></table></td></tr>
<tr><td>2011-2012</td><td>Au 31 mars 2012, 66 ententes étaient en vigueur et couvraient 65 fabricants.
ENTENTES AVEC LES FABRICANTS PHARMACEUTIQUES
<table><tr><th></th><th>2011-2012</th></tr><tr><td>Nombre d'ententes</td><td>66</td></tr><tr><td>Nombre de fabricants visés par les ententes</td><td>65</td></tr><tr><td>Nombre de produits concernés</td><td>969</td></tr><tr><td>Sommes versées en application des ententes</td><td>364 400 $</td></tr></table></td></tr>
<tr><td>2012-2013</td><td>Au 31 mars 2013, 68 ententes en vigueur concernaient 68 fabricants.
ENTENTES AVEC LES FABRICANTS DE MÉDICAMENTS
<table><tr><th></th><th>2012-2013</th></tr><tr><td>Nombre d'ententes[57]</td><td>68</td></tr><tr><td>Nombre de fabricants visés par les ententes</td><td>68</td></tr><tr><td>Nombre de produits concernés</td><td>979</td></tr><tr><td>Sommes reçues des fabricants en application des ententes</td><td>14,8 M$</td></tr></table></td></tr>
<tr><td>2013-2014</td><td>Conformément à ce qui a été annoncé par le ministre des Finances et de l'Économie, lors du discours sur le budget du 20 novembre 2012, le ministre de la</td></tr>
</table>

<table>
<tr><td></td><td>Santé et des Services sociaux a aboli le mécanisme d'indexation annuelle des prix des produits inscrits à la Liste des médicaments. Par le fait même, les ententes de contribution signées dans le but d'alléger le poids financier de l'indexation des prix ont été résiliées. Cette résiliation était applicable à partir du 1er avril 2013. Malgré cette résiliation, les fabricants étaient tenus de verser des sommes au cours de l'exercice 2013- 2014 en application des ententes pour l'exercice 2012-2013. Au 31 mars 2014, il n'y avait donc plus d'entente en vigueur.
ENTENTES AVEC LES FABRICANTS DE MÉDICAMENTS
<table><tr><th></th><th>2013-2014</th></tr><tr><td>Nombre d'ententes[63]</td><td>0</td></tr><tr><td>Nombre de fabricants visés par les ententes</td><td>0</td></tr><tr><td>Nombre de produits concernés</td><td>0</td></tr><tr><td>Sommes reçues des fabricants en application des ententes[64]</td><td>6,4 M$</td></tr></table></td></tr>
<tr><td>2014-2015</td><td>Conformément à ce qui a été annoncé par le ministre des Finances, lors du discours sur le budget du 20 novembre 2012, le ministre de la Santé et des Services sociaux a aboli le mécanisme d'indexation annuelle des prix des produits inscrits à la Liste des médicaments. Par le fait même, les ententes de contribution signées dans le but d'alléger le poids financier de l'indexation des prix ont été résiliées. Cette résiliation était applicable à partir du 1er avril 2013. Au 31 mars 2015, il n'y avait donc plus d'entente de contribution en vigueur et aucune somme n'a été versée par les fabricants au cours de l'exercice financier 2014-2015.</td></tr>
<tr><td>2015-2016</td><td>En vertu des articles 52.1 et 60.0.1 de la Loi sur l'assurance médicaments (RLRQ, chapitre A-29.01), le ministre de la Santé et des Services sociaux peut conclure, avec les fabricants, des ententes de partage de risques financiers, des ententes de contribution visant à atténuer les retombées négatives d'une hausse de prix sur le régime public ainsi que des ententes d'inscription à la Liste des médicaments. Ces dernières sont maintenant possibles depuis les modifications apportées par le projet de loi 28, entré en vigueur le 21 avril 2015.

En vertu de l'article 40.9 de la Loi sur la Régie de l'assurance maladie du Québec (RLRQ, chapitre R-5), la Régie doit fournir, dans son rapport financier, des renseignements relatifs à ces ententes.

Au 31 mars 2016, il y avait 11 ententes d'inscription signées. Elles concernent 8 fabricants et 16 produits.
Les fabricants et les médicaments concernés sont :</td></tr>
</table>

	<table><tr><th>Fabricant</th><th>Produit</th></tr><tr><td rowspan="3">Merck Canada Inc.</td><td>Januvia®</td></tr><tr><td>Janumet®</td></tr><tr><td>Janumet® XR</td></tr><tr><td>Aegerion Pharmaceuticals Inc.</td><td>Juxtapid[MC]</td></tr><tr><td>Pendopharm, une division de Pharmascience Inc.</td><td>Ibavyr[MC]</td></tr><tr><td>Astellas Pharma Canada, Inc.</td><td>Xtandi[MD]</td></tr><tr><td>Celgene Inc.</td><td>Pomalyst®</td></tr><tr><td rowspan="2">GlaxoSmithKline Inc.</td><td>Advair®</td></tr><tr><td>Advair® Diskus®</td></tr><tr><td rowspan="3">GlaxoSmithKline Inc.</td><td>Serevent®</td></tr><tr><td>Serevent® Diskus®</td></tr><tr><td>Serevent® Diskhaler®</td></tr></table> <table><tr><th>Fabricant</th><th>Produit</th></tr><tr><td>GlaxoSmithKline Inc.</td><td>Breo® Ellipta®</td></tr><tr><td>GlaxoSmithKline Inc.</td><td>Anoro[MC] Ellipta®</td></tr><tr><td>Novartis Pharma Canada Inc.</td><td>Ultibro[MD] Breezhaler[MD]</td></tr><tr><td>Pfizer Canada Inc.</td><td>Xalkori[MD]</td></tr></table> Au cours de l'exercice financier 2015-2016, aucune somme n'a été reçue des fabricants de médicaments en application des ententes signées, la période pour le calcul des sommes n'ayant pas été complétée.
2016-2017	En vertu des articles 52.1 et 60.0.1 de la Loi sur l'assurance médicaments (RLRQ, chapitre A-29.01), le ministre de la Santé et des Services sociaux peut conclure, avec les fabricants, des ententes de partage de risques financiers, des ententes de contribution visant à atténuer les retombées négatives d'une hausse de prix sur le régime public ainsi que des ententes d'inscription à la Liste des médicaments. En vertu de l'article 40.9 de la Loi sur la Régie de l'assurance maladie du Québec (RLRQ, chapitre R-5), la Régie doit fournir, dans son rapport financier, des renseignements relatifs à ces ententes. Au 31 mars 2017, il y avait 50 ententes d'inscription en vigueur. Elles concernent 20 fabricants et 59 produits. Les fabricants et les produits concernés sont : <table><tr><th>Fabricant</th><th>Produit</th></tr><tr><td>Aegerion Pharmaceuticals inc.</td><td>Juxtapid[MC]</td></tr><tr><td>Allergan inc.</td><td>Ozurdex[MC]</td></tr><tr><td>Astellas Pharma Canada, inc.</td><td>Xtandi[MC]</td></tr><tr><td rowspan="3">AstraZeneca Canada inc.</td><td>Onglyza[MC]</td></tr><tr><td>Komboglyze[MC]</td></tr><tr><td>Forxiga[MC]</td></tr><tr><td rowspan="2">Bayer inc.</td><td>Adempas[MC]</td></tr><tr><td>Xarelto[MC]</td></tr><tr><td rowspan="4">Boehringer Ingelheim (Canada) ltée</td><td>Spiriva[MC] Handihaler[MC]</td></tr><tr><td>Pradaxa[MC]</td></tr><tr><td>Giotrif[MC]</td></tr><tr><td>Jardiance[MC]</td></tr><tr><td></td><td>Ofev[MC]</td></tr></table>

Fabricant	Produit
Bristol-Myers Squibb Canada	Orencia[MC]
	Eliquis[MC]
	Daklinza[MC]
Celgene inc.	Pomalyst[MC]
Corporation AbbVie	Holkira[MC] Pak
Corporation de soins de la santé Hospira (une compagnie appartenant à Pfizer)	Inflectra[MC]
Gilead Sciences inc.	Zydelig[MC]
	Epclusa[MC]
	Harvoni[MC]
	Sovaldi[MC]
GlaxoSmithKline inc.	Advair[MC]
	Advair[MC] Diskus[MC]
	Anoro[MC] Ellipta[MC]
	Breo[MC] Ellipta[MC]
	Serevent[MC]
	Serevent[MC] & Diskhaler[MC]
	Serevent[MC] Diskus[MC]
Hoffmann-La Roche ltée	Actemra[MC]
	Actemra[MC] s.c.
Janssen inc.	Imbruvica[MC]
	Zytiga[MC]
	Invokana[MC]
Merck Canada inc.	Janumet[MC]
	Janumet[MC] XR
	Januvia[MC]
	Zepatier[MC]

Fabricant	Produit
Novartis Pharmaceuticals Canada inc.	Ultibro[MC] Breezhaler[MC]
	Afinitor[MC]
	Jakavi[MC]
	Cosentyx[MC]
	Tobi Podhaler[MC]
	Mekinist[MC]
	Tafinlar[MC]
	Gilenya[MC]
	Entresto[MC]
	Xolair[MC]
Pendopharm, une division de Pharmascience inc.	Ibavyr[MC]
Pfizer Canada inc.	Xalkori[MC]
	Xeljanz[MC]
	Inspra[MC]
	Inlyta[MC]
	Sutent[MC]
	Arnuity[MC] Ellipta[MC]
Sunovion Pharmaceuticals Canada inc.	Latuda[MC]
	Aptiom[MC]
UCB Canada inc.	Cimzia[MC]
Somme globale annuelle provenant des fabricants en application des ententes d'inscription	**121,8 M$**