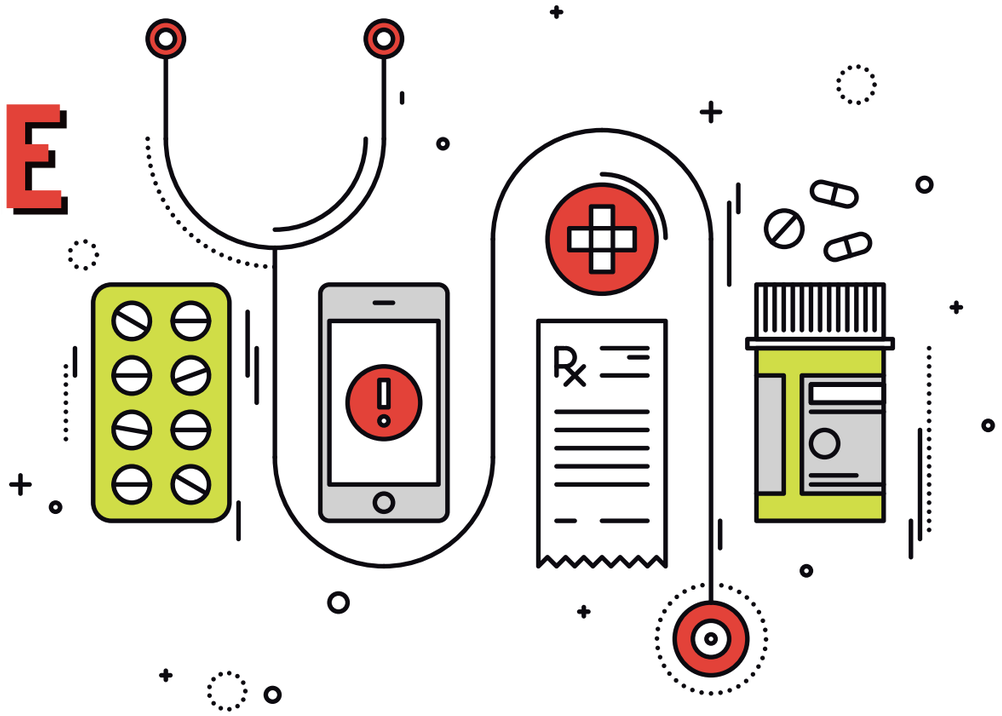
UNSTOPPABLE MOMENTUM?

Recent developments at the federal level have significantly boosted discussions about a national pharmacare program. What did a recent parliamentary report say about the issue and what are the implications for plan sponsors and the benefits industry?

By *Sonya Felix*



Universal pharmacare is an idea that has been kicking around for decades in Canada. Yet despite numerous studies calling for a universal single-payer pharmacare program to ensure all Canadians have access to prescription drugs, the country's drug system remains a patchwork of public and private plans.

This spring, the House of Commons' standing committee on health added another report to the growing pile, but not everyone agrees with the report's conclusion. Many proponents believe universal pharmacare would deliver better health outcomes and be more cost-effective, while others worry about potential costs, access to new drug therapies and the impact on the private drug benefits industry.

Two months before the committee's report came out in April, the federal budget included the announcement of an advisory council, led by Dr. Eric Hoskins, to study the implementation of a national pharmacare program. That development, together with the committee's report, has got the attention of private drug plan sponsors, says Karen Millard, Canadian research and compliance leader for Willis Towers Watson.

"Everyone wants drug coverage to be more equitable, sustainable and affordable. Although the [health] committee viewed universal pharmacare as the best way forward, we hope Dr. Hoskins will consider many options. Our plan sponsor clients understand that significant change is likely but also that it is too soon to tell what measures will be implemented."

The health committee's report

The health committee spent two years studying the development of a national pharmacare program as an insured service under the Canada Health Act. The 128-page report outlined current challenges and gaps in coverage, and provided an in-depth examination of potential costs and savings if most drug spending fell under one public payer. The report offered 18 recommendations on how to expand the Canada Health Act to include prescription drugs dispensed outside of hospitals, the development of a common voluntary national formulary, improving drug pricing and reimbursement processes, and better data and information systems.

The committee heard from more than 100 witnesses representing a wide range of drug system stakeholders, including insurers, academics, patient groups, unions, health-care professionals, generic and brand pharmaceutical companies, employer groups and various government agencies. It also commissioned the parliamentary budget officer to estimate the cost of providing universal prescription drug coverage.

The committee considered two distinct options: a universal, single-payer public prescription drug program, or reforming the existing system with targeted efforts to address gaps in coverage. While witnesses' views ran the gamut, the committee voted unanimously in the end for the first option. In its view, expanding the Canada Health Act to include prescription drugs dispensed outside of hospitals as an insured service is the best way forward.

"The basic concept of universal, single-payer pharmacare is to provide comprehensive public coverage for Canadians' medicine needs," says Don Davies, the New Democratic Party's health critic and the health committee's vice-chair.

"Just as we have done for doctors and hospitals, it is most efficient and effective to provide prescription coverage to everyone through a single-payer system."

Multiple issues examined

As part of its analysis, the committee looked at Canada's current drug coverage challenges, and the access issues under today's mix of 70 public and 113,000 private plans, in particular. While the vast majority of the population has some type of coverage for prescription drugs through public or private insurance plans, some gaps exist. For example, 21 per cent of Canadians obtain public drug coverage through provincial or territorial drug programs, but eligibility requirements leave some people with hefty out-of-pocket costs. Although 70.5 per cent of Canadians have full or partial coverage through private drug plans sponsored by unions, associations and employers, witnesses noted employment didn't guarantee drug coverage, as low-wage and part-time workers are least likely to have drug benefits through the workplace. About two per cent of Canadians have no coverage at all.

Witnesses linked the financial burden of out-of-pocket costs to poorer health outcomes: almost one in four Canadians report not filling a prescription because of the cost: a scenario that can lead to other costs since non-adherence contributes to higher rates of hospitalization and even premature death. "In Canada, non-adherence is estimated to cost between $7 billion and $9 billion per year," Dr. Monika Dutt, past chair of Canadian Doctors for Medicare, told the committee.

Variations in formularies from one plan to another create further inequities and gaps in coverage. On the public side, plans differ in decisions to list expensive specialty drugs such as biologics, oncology medications and drugs for rare diseases. And public catastrophic drug plans typically require substantial deductibles before coverage kicks in. Many private plans, on the other hand, have open formularies and few restrictions on the number and type of drugs prescribed. As well, privately insured plans tend to offer greater and more timely access to medications than the public plans. Witnesses noted one way to harmonize prescription drug coverage is through a common national formulary.

On the issue of rising drug costs, witnesses pointed out that Canadians face higher drug prices than people in other Organisation for Economic Co-operation and Development countries and identified some of the options for achieving greater cost savings. While the pan-Canadian Pharmaceutical Alliance negotiates reduced drug prices on behalf of governments, only generic discounts are accessible to both public and private plans so far. Witnesses stressed that further reductions are possible if the alliance negotiates prices on behalf of the entire market. They also called for more transparency in negotiations.

Why not reform the existing system?

After the February budget, Finance Minister Bill Morneau suggested a national pharmacare system would be a "fiscally responsible" effort aimed at filling in the gaps, rather than providing drug coverage to those already covered by existing plans.

As Joe Farago, executive director of private payers and investment at Innovative Medicines Canada, explains, the existing approach provides benefits to almost 23 million workers through private insurance and typically offers greater breadth in terms of the number of drugs covered and quicker access to new therapies than public programs.

"Drug coverage is a vital component of employer-sponsored benefits plans," says Farago. "They help keep employees healthy and productive. Are employees willing to trade off the coverage they have now for a public plan? Many of those individuals who are doing well on private insurance see the value of Canada's dual system but recognize the importance of filling in the gaps to ensure all Canadians have

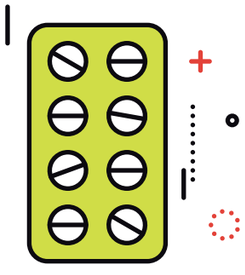
OVERVIEW OF PRESCRIPTION DRUG COVERAGE IN CANADA

21%
of Canadians obtain public drug coverage through provincial or territorial drug programs

70.5%
of Canadians have full or partial drug coverage through programs sponsored by employers, unions or associations

2%
of Canadians have no drug coverage at all

Source: Report by the House of Commons' standing committee on health, April 2018



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COMPARING DRUG SPEND

Quebec spends **$1,087** per capita on drugs compared to **$912** in the rest of Canada

$603
per capita is the median expenditure for OECD countries with universal public drug plans

Average out-of-pocket expenses are highest in **Quebec ($1,495)** and lowest in **Ontario ($823)**

Source: Report by the House of Commons' standing committee on health, April 2018

access to the medicines they need."

The health committee did consider the feasibility of reforming the existing public/private system to address gaps in drug coverage. Some witnesses argued for a more targeted approach to filling gaps, coupled with greater collaboration between the private and public sectors to ensure consistent drug pricing, dispensing fees and additional markups across drug plans. Others suggested improving access through public-private collaboration to create a minimum national formulary and a common approach to reimbursing drugs for rare diseases.

The committee also compared pharmacare programs that already exist in Canadian provinces and territories and other countries. British Columbia's income-based pharmacare program and Quebec's mandatory public/private drug insurance scheme often come up as potential models for national coverage.

However, Steve Morgan, a professor with the school of population and public health at the University of British Columbia, says "neither the B.C. nor the Quebec model achieve the goals that one would reasonably set out for a universal pharmacare." He believes none of the provincial pharmacare frameworks is perfect in how they finance medically necessary prescription drugs because they tend to diminish pharmaceutical purchasing power, impose considerable patient charges and isolate the management of prescription medications from other key components of the health-care system.

Rather than filling in coverage gaps across the country, the health committee concluded that the development of a single-payer universal program was the best way to create equity in access and reduce costs. Such a program would require amending the Canada Health Act to include drugs prescribed by a licensed health-care practitioner and dispensed outside of hospitals in accordance with a common voluntary national formulary.

The universal option

Under the health committee's vision for national pharmacare, significant financial support from the federal government would enable the provinces and territories to commit to common standards for prescription drug coverage. It suggested, however, that such an approach should remain voluntary from a constitutional perspective. Since the provinces and territories have control over health care, each jurisdiction would continue to manage its own provincial formulary based on a common national approach. It remains unclear how that would work, but the committee recommended the development of an evidence-based formulary through an independent, transparent and empirically driven process.

Other elements of the program would include co-ordinated purchasing to buy prescription drugs in bulk, streamlined administration by replacing the hundreds of private drug plans currently operating across Canada and better prescribing practices to make more effective use of generic options and less expensive drugs with similar efficacy.

To estimate the cost, the committee commissioned the federal parliamentary budget officer to undertake a study based on a formulary containing drugs currently found on Quebec's list of medications covered by its public prescription drug insurance plan. The Quebec formulary covers 8,000 out of the 13,000 drugs available in Canada and forms the basis of coverage for both private and public plans in that province.

Using the Quebec formulary as context and looking at the potential impact of a range of factors, including behavioural impacts, the cost of copayment exemptions, therapeutic mix or drug market composition, the price of drugs (potentially reduced through negotiations with manufacturers) and markups and fees, the parliamentary budget officer projected annual savings of $4.2 billion after comparing total expenditures across the country on drugs covered by Quebec's program. If the pharmacare program had been in place in 2015/16, the projected total cost (based on a negotiated 25 per cent reduction in drug prices) of that list of drugs is $20.4 billion. The figure is 83 per cent of the actual 2015/16 drug expenditure without pharmacare.

"It is vital to ensure that Canadians understand that public, universal pharmacare can be implemented, and billions of dollars in savings realized, simply by re-organizing our system," says Davies.

"Using the PBO methodology as an example, the math is straightforward. Since the federal and provincial governments already spend $12 billion on pharmaceuticals, they'd have to raise a further $8.4 billion. Given that $9 billion in private sector spending would be eliminated by universal pharmacare, the federal government would raise the entire additional public share of pharmacare through a targeted revenue levy redirecting these funds to the federal government. This would save the private sector $600 million per year."

Some witnesses at the committee suggested the parliamentary budget officer's estimates were too conservative and noted savings under a national pharmacare program would likely be higher. Among them is Morgan, who suggested the savings could be upwards of $7 billion per year, taking into consideration reduced administrative costs, the impact of joint price negotiations and drug purchasing and lower spending on drugs offering limited therapeutic benefit.

Private payer concerns

While all stakeholders agree that all Canadians should have access to prescription drugs, the big question on many people's minds is how to pay for a universal national pharmacare program. A possible scenario is a tax on employers.

"Whatever approach is chosen, it should be done in steps to ensure the plan sponsors, employee groups and supporting vendors have time to adjust."

Funding pharmacare by raising payroll taxes won't be popular among business owners, especially some of the smaller employers that don't currently offer benefits plans to employees, says Dan Kelly, president and chief executive officer of the Canadian Federation of Independent Business. "Any additional payroll tax would be unwelcome from our perspective. We are already seeing increases in payments to EI and CPP."

Large employers often view drug benefits as a valuable part of their total reward packages for attracting and retaining workers, says Millard. "They don't want to give that up and instead, potentially, have a payroll tax for national pharmacare that they can't control and employees are unlikely to value."

David Willows, chief innovation and marketing officer at Green Shield Canada, says it remains unclear what kind of windfall would accrue to plan sponsors, especially if they end up paying higher taxes to fund a pharmacare program. "In a more collaborative model, where public and private payers merge their purchasing power together, we would see the continuation of private drug plans but ideally with lower costs and a more sustainable future for those private plans."

Some committee witnesses warned that employees with private benefits plans aren't likely to accept pharmacare if it means losing the generous coverage they have now. But unions are some of the biggest advocates for national pharmacare.

"It's true that the majority of our members have some coverage, but we also represent a lot of part-time workers who don't," says Katha Fortier, assistant to Unifor's national president. "And the reality of every union member is that they don't necessarily have enough coverage. High copays, deductibles and caps can make it difficult when expensive medicines are prescribed."

Together with other organizations like the Council of Canadians, the Canadian Labour Congress and the Canadian Health Coalition, Unifor is asking employers to sign a petition in support of universal pharmacare. "We thought it would be a simple process given that employers are always asking for concessions on benefits," says Fortier. "Some employers are supportive, but we are surprised that most employers seem reluctant to sign."

Three to four years ago, when Willis Towers Watson started talking to plan sponsor groups about the potential impact of a national pharmacare program, a large number of them were taking a wait-and-see approach but expecting little would happen in the foreseeable future, says Millard. "That's changed with the release of the [health committee] report and also because of the announcement that Eric Hoskins is leading an advisory council to study the implementation of a national pharmacare program. Sponsors now want help to understand how the public-private system may change and how that could impact business and plan members."

There's also a concern about how changes could affect the broader benefits industry.

Willows predicts the impact on the different players — benefits consultants, pharmacy benefit managers, insurers and private plan sponsors — will be significant. "If the public systems do not cover all prescription drugs, as we see now with existing provincial drug programs, we could see top-up insurance emerge and a role for those stakeholders to continue on in, but the volumes of claims and dollars and broker commissions would be significantly diminished. And in any business, decreased revenue means fewer jobs."

Additional momentum

By the spring of 2019, Hoskins' council is to add its own recommendations on pharmacare. "I don't think this council is supposed to go back to square one and ask, yet again, whether Canada should have universal pharmacare," says Morgan.

"I believe the council is supposed to determine how best to achieve universal pharmacare, given the complexities of our federation, the need to flow a portion of the private financing of medicines today into a public drug plan of the future and the likely desires for a system that allows for some flexibility for provinces, employers and individual citizens to choose additional, complementary coverage of things not on a national formulary."

In the meantime, the health committee's report has grabbed the attention of the benefits industry. "Plan sponsors have a big role to play and must be willing to look at all the recommendations," says Millard.

"We're hoping there will be opportunity to discuss the pros and cons of many options for changing the public-private model and hope for flexibility in the options available to plan sponsors and plan members. Whatever approach is chosen, it should be done in steps to ensure the plan sponsors, employee groups and supporting vendors have time to adjust."

Sonya Felix is a Vancouver Island-based freelance writer.

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