Access, equity and innovation: Rethinking private benefits in Canada

In May, *Benefits Canada*'s Canadian Leadership Council on Drug Plan Partnerships convened industry thought leaders to explore innovative strategies for maintaining the sustainability and effectiveness of private drug plans in Canada.

Pharmacy's expanding role: Bridging the growing gaps in the Canadian health-care ecosystem

As drug costs climb and primary care access becomes more strained, the role of pharmacy is rapidly evolving in Canada, said Karen Kesteris, vice-president, payor partnerships at Shoppers Drug Mart. Once seen primarily as dispensers of medication, pharmacists are now frontline providers delivering accessible, essential care to Canadians — often bridging the growing gaps in the health-care ecosystem.

During the COVID-19 pandemic, the value of pharmacists became undeniable. Today, said Kesteris, with one in five Canadians lacking a family physician and chronic conditions like diabetes and cardiovascular disease on the rise, pharmacists are increasingly positioned to meet patients where they are and provide immediate, community-based care.

Unfortunately, noted Anu Sharda, senior director, payor partnerships at Shoppers Drug Mart, while pharmacists may be permitted to prescribe treatments for minor conditions, perform testing and manage chronic diseases, their scope and public reimbursement varies by province. This inconsistency can create a significant access gap.

A recent pilot program in Nova Scotia (the Community Pharmacy Primary Care Initiative) illustrates the potential impact of expanded pharmacy services. In Nova Scotia, pharmacists helped contribute to a 9.2 per cent reduction in low acuity visits to emergency rooms. The pilot demonstrated how well-integrated pharmacy services can ease burdens on the broader system.

"The COVID-19 pandemic was unfortunately a wake-up call that preventative vaccines are essential," said Sandra Ventin, associate vice-president at Gallagher, who sees value in private plans reimbursing preventative vaccines (as a secondary payer after provincial plan reimbursement) that pharmacists are authorized to prescribe and administer.

Although some may argue that since pharmacists' services replace what a doctor would provide, they should be government funded, "pharmacists can serve as an effective alternative to employer-funded virtual care, reducing the need for lengthy clinic or ER visits and help members stay at work," said Hannerie Kassabian, director of consulting at AGA Benefit Solutions.

"It's clear that, in an overburdened health-care system, pharmacists are uniquely suited to deliver frontline care that contributes to workplace productivity," said Kesteris.

PHOTOS BY MICHELLE QUANCE

KEY TAKEAWAYS

- ☐ Ask your payer to reimburse unfunded preventative vaccines that pharmacists are authorized to prescribe and administer.
- ☐ Consider pharmacists as an alternative health-care provider, complementing other providers to improve access to care. Note that funding models vary by province and service type.

Obesity and access to care: Shifting the narrative in private benefits plans

Although obesity is now recognized as a biological, chronic disease, it is still widely stigmatized, said Dr. Sean Wharton, general internal medicine and obesity medicine practitioner and medical director at the Wharton Medical Clinic.

Obesity treatment coverage continues to pose a challenge for health benefits plans, as perceptions shift toward recognizing obesity as a medical condition rather than a result of personal choices or willpower.

"I find it deeply concerning that obesity continues to be treated differently from other chronic health conditions," said Gord Hart, chief executive officer of Selectpath Benefits & Financial Inc. "We do not question coverage for diseases like cancer, arthritis or Crohn's — nor should we. The responsibility must shift back to insurers to ensure anti-obesity medications are included in benefits programs without bias or exception. Employers should not be left to shoulder this burden alone."

Chris Gory, employee benefits advisor at Orchard Benefits, noted inconsistency across payers and plans, with some covering anti-obesity medications for large groups but not for small ones. Even within the same insurer, offerings may vary widely, which creates inequities for plan members and confusion for plan sponsors.

"The differences in plan standards for obesity coverage by group size could be due to underwriting arrangement," said Marie-Hélène Dugal, national pharmacy strategy lead at Medavie Blue Cross. For example, Medavie Blue Cross made weight management coverage a standard benefit for all new fully insured groups in 2020 and "while we actively promote adoption for ASO groups, the plan sponsor ultimately manages both the risk and the structure of these plans."

Dugal emphasized that high costs of obesity drugs and the broad demographic eligible that meet BMI thresholds create plan sponsor concerns for affordability. She noted that while many employers are willing to reimburse medications with clear medical value, there's a desire for criteria that support appropriate use — such as

covering for those with associated comorbidities or who have holistic treatment plans.

Dr. Wharton cautioned that such restrictions may inadvertently block access for underserved populations who can't access specialized obesity clinics, suggesting that family physicians and virtual care providers must also be empowered to offer treatment within a broader care model.

He also explained that current BMI cutoffs used to determine treatment eligibility for obesity treatments were developed based on white European male populations and do not reflect the diversity of those living with obesity, which could lead to inconsistent or inadequate benefits coverage.

Plan sponsors and insurers are grappling with affordability, equity and appropriate usage. Mark Goldasic, partner at Jones DesLauriers, drew parallels between the evolving treatment of obesity and how mental-health coverage in benefits plans has become more widely accepted. He said that obesity must follow a similar trajectory — one that includes reducing stigma, increases awareness and normalizes coverage.

Goldasic also emphasized the importance of proactively putting obesity drugs on the agenda with clients. Advisors must navigate a delicate balance: clearly communicate the potential benefits for workforce health and productivity, while also preparing clients for the cost implications. "The key is to educate clients thoroughly, so they can make informed decisions based on whether coverage aligns with their goals and plan sustainability. It's not about pushing a solution — but rather offering informed choice."

KEY TAKEAWAYS

- ☐ Ensure health benefits plans recognize that obesity is a chronic medical condition and not a lifestyle choice.
- ☐ Review how stigma around obesity is recognized and handled within your organization.

The expanding role of private payers in supporting working Canadians living with cancer

The private payer community — including plan sponsors and insurers — plays a vital role in closing cancer care gaps by ensuring timely access to new treatments, diagnostics and support services — helping Canadians stay healthy, resilient and productive, said Heather McDonald, vice-president at AstraZeneca Canada.

Cancer is increasingly understood as a chronic, episodic disease that many people live with and work through, said Chris Bonnett, principal at H3 Consulting. He explained that nearly one in two Canadians will receive a cancer diagnosis in their lifetime, with rising rates among younger, working-age individuals. Survivorship is growing, with 1.7 million Canadians living beyond their diagnosis for up to 25 years.

Cancer remains a major concern for plan sponsors. Bonnett pointed out that although cancer currently accounts for only four to five per cent of total private drug plan costs, this figure is expected to rise, as one-third of drugs in development are oncology treatments.

The Canadian Cancer Society estimates the average patient will incur nearly $33,000 in lifetime costs related to their cancer, half of which is out-of-pocket. Amounts this high are especially hard on younger workers, low-income earners and small business owners, said Bonnett.

Alvina Nadeem, a health-care consultant, patient advocate and cancer survivor, emphasized the personal toll, such as needing costly injections after her cancer treatment left her neutropenic. She described the emotional and administrative strain placed on patients already at their most vulnerable.

Dr. Christine Brezden-Masley, a senior practicing medical oncologist at Mount Sinai Hospital and medical director of the cancer program at Sinai Health System, pointed out that despite having health benefits, many patients face multiple barriers to accessing care, such as delays caused by prior authorizations, lack of coverage for critical diagnostics and fragmented treatment logistics — like being forced to receive anti-cancer infusions outside of hospitals.

New personalized therapies are transforming cancer care, said Dr. Brezden-Masley, who explained that some cancers are driven by specific genomic alterations, which can be identified through genomic testing of tumor DNA. But unfortunately, she said, benefits plan design hasn't caught up. Companion diagnostics, blood-based tests that determine if a treatment is appropriate, are often not covered, despite being essential to matching patients with life-saving therapies. "This lack of integrated coverage highlights the need for a more cohesive approach to cancer treatment, ensuring both the test and the therapy are accessible together to ensure appropriate care." Dr. Brezden-Masley also advocated for improved prior authorization processes for patients who need rapid access to life-saving therapies.

Some council members suggested that health insurance was fundamentally intended for unexpected, catastrophic health expenses. They acknowledged that plan sponsors may not be able to pay for everything and will have to make difficult choices. Perhaps expenses for vision, massage or a chiropractor are not catastrophic?

It was also recommended that while plan sponsors are understandably concerned about the cost of coverage, the discussion could evolve to highlight the value that coverage can deliver. Advancements in cancer treatment may reduce absenteeism and disability and support patients in returning to the workforce following treatment.

Others suggested that there is an opportunity to improve patient navigation across public and private plans, as many patients find themselves bouncing back and forth between them. "We need to get out of our silos, because patients are not in silos," said Bonnett.

Nadeem urged payers and plan sponsors to see themselves not just as financial backers, but as health-care partners, walking with patients from diagnosis to survivorship. "We have the same goal. We both want me to get better. Our core reason might be different, but it's the same outcome."

Gory noted an unexpectedly high number of cancer cases among his clients last year. Moving forward, he plans to prioritize sharing insights with plan sponsors — highlighting the impact on employees and their families.

The discussion highlighted the increasing complexity and cost of cancer and its rapidly advancing treatment options, said Bonnett, emphasizing the evolving role of private payers in supporting working Canadians living with cancer.

KEY TAKEAWAYS

- ☐ Assess how your organization supports plan members and their families living with cancer.
- ☐ Ensure your benefits plan reimburses cancer therapies and companion diagnostics that determine appropriate cancer treatment.

Balancing innovation, access and sustainability

Berkeley Vincent, president at Johnson & Johnson Innovative Medicine Canada, stressed the critical role of the dual public and private market system and the importance of preserving the private insurance market, which offers faster access and broader drug coverage.

Brad Millson, general manager, real world solutions at IQVIA, presented findings from the IMC 2025 Cost Driver Report that revealed an overall 7.3 per cent increase in private drug claims costs, driven mainly by higher utilization (4.4 per cent), with a smaller contribution from rising cost per claim (2.9 per cent). Despite the industry focus on high-cost drugs, the report showed that the biggest contributor to drug claims growth was for medications that cost less than $10,000 per patient per year.

Joe Farago, executive director, market access at Innovative Medicines Canada, shared results from a recent survey that showed new drugs for rare diseases frequently face private plan reimbursement delays of 18 months or more and 12 to 18 months for new specialty medications. These delays leave families with private coverage navigating serious health conditions without access to long awaited treatments. Unfortunately, many patients hesitate to speak up about these waits, because they fear that revealing their or a family member's serious condition and the associated high treatment costs could be seen as a burden to their employer. As a result, these challenges often remain hidden from plan sponsors.

Farago raised concerns about the private market becoming increasingly like the public system in terms of speed and breadth of coverage. "Historically the private market would list much quicker; however, we see that this has eroded over time and our concern is if the difference between the public insurance and the private insurance gets too close, it eliminates the value proposition of the dual payer market."

Farago cautioned that the bulk purchasing program proposed in the Federal Pharmacare Act would effectively force private plans to align with government drug coverage. "This alignment could undermine the distinct value of private plans, potentially paving the way for a single-payer system, which would reduce patient choice and delay or restrict access to life-saving treatments."

There was discussion amongst council members about therapeutic classes that appear to have multiple drugs to treat the same condition. Millson noted that patients respond differently to the same drug and may need to try multiple treatments before they find one that works for them. Farago argued that more products drive competition and can lead to reduced costs. Each new treatment offers incremental innovation and alternative treatments for patients who cannot tolerate or benefit from existing ones. Innovation in drug development frequently results in major breakthroughs and even potential cures. For example, over a 25-year period, the management of hepatitis C evolved from effective yet difficult treatments to the development of a cure, thanks to steady, incremental advances in therapy. "Without access to a diverse range of medications, some patients would be unable to receive the treatment they need or have hope for a cure for their condition," said Farago.

"The irony is that while these new drugs can be life-changing for the patients who need them, they actually have a minimal effect on the projected costs of total future private drug plan costs from a forecasting standpoint," said Millson. Unfortunately, because each health benefits plan's claims history is used to determine future premiums, even a single claim for one of these new drugs could substantially increase an organization's plan costs.

Although pooling is intended to protect plans from the impact of high-cost claims, Elaine Yedlin, chief operating officer at Johnston Shaw, suggested "we need a real conversation around pooling, especially for small business, and whether it really protects plan sponsors from cost increases." She noted that, for smaller businesses, pooling charges represented up to a quarter of health premiums and "you're looking at effective target loss ratios of 50 to 60 per cent."

As a result, Yedlin noted that she is seeing more plan sponsors implementing drug caps to avoid high pooling premiums. "It's understandable — if they don't currently have any high-cost claimants, it seems like a win-win: no one loses coverage and they can significantly reduce their health benefits costs." However, her concern is that as more employers take this approach and effectively remove lower-risk groups from the pool, it

may distort the overall risk balance and could ultimately drive pooling charges even higher for those who remain.

Frédéric Leblanc, strategic leader, drug programs at iA Financial Group, highlighted the challenge for insurers. Plan members are anxious to get coverage for newly approved treatments, while plan sponsors push back on rising costs. "This creates a complex balancing act between access, affordability and sustainability," he noted.

Pamela Hinam, managing director at Sterling Brokers, suggested that "we need to look at the big picture because when we evaluate the cost of conditions like obesity and cancer, focusing only on short-term drug expenses misses the broader financial impact." These conditions can evolve into long-term disability claims, which require substantial reserves and create a cumulative cost burden, affecting sustainability and premiums. "A short-term, narrow view of cost management overlooks these downstream risks."

"It's time we reaffirm the value of Canada's dual market system and make it clear that private plans play a critical role in delivering timely, accessible care to Canada's working population," urged Vincent.

KEY TAKEAWAYS

- ☐ Ask your payer how long plan members are waiting to access new treatments.
- ☐ Advocate for pooling modernization to share risk more equitably amongst private plans.

Moderator and writer: Suzanne Lepage, private health plan strategist, Suzanne Lepage Consulting Inc.

NEXT STEPS FOR PLAN SPONSORS

- ☐ Ask your payer to reimburse unfunded preventative vaccines that pharmacists are authorized to prescribe and administer.
- ☐ Consider pharmacists as an alternative health-care provider, complementing other providers to improve access to care. Note that funding models vary by province and service type.
- ☐ Ensure health benefits plans recognize that obesity is a chronic medical condition and not a lifestyle choice.
- ☐ Review how stigma around obesity is recognized and handled within your organization.
- ☐ Assess how your organization supports plan members and their families living with cancer.
- ☐ Ensure your benefits plan reimburses companion diagnostics that determine appropriate cancer treatment.
- ☐ Ask your payer how long plan members are waiting to access new treatments.
- ☐ Advocate for pooling modernization to share risk more equitably amongst private plans.

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