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Smart Health Benefits Coalition
HESA Committee Brief
Bill C-64

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About the Smart Health Benefits Coalition

The Smart Health Benefits Coalition (SHBC) is a united advocate for smart, innovative solutions that result in timely and positive change for uninsured and underinsured Canadians. Formed in 2023, the SHBC is comprised of over a thousand workplace advisors across every province who help employers implement and manage their group benefits and group retirement plans.

Through six member organizations, SHBC's local businesspeople support more than 65,000 small and medium-sized employers with their employee drug plans, including over 4,800 union member drug plans. Together, these leading organizations support robust benefit plans for 10 million Canadians and their families.

SHBC's member organizations include: Benefits Alliance, Gallagher, GroupHEALTH, Hub International, Navacord, People Corporation, Conference for Advanced Life Underwriting.

Our Top-Line Position

The SHBC fully agrees - it is unacceptable that people in our communities across Canada are currently living with little or no coverage for essential medications; having slipped through the cracks of the public and workplace systems. Even though 97% of Canadians have some drug coverage under public and workplace plans[1] nearly 1 in 5 Canadians still report having some difficulty affording out-of-pocket drug expenses.[2]

We recognize that this is an affordability and access challenge that needs smart solutions to ensure people are getting the effective and accessible therapies for their needs, and that our health system is there for Canadians when they rely on it most. We believe that Canada can work with provinces to better solve these challenges, both faster and more cost effectively. By focusing net-new public resources and policy energy on filling the gaps and taking a progressive approach to affordability, Canada would be prioritizing the issues of the current landscape.

This vision can certainly include select medications for Canadians that come at no cost to the patient, far more manageable in a multi-payer system that spreads risk and costs more widely and mandates a minimum level of coverage for all types of plans. Leveraging and expanding access to the already robust health benefits infrastructure is not only significantly less costly, but also the best way to balance enhanced access to drugs for Canadians everywhere. It also does this without disrupting a stable ecosystem of health and retirement benefit programs that Canadians rely on for much more than drugs.

[1] "Understanding the Gap: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage", Conference Board of Canada, 2022: https://www.conferenceboard.ca/wp-content/uploads/2022/10/understanding-the-gap-2.0_2022.pdf

[2] "Inequities in pharmaceutical access and use", Statistics Canada, 2022, https://www150.statcan.gc.ca/n1/daily-quotidien/221102/dq221102a-eng.htm

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Critical Considerations

1. A first-payer model will require taxpayers to carry the whole cost of drugs and fees. Currently, employer-sponsored drug benefits provide over $20B toward medication for Canadian families every year, as a well-functioning part of our comprehensive healthcare system.[3] Employer-sponsored plans typically cover more than three times as many drugs as public plans and approve new drugs for use more than three times as fast as governments do.[4]

2. As outlined in the Canada Health Act, where there is a single-payer public reimbursement system, private insurance contracts would not be permitted to pay for the publicly covered drugs. Therefore, neither employers nor Canadians will have a choice between existing coverage and public coverage as proposed in C-64. Rather, they will be required to use the public plan for these specific treatments and can only rely on an employer-sponsored plan for any treatments not covered under the limited public formulary. This will cause confusion, potentially layer costs on to patients, and likely lead to reduced coverage under employer-sponsored plans seeking efficiencies with a new public payer. Additionally, this has a tremendous impact on the recent cost estimate from the Parliamentary Budget Officer, as the $4B currently covered by private plans would necessarily be borne by a single-payer model.

3. The biggest cost pressure is rare disease and high-cost therapies, like those for cystic fibrosis, Crohn's, and cancer. One family with a high-cost illness on a benefits plan can wildly skew costs borne by the employer-sponsored plan's premiums, while still leaving the family potentially with significant out-of-pocket expenses that could amount to tens of thousands of dollars or more. These extraordinary cost pressures, occurring already at a difficult time for a family, are potentially devastating.

Our Concerns with Bill C-64

- ✗ Compels a first-payer model and payment requirements, without alternatives.
- ✗ Canadians in provinces that decline first-payer agreements will receive unfair treatment relative to fellow Canadians; stark contrast to promises made to public.
- ✗ Proposed drug list for public coverage is not comprehensive, leaving a large proportion of patient families in difficult situation; potentially forced to change treatments, which may be less effective, or incur new costs to keep a prescribed treatment plan working for them.
- ✗ Creates uncertainty for employer-sponsored and union negotiated plan choices and cost.
- ✗ Replacing payer/shifting costs to taxpayer vs. adding value and solving known gaps
- ✗ Absence of clear mandate to conduct and publish comparative findings between first-payer and other pharmacare models, prior to further phases of pharmacare development.

[3] "Annual Report 2022", Patented Medicine Prices Review Board, 2022, https://www.canada.ca/en/patented-medicine-prices-review/services/annual-reports/annual-report-2022.html
[4] "Unlocking the Benefits: Private Drug Coverage's Role in Canada's Healthcare Landscape", 2023, https://innovativemedicines.ca/browse-by/private-drug-coverage/

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SHBC Smart Solutions Summary

- ✓ Use net-new taxpayer funding in a way that gets coverage and cost relief to those in need, faster and directly, rather than tying up billions of dollars every year to backfill existing employer-sponsored coverage that already works well for 4 out of 5 Canadians.

- ✓ Smart social policy objectives – like no-cost, universal access to contraception and diabetes treatment – are achievable and can be more robust if government targets fiscal resources to extend coverage to those without it and to cover out-of-pocket expenses as a last-payer within existing provincial and workplace plan frameworks.

- ✓ Require a common minimum formulary for all employer sponsored and provincial drug plans to create predictability and a "floor" of coverage across Canada.

- ✓ Require common pricing of a minimum or wider formulary, facilitated by inviting insurers and plan administrators to participate in the pan-Canadian Pharmaceutical Alliance (pCPA) that is currently open to governments only.

- ✓ Work with provinces to create a coordinated national system of rare disease, catastrophic and high-cost drug coverage, removing these exponential cost pressures off individual patient families and employer's insurance premiums.

- ✓ Update the Canada Health Act and work with provinces to include common out-of-hospital therapies (e.g. cancer treatments) that are in the best interests of patients and healthcare systems, and consistent with Canadians' expectation of entitlement to universal treatment for major illnesses within the public healthcare system.

Recommended Amendments to Bill C-64

Ensure Coverage Available to Canadians Regardless of Province

The SHBC is concerned that Canadians will be left behind in provinces where the federal and provincial government are unable to reach agreements within the narrow, first-payer requirements of Bill C-64. Canadians using diabetes and contraceptive therapies in provinces that reject this model should not be made to suffer for fraught federal-provincial relations or political debates. The current messaging from government and Bill C-64 supporters is exacerbating this risk by setting unrealistic expectations with Canadians and causing significant confusion on the ground.

Without intervening in the core aims of Bill C-64, the SHBC proposes an amendment that would allow the Minister of Health to enter into secondary negotiations with provinces, as proscribed in Bill-64 currently, in the event that primary negotiations break down and a province were to

formally reject the single-payer pharmacare scheme. This clause should allow for Canada to negotiate and enter into an agreement with, and make payments to, a province where universal, no-cost treatments are made available without the restriction to "first-payer" models.

Proposed amendment #1 – C-64, Section 6

Insert a new subsection **6 (4)** entitled **Alternative coverage agreement:**

If the Minister has been notified by a province or territory rejecting an agreement for universal, single-payer, first-dollar coverage for specific prescription drugs and related products intended for contraception or the treatment of diabetes, as described in subsection (1) and (2), the Minister may enter into subsequent negotiations with the province or territory on an agreement to provide payments to provinces or territories in a manner not described in subsections (1) and (2) but consistent with the principles set out in section 4 of the act.

Consult All Major Drug Purchasers and Include Them in pCPA to Lower Costs

The SHBC believes one of the most immediate and impactful ways to lower drug costs for all Canadians is to expand the membership of the pan-Canadian Pharmaceutical Alliance (pCPA) to include insurers and plan administrators. These entities are among the largest purchasers of drugs in Canada and similar in scale to provincial health systems. Getting a better deal for Canadians whether they access their prescriptions through a hospital, a provincial drug plan, or a workplace plan, is an important way to lower costs for Canadians and providers.

As Section 9 of Bill C-64 makes it a requirement to create a national bulk purchasing strategy within a year of the legislation receiving royal assent, an amendment should be made to ensure that the strategy will be developed with all major drug purchasers in Canada, to ensure the highest possible collective purchasing power.

Proposed amendment #2 – C-64, Section 9

Amend **Section 9** by adding new subsection **(2)** entitled **For greater certainty**, and new subsection (3) entitled **Agreement with provinces and territories:**

9 (1) The Minister must, after discussions with the provinces and territories, request that the Canadian Drug Agency develop, in collaboration with partners and stakeholders and no later than the first anniversary of the day on which this Act receives royal assent, a national bulk purchasing strategy for prescription drugs and related products to support the principles set out in paragraphs 4(a) to (d).

For greater certainty

(2) For greater certainty, partners and stakeholders in (1) must include all bulk purchasers of drugs in Canada, including provinces, territories, insurance carriers and benefit plan administrators.

Agreement with provinces and territories

(3) The Minister must engage with partners and stakeholders for the purposes of reaching an agreement to include all bulk purchasers of drugs as described in subsection (2) as members of the pan-Canadian Pharmaceutical Alliance to support the principles set out in paragraphs 4(a) to (b).

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Provide Canadians with a Cost-Benefit Analysis Prior to Further Steps

The SHBC also recognizes and lauds the Minister for clearly articulating his position that any agreements reached with provinces for a first-payer model will be considered as an important opportunity to evaluate and review the costs, benefits, and implementation of different approaches, prior to taking further steps in the years ahead. In fact, a secondary agreement resulting from SHBC's first proposed amendment that uses a different payment system to achieve the pharmacare policy objectives of universality and no-cost-to-patient for certain drugs would be an ideal comparator to evaluate different approaches in real time.

The SHBC proposes an amendment to Bill C-64, complimentary to other reporting requirements contained in the bill, that would ensure a public accounting and cost-benefit analysis is prepared and released, prior to any consideration of an expanded single-payer system. Canadians deserve to know the facts and costs before governments take further steps that may irrevocably impact their ability to access and afford a wider range of medications currently provided for under workplace plans.

Proposed amendment #3 - C-64, Section 11

Insert new subsections after **Section 11 (3)** entitled **(4) and (5)**

(4) The written report described in (3) shall contain a comprehensive analysis and comparison of the costs and savings realized under agreements reached with provinces pursuant to section **6 (1)** and **(2)** of the act and costs and savings realized under other models of pharmacare as may be present in certain provinces, and the report shall be tabled in Parliament by the Minister no later than 30 days after it is received by the Minister.

(5) No further expansion of pharmacare as described under any section of this Act shall occur until the report described in (4) is tabled in Parliament.

Understanding the Challenges

Underserved Canadians

The statistics show that relatively few people, 3%, have no coverage, while 22% report having difficulty affording medication. This wider measure represents about 1 in 5 people who may be experiencing one or more types of difficulty:

- The underinsured who have lower levels of coverage for drug types and/or higher cost-sharing;
- Individuals with more serious conditions facing extraordinary or catastrophic financial burden from long-term and/or high-cost therapies, including cancer treatments;
- Canadians having trouble with household affordability overall.

Fiscal stresses on families are challenging enough, however the ramifications of therapies that are not accessible or not taken are costly to our healthcare system and destructive to patients' and their families' lives.

While these statistics also reflect that a strong, functioning foundation of effective, affordable coverage exists for most Canadians - nearly 4 in 5 – there remains an equity challenge, particularly facing youth and marginalized communities with inadequate levels of coverage, or no coverage at all, typically with work in precarious or lower-paid sectors. Meanwhile, most middle-class families with a workplace benefits plan have comprehensive access and less cost – including households with two benefits plans in effect where out-of-pocket costs are often zero when shared between plans. There are smart solutions to fill these gaps and underpin affordability for patients.

Out-of-Pocket Expenses

It is important to understand that what is described as out-of-pocket expenses can vary widely. Patients may pay out-of-pocket as a result of one or more factors in their public or workplace benefits insurance plan: co-payments, annual reimbursement caps, insurance premium cost-sharing, or in the rare case that a necessary therapy is not covered by an existing plan.

However, we must not lose sight of the fact that high-cost therapies, out-of-hospital cancer treatment and rare-disease drugs can have an unexpected and catastrophic impact on people who are facing difficult personal health circumstances. These can be bankruptcy-level events for families without the financial resources to cover a 10% or 20% co-pay on a drug costing tens or hundreds of thousands, or even a million plus dollars – per year.

Rare Disease and High-Cost Drugs

To the SHBC, the growth in high-cost therapies and out-of-hospital treatment not covered by provincial health insurance (including cancer treatments) are the most pressing problems within the system, and have a direct bearing on health benefits coverage and system costs – both public and employer based. These types of unexpected and catastrophic situations are difficult for the patient and their families to manage and afford, but also for employer plan sponsors who may not be large enough or able to pool that risk across the broader population, and then risk having to reduce or limit coverage that becomes simply unaffordable.

SHBC members are at the frontline of advising and supporting businesses and families navigating these issues in our home communities across Canada. Businesses are worried about how to support their employees and balance risks of unexpected costs or disruption to their workplaces. And when difficult situations arise SHBC members work closely with employers and plan members to navigate these complex systems, including the gaps.

Canadians deservedly believe that their universal healthcare system is supposed to be there for them, especially when facing a serious, chronic or rare illness. Some Canadians still believe that all cancer care in Canada is covered by provincial health insurance plans. Unfortunately, this is simply not the case. Since the advent of our hospital focussed healthcare funding frameworks in the 1970's, vastly more treatments are delivered outside hospitals today, transferring the cost

from public insurance to benefits plans and/or out-of-pocket funds to cover increasingly standard at-home treatments and therapies.

Contraceptives and Diabetes Treatment

The SHBC recognizes and supports the public policy objectives of achieving universal coverage of contraceptives and diabetes therapies, including at no out-of-pocket cost to patients. The benefits of ensuring women have the autonomy to manage their own reproductive health, without cost or accessibility challenges, is an important stride that will empower and support women and avoid costs to the healthcare system and other economic costs more generally.

Similarly, helping Canadians living with or at-risk of diabetes to maintain a high quality of life, avoid adverse healthcare outcomes, and manage the cost burden for this lifelong condition. As a more complex condition, the SHBC is concerned that the proposed list of diabetes treatments will not be able to meet the full needs of the patient population, causing potential for patients to have to resort to navigating multiple plans for their needs.

Universal, no-cost access to these classes of drugs is completely achievable in a pharmacare model where public funds are targeted to fill the gaps rather than pay 100% under a "first payer" model exclusively run and paid for by governments. A model of public pharmacare that gets adequate coverage applied to those without it, creates minimum levels of coverage for all types of benefits plans – public and employer, and uses "last payer" models to support cost-free or cost-supported models in priority or essential categories.

Provincial Drug Plan Models

Currently, each province sets their own provincial drug formulary for those entitled to coverage, typically seniors, social assistance recipients, and residents of long term or institutional care. These plans typically include co-payments, dispensing fees, annual limits, income testing and other cost-controls.

In some provinces, employer sponsored plans coordinate with these provincial plans, including to offset out-of-pocket costs and maximum limits and to enhance access for more medications. Often as much as twice as many drugs are covered under employer-sponsored plans than are available in the public benefit plan. Some provinces also have catastrophic coverage that is available once expenses exceed a certain threshold of family income, as high as 12%.[5]

Three provinces currently provide more comprehensive models of drug coverage and are natural comparators in the pharmacare context: British Columbia, Prince Edward Island and Québec. British Columbia offers income-based universal coverage to its residents for prescription medications and high-cost drugs under an essential formulary. Residents are required to register for the provincial program, and consent to yearly income verification by the Canada Revenue

[5] "Catastrophic Drug Coverage in Canada", Library of Parliament, 2016, https://lop.parl.ca/staticfiles/PublicWebsite/Home/ResearchPublications/BackgroundPapers/PDF/2016-10-e.pdf

Agency (CRA) to receive ongoing coverage. In other words, the level of coverage a resident receives in British Columbia is dependent on how much they earn through their employment year-to-year. This model intends for those with the greatest need receive the most help, while constraining fiscal exposure.

Prince Edward Island provides coverage for all its residents, under the age of 65 and who do not already have coverage, under an essential formulary. After applying and being approved, residents will be covered for generic drugs and protected from out-of-pocket costs to a maximum amount. Like British Columbia, this model covers those who need it most, while maintaining fiscal prudence.

Québec ensures standard universal coverage levels by requiring private plan sponsors to meet or exceed its drug formulary, while also requiring employees to either join these employer programs, if available, or take public coverage. This works well to ensure an individual is covered at work or through the public program, and that a mandated pooling plan funded by the private insurers ensures risk is appropriately pooled (spread out) – in particular for high-cost or catastrophic coverage that a single employer plan would struggle with or be unable to fund.

Each of these provinces demonstrates different models to achieve similar outcomes as desired under the proposed federal policy. Mandated coverage of essential medicines and spreading cost and risk between employers and the government is a win-win solution that has each of these stakeholders playing a significant role and applying expertise and fiscal resources where they are most effective.

Employer-Sponsored Benefits

Canadian businesses and organizations have chosen to have benefit plans that offer competitive pharmaceutical coverage. In 2021, workplace expenditure on drugs in Canada was in excess of $20 Billion. This figure grew by 7.4% over 2020, most recently due to the skyrocketing cost of rare disease or specialized therapies and is anticipated to grow rapidly year over year.

Despite this trend, employers have continued to shoulder a large portion of the drug costs within the healthcare system to make sure their employees and their families are healthy, focused and at work contributing to the economic engine of Canada. While most medical conditions are easily treated by the extensive coverage offered by employer-sponsored plans, specialty drugs for specific medical conditions – that can cost anywhere from $10,000 up to over $1 million per annum – are the most important challenge faced by workplace plans.

With respect to employer-sponsored benefit plans, there are several important factors to consider when comparing access and affordability to public-plan coverage. Employer-sponsored plans have generally covered more than double the number of drugs when compared to provincial drug plan formularies, which means wider access for patients and families to more comprehensive drug and treatment options, including where that cost may not have been covered

at all under a public model.[6] Employer-sponsored plans are also more than three times as fast to review and approve new medications entering the market than public plans, providing faster access for patients to new therapies – sometimes years sooner than the same drug becoming available on public plans. [7]

Employers also enjoy the freedom of choice between insurers and third-party vendors to allow them to tailor the most appropriate coverage and service experience for their employees and their families. This includes the service that SHBC members provide day in and day out to businesses small and large, unions, nonprofits and public sector clients, helping employers *and* employees to navigate complex systems and critical decisions about options.

A publicly-administered plan cannot replicate the support these local service providers offer, including the materially better outcomes for families that it facilitates by bringing this expertise and advocacy to bear.

[End of submission]

[6] "Understanding the Gap: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage", Conference Board of Canada, 2022: https://www.conferenceboard.ca/wp-content/uploads/2022/10/understanding-the-gap-2.0_2022.pdf
[7] "Canadian Drug Access Pathway, Innovative Medicines Canada, 2022, https://innovativemedicines.ca/wp-content/uploads/2022/11/6132_IMC_Drug-Cost-Process-Map_update_Nov2022_v9.pdf