INNOVATIVE MEDICINE CANADA'S PRIVATE PAYER POLICY SUMMIT OCTOBER 2020

PHARMACARE SESSION

October 20, 2020, 1:00 — 3:00 pm EST

Over thirty representatives from the private health group insurance industry, pharmaceutical manufacturers and patient groups participated in this virtual event, moderated by Marilee Mark, Group Benefits Strategist, Marilee Mark Consulting. Attendees heard from presenters, answered online polling questions and participated in a group discussion. The presenters were:

- Chris Bonnett, Principal Consultant, H3 Consulting
- Jean-François Chalifoux, President and CEO, SSQ Insurance
- Joe Farago, Executive Director, Private Payers & Investment, IMC
- Pamela Fralick, President, IMC (opening remarks)
- Dr. Seema Nagpal, Vice-President, Science and Policy, Diabetes Canada

Private health insurance provides coverage for 62% of Canadians.[1] Yet advisors to government regarding a national pharmacare program have largely ignored, dismissed or oversimplified the role of private insurance in their pursuit of a single public-payer system. It is incumbent on insurers, advisors, pharmacy benefit managers (PBMs) and plan sponsors to come together to determine how to be at the table and how they can lead, facilitate or advocate in the national interest.

Prior to the COVID-19 pandemic, the Liberal government expressed support for single-payer pharmacare. However, the funding model was never made clear. The government did not appear to have a clear definition of pharmacare, and provincial-territorial government support is limited. Unaligned and conflicting external stakeholder positions contributed to a deepening state of inertia at federal and provincial-territorial levels. Public opinion polls showed that despite general support for national pharmacare, Canadians do not want to lose their private plan or receive less coverage. Currently, private plans cover significantly more medications than public plans and it is estimated that a single public-payer program could displace close to 8 million Canadians from their current medications.[1]

COVID-19 has shifted perspectives and amplified the barriers and disadvantages of a single public-payer system. This represents an opportunity for the private insurance sector to help governments reimagine the delivery of universal coverage in a way that is more impactful for patients and more fiscally responsible and achievable for both public and private payers.

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[1] *Understanding the Gap: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage. The Conference Board of Canada and Innovative Medicines Canada. 2018 January.*

The following definition sets the stage for an achievable national pharmacare program: "A pan-Canadian strategy recognizing federal, provincial and territorial leadership to enable timely, consistent and universal access to medicines based on need."

More research is required to better assess the problem and determine appropriate solutions. Some advocates of a single payer system claim that that 4 million Canadians lack coverage. However, this figure includes 3.6 million who are eligible for public coverage but who are not enrolled. 98.2% of Canadians have access to some form of public or private coverage.[1]

The federal government could make use of its resources and position by developing national standards and taking a facilitative role that respects provincial jurisdiction and builds upon today's mixed-payer model for drug insurance. For example, a national standard for out-of-pocket costs would be a significant and fiscally responsible step toward equity and universal access.

Learnings from current universal, mixed-payer models in Canada (e.g. the western provinces and Quebec) can help guide the development of national standards. Provinces can adapt or close gaps in their current systems to meet this nationally defined outcome.

Separate from pharmacare, the federal government should proceed posthaste with a national strategy for drugs to treat rare diseases (DRDs). The cost and complexities of DRDs require federal leadership in terms of access and funding. Provinces and territories as well as private insurance providers have indicated that a national strategy for DRDs is something with which they can align. The current pooling mechanism on the private side is increasingly inadequate.

PHARMACARE SUMMIT POLL RESULTS

DO YOU AGREE WITH…

Extending public coverage to the uninsured population?
50% Strongly Agree; 42% Agree; 8% Neutral

Creating a national pooling mechanism for high-cost claimants?
39% Strongly Agree; 30% Agree; 17% Neutral; 4% Disagree; 9% Strongly Disagree

Establishing a national strategy for coverage of Drugs for Rare Diseases?
75% Strongly Agree; 4% Agree; 4% Neutral; 4% Disagree; 13% Strongly Disagree

Patient groups emphasized that the pharmacare discussion must focus on improved access and by extension improved health outcomes, not on cost savings. Any policy change must not reduce access to proven treatments, particularly treatments that are part of clinical practice guidelines. Current gaps in coverage must be addressed and while savings can be a desired result, it must not overshadow the primary objective of improved access.

In conclusion, the current political and fiscal environments have opened a window of opportunity for stakeholders within private insurance to come together and better communicate its important role in supporting access to prescription drugs. As already demonstrated by some jurisdictions in Canada and around the world, a mixed-payer model can more effectively and affordably meet the needs of all stakeholders, particularly those of patients, than a single public-payer model.

DRUG PRICING AND REIMBURSEMENT SESSION

October 27, 2020, 1:00 — 3:00 pm EST

Over thirty representatives from the private health insurance industry, pharmaceutical manufacturers and patient groups participated in this virtual event, moderated by Marilee Mark, Group Benefits Strategist, Marilee Mark Consulting. Attendees heard from four presenters, answered online polling questions and participated in a group discussion. The presenters were:

- Wayne Critchley, Senior Associate, Global Public Affairs
- Pamela Fralick, President, IMC
- Brian Heath, Vice-President and General Manager, Amgen
- Brad Millson, Senior Principal, Health Access & Outcomes, IQVIA

Even prior to changes scheduled to come into effect on January 1, 2021, PMPRB's price ceiling control system is unique to Canada. For many years Canadian drug prices have been 20% below the median of highly industrialized countries and have not increased by more than the Consumer Price Index. To lower maximum prices further, PMPRB reform comprises three elements: 1) a revised list of comparator countries; 2) new price factors including pharmacoeconomics; and 3) a new requirement to file prices net of confidential rebates to public and private payers. Canada is the first country in the world to incorporate the latter two factors into direct price regulation. Some of PMPRB's models contemplate price reductions of as much as 70%, depending upon the medicine. In addition, the new Guidelines intended to implement these regulatory changes are complex and allow for more subjective assessments by PMPRB staff.

The presentations highlighted some of the major challenges with the PMPRB reform:

- lack of consensus on the nature of the problem and the objectives of reform, i.e., price levels relative to other countries or mechanisms to cover newer high cost treatments;
- uncertainty that PMPRB is the appropriate vehicle as it is based on patent laws and unconnected to the coverage decisions of public and private plans; and
- the potential impact on access to new therapies; the reforms create an uncertain, complex and contentious pricing environment that may discourage new drug launches.

While Canada is currently a top-tier market in terms of investment in clinical trials and timing of launches, the PMPRB reforms may disrupt this position. A study by Life Sciences Ontario found a substantial decline in drug launches in Canada in 2019 compared to other countries. Summit participants noted that new cancer therapies, a new antibiotic needed for antibiotic resistance, and a breakthrough drug for cystic fibrosis are among the drugs whose launches have been delayed due to the impending changes.

Patient groups expressed particular concern about the negative impact on access for unmet patient needs. A delay of even six months can have a drastic effect on quality of life, or result in death. Access to breakthrough medicines is already challenging due to Canada's fragmented system. PMPRB's new framework has heightened patients' anxiety that new life-changing medications sold elsewhere will not be available in Canada.

DRUG PRICING AND REIMBURSEMENT SUMMIT POLL RESULTS

Should the PMPRB delay the Implementation of the Guidelines given the challenges with COVID?
61% Yes; 39% No

Are you concerned that the proposed PMPRB reform will lead to a reduction in new medicines in Canada?
30% Very Concerned; 26% Somewhat Concerned; 30% Neutral; 4% Somewhat Not Concerned; 9% Not Concerned

DO YOU BELIEVE THAT …

Private market stakeholders (insurers, advisors, plan sponsors and PBMs) understand the PMPRB guidelines and implications of proposed changes?
26% Yes; 74% No

Government should meet with pharmaceutical industry to negotiate a plan that will lower drug prices while ensuring companies have a viable market in Canada to launch new drugs?
100% Yes

Access cannot simply be addressed through price regulation. Funding models for high-cost drugs have not kept pace with medical innovations. For private plan sponsors, high-cost drugs are like a game of chance and have led to drug plan caps, health spending accounts and other risk-management measures that are not ideal. Plan sponsors emphasized the overriding need for an insurance model that spreads risk far more effectively than the current pooling mechanism in order to attain a successful balance between lower costs and good access. The PMPRB reforms do not address this issue.

Countries throughout the developed world use health technology assessment (HTA) to help inform negotiations for coverage of high-cost drugs. But no country uses it directly to set a price as proposed by PMPRB. Instead, other countries are making more sophisticated use of HTA to manage access (e.g., through risk sharing that sees the payer cover the drug but the manufacturer will repay if the drug does not achieve measurable objectives over time).

Consultation with government on the PMPRB reforms was not meaningful since the government did not appear to take suggestions from the patient groups, the pharmaceutical industry, and other stakeholders seriously. Participants unanimously agreed that the government should sit down with the industry to negotiate a plan that will lower drug prices while ensuring companies have a viable, predictable market in Canada to launch new drugs.

Plan sponsors did not take part in consultations, despite the fact that well over half of Canadians have coverage under a private plan. Three-quarters of the summit participants believe that private market stakeholders do not understand the PMPRB reform and its implications. More education is needed to engage employers; for example, by making the connection between drug benefits and disability costs. It was also suggested that it is incumbent on insurers, advisors and third-party administrators to proactively serve as the collective voice for employers.

In conclusion, while all stakeholders agree on the need for reasonable drug prices, many argue that PMPRB reforms have gone too far and raise deep concerns about access to new drugs, particularly breakthrough treatments. The employer stakeholder group is both under-represented and minimally engaged, suggesting the need to raise awareness of the reforms and how they may negatively affect businesses and their workforces—and how they do not effectively address the need for a new strategy to affordably provide coverage for high-cost, breakthrough drugs.