Smart Health Benefits Coalition

[Cover Page]

Smart Health Benefits Coalition
SOCI Committee Brief
Bill C-64

Submitted by:
Carolyne Eagan, Principal Coalition Representative & President of Benefits Alliance

Contents

Smart Health Benefits Coalition

Introduction

On behalf of the Smart Health Benefits Coalition (SHBC), we appreciate the opportunity to provide input on Bill C-64 to the Senate Committee on Social Affairs, Science and Technology. The SHBC is a united advocate for smart, innovative solutions that result in timely and positive change for Canadians' health and our cherished healthcare system, including access and affordability of drugs at the centre of the current discussion on Pharmacare.

While we understand the government's aim to make prescription medications more accessible and affordable for all Canadians, we are deeply concerned that Bill C-64, in its current form, could unintentionally disrupt the effective and complementary relationship between employer-sponsored health plans and public healthcare programs.

The Senate plays a critical role in the legislative process, and it is the Senate's duty to scrutinize and fix flaws in proposed laws that may have unintended negative consequences. We believe that Bill C-64 requires amendments to safeguard the ongoing viability of employer-sponsored drug plans, which millions of Canadians rely on for coverage. Without these amendments, the legislation could result in significant disruptions, confusion, and unanticipated costs.

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 seven 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]

[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

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.

Unintended Consequences of Bill C-64: Disruption to Employer-Sponsored Drug Plans

One of the most concerning aspects of Bill C-64 is its use of rigid terms that will irreversibly damage the functioning of benefits millions of Canadians rely on today. The use of “single-payer” and “first-dollar coverage” in particular will eliminate the promised “choice” of Canadians to access their existing workplace coverage. In turn, this will cause the financial estimates of Budget 2024 and the Parliamentary Budget Office to be grossly underestimated, when considering that a single payer and first dollar public plan will prevent patients from accessing these drugs in any other way than the public plan.

What our advisors know is that where provincial health insurance operates under “universal, single-payer, first-dollar coverage,” insurance companies are prohibited from covering any treatment or drug that is also covered under a publicly insured, single-payer system. This means that even if public health programs offer only partial coverage, or provide coverage with significant delays, private insurers will be barred from offering additional coverage for those same medications or services.

Our advisors regularly navigate these challenges, and they have seen firsthand how such provisions create conflicts between insurers and public healthcare systems. For instance, in areas like cancer care and high-cost medications, there are often disagreements between private insurers and provincial public health plans about what constitutes a "publicly insured" service or therapy. While a provincial plan may technically cover certain high-cost drugs, accessing those drugs through the public system can involve lengthy wait times or restrictive eligibility criteria. In such cases, Canadians have relied on their employer-sponsored plans to get faster access to critical treatments.

Smart Health Benefits Coalition

Under Bill C-64, this type of flexibility and choice could be lost. If employer-sponsored plans are no longer permitted to cover medications that are also included in the national pharmacare program, Canadians may find themselves with fewer options for accessing the drugs they need. This could lead to mass confusion, as employees and their families may not understand whether they are eligible for coverage through their private plan or the public system, or in many cases will be required to "stich together" coverage if they use therapies that are both on and off the list of approved drugs (especially in diabetes care). Worse, Canadians could face significant delays in receiving necessary medications or be forced to pay out-of-pocket for drugs that were previously covered by their employer-sponsored plan.

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.

[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/

Smart Health Benefits Coalition

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.

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.

- ✓ 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.

The Senate’s Role: Fixing Flaws in Bill C-64 – Suggested Amendments

The Senate has a critical role in the legislative process, ensuring that laws passed by the House of Commons are thoroughly reviewed, refined, and, where necessary, amended. Bill C-64, while well-intentioned, contains several significant flaws that could disrupt the healthcare system,

harm employer-sponsored drug plans, and ultimately limit Canadians' access to essential medications.

There has been a clearly and oft stated policy intention of the Minister of Health and the Government of Canada, including similar descriptions and comments by other Ministers of the Crown, the Prime Minister and government MPs, that Canadians will continue to be able to "choose" whether they access prescriptions for covered treatments through a new public plan arising from C-64, and any existing coverage from employer sponsored insurance plans.

Unfortunately, the bill as currently written specifically and purposely circumvents this public interpretation from government policy and decision makers by using the terms "single payer" and "first dollar" coverage, which in and of themselves irrevocably prevent such a "choice" being offered to Canadians.

Single payer means there can be no other payer besides governments. This also impacts the budgeting projections of both the Ministry of Finance (Budget 2024) and the Parliamentary Budget Officer, who account for the vast majority of costs to be borne by employer-sponsored insurance plans, which cannot be true if "single payer" and "first dollar" remain in the legislative text.

SHBC recognizes and generally supports the recommendations of other stakeholders concerned about issues with respect to the continued and sustainable relationship between public and employer-sponsored insurance plans. For this submission, SHBC has focussed on any use of "single payer" and "first dollar" as the most impacting and root-cause issues at play in the current iteration of the legislation, however would encourage the committee to review other amendments.

Payments

6 (1) *The Minister must, if the Minister has entered into an agreement with a province or territory to do so, make payments to the province or territory in order to ~~increase any existing public pharmacare coverage — and to provide universal, single-payer, first-dollar coverage —~~* **provide new or additional coverage to residents** *for specific prescription drugs and related products intended for contraception or the treatment of diabetes***.**

For greater certainty

(2) *For greater certainty, any agreement referred to in subsection (1) with a province or territory is to provide for ~~first-dollar coverage~~* **access to these medications in such a way as to ensure no cost** *to patients.*

…

11 (1) *The Minister must, no later than 30 days after the day on which this Act receives royal assent, establish a committee of experts, and provide for its membership, to make recommendations respecting options for the operation and financing of ~~national, universal, single-payer~~ pharmacare.*

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 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.

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

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 40%-50% more 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 three times faster 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.

---

[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

Smart Health Benefits Coalition

Conclusion

Bill C-64 represents a significant shift in the approach to drug coverage in Canada. While its goals are commendable, the potential unintended consequences require careful consideration and amendment. The Smart Health Benefits Coalition urges the Senate Committee to address these concerns to ensure that any changes to the pharmacare system enhance coverage and access without undermining the critical role of employer-sponsored drug plans or causing unnecessary disruption.

We look forward to engaging further on this issue and working collaboratively towards solutions that will benefit all Canadians.

[End of submission]