Canadian Life & Health Insurance Association

Association canadienne des compagnies d'assurances de personnes

Submission to the

STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY ON AN ACT RESPECTING PHARMACARE (BILL C-64)

September 23, 2024

EXECUTIVE SUMMARY

All Canadians should have access to the drugs they have been prescribed. The federal government should focus on ensuring Canadians have access to prescription drugs by focusing scarce federal dollars on those without coverage.

At the House of Commons study on Bill C-64, the Minister of Health stated that "somebody who has existing coverage can continue to use that coverage." However, the legislation is not clear and repeatedly calls for single payer pharmacare in Canada, with no mention of workplace benefit plans.

This legislation does not help reduce the gap in prescription drug coverage for all drugs, instead Bill C-64 risks:

- Disrupting existing prescription drug coverage paid for by employers;
- Limiting choice for Canadians;
- Using scarce federal fiscal resources to replace existing coverage; and
- Failing to provide coverage for uninsured Canadians who rely on other medications beyond a short list of diabetes medications and contraceptives.

The CLHIA recommends that the Bill be amended to focus on ensuring universal coverage for all Canadians by addressing any gaps that currently exist and to ensure that the Bill reflects the Minister's intention for Canadians to be able to continue to access their drug coverage through workplace benefit plans.

We have provided more details in our submission. Section one provides further details on our industry's key concerns with the Bill. Section two presents our industry's recommended amendments to the Bill. The annex provides data on workplace benefit plans coverage for diabetes medications, diabetes devices or supplies, and contraceptives.

SECTION ONE: KEY CONCERNS AND CONSIDERATIONS

Scope of Bill C-64 is broad and may be a significant disruption to existing prescription drug coverage that is working well for the vast majority

Workplace benefit plans are a key pillar of Canada's healthcare system. 27 million Canadians have access to prescription drug coverage through their workplace benefit plans. These plans are valued by Canadians. Survey data shows that nearly 90% of Canadians place a high value on these benefits and 85% found these plans helpful in saving them money[1]. Further, in 2022, Canada's life and health insurers paid out $14.3 billion for drugs, which accounts for over 35% of prescription drug spending in Canada[2].

Bill C-64 must be read in its entirety to understand the implications for Canadians. The Bill seeks to provide single-payer drug coverage for diabetes medications and contraceptives, which would preclude workplace benefit plans from covering the drugs on the federal government's list. While not defined in Bill C-64, as noted in the Advisory Council on the Implementation of National Pharmacare (ACINP) Report, a single-payer system is one that is national and publicly-funded and administered. This means there is no role for workplace benefits under a single-payer pharmacare program.

Bill C-64 goes further than contemplating a new pharmacare program for diabetes and contraceptives. It also requires the federal government to begin negotiations with provinces to provide universal pharmacare coverage for an "essential medicines list" no later than 12 months after Bill C-64 gets royal assent. The scope of this legislation, therefore, will disrupt a significant portion of the coverage that 27 million Canadians currently rely on. There are material and many unknown risks to disrupting existing programs.

The Bill does not reflect the Minister's stated intentions and overall plan for pharmacare – risking private drug plans

There is a significant lack of transparency and clarity around the Government of Canada's intentions and overall plan for a future pharmacare program. During second reading debate, the Minister of Health stated that, "people who have an existing drug plan are going to continue to enjoy the access that they have to their drugs." The text of the Bill does not reflect the Minister's statement that "somebody who has existing coverage can continue to access that coverage." The Bill, much of which is ambiguous and calls for universal, single-payer pharmacare in Canada, does not mention workplace benefit plans. If the government intends for existing drug plans to continue under its pharmacare model, the current drafting of the Bill does not support this view and must be amended to provide clarity on the intent.

Another source of ambiguity about the future model is Section 4. While the Bill does not expressly prohibit Canadians from purchasing supplementary drug benefit plans, or insurers from offering such plans, Section 4 of the Bill requires the Minister to consider certain principles and the *Canada Health*

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[1] Abacus, 2023.
[2] CLHIA 2022 Factbook.

Act ("**CHA**")[3] while working towards the implementation of national universal pharmacare. Like Bill C-64, the CHA, does not expressly prohibit the selling of supplemental medical insurance.

However, the interpretation of the CHA's principles has resulted in provincial legislation that prohibits anyone except the public insurer from paying for insured health services, including an employer benefits plan. Section 4's requirements create an unclear role for the CHA and its principles, creating uncertainty about the government's intended pharmacare model.

In addition to creating uncertainty about the role of the CHA principles, other principles seem to suggest a model that does not align with the Minister's statement during second reading debate[4], referenced above. Section 4 places strong pressure on the Minister to consider a full public coverage program, based on the express principles of "accessibility" and "affordability" in addition to the requirement to consider the CHA. These considerations could create practical and even legal barriers to patients or employers purchasing supplementary drug insurance for drugs on the national formulary.

The preamble to this Bill also references several external publications that will impact future interpretations of the Pharmacare Act, creating greater uncertainty. Section 13 of Canada's *Interpretation Act* requires consideration of the preamble when determining the purpose and objective of the Act.[5] Since the preamble references these external publications, they will factor into a court's ultimate interpretation of the future Pharmacare Act.

For example, the seventh preamble statement in the Bill states that the Government of Canada is committed to establishing a pharmacare program that is informed and guided by the recommendations from the report by the ACINP Report [6] and the CHA. The ACINP Report itself makes recommendations that the Government of Canada implement a pharmacare program modelled on the CHA.

Given its inclusion in the preamble, the ACINP Report will likely be informative when courts are called on to interpret the various undefined terms and provisions of the future Act. Multiple references to the CHA and other external reports that may have the effect of indirectly importing the CHA principles into a future pharmacare program or the funding agreements. This would lead to a full coverage, public program that the Parliamentary Budget Office has estimated to cost nearly $40 billion annually[7]. As set out above, incorporating CHA principles into the model conflicts with the Minister's intention stated in the House that existing workplace drug plans should continue.

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[3] *Canada Health Act*, RSC 1985, c C-6.
[4] Canada. Parliament. House of Commons Debate, 44th Parliament, 1st session, vol. 151, issue 309, May 6, 2024. (Online).
[5] *Interpretation Act*, R.S.C., 1985, c. I-21.
[6] *A Prescription for Canada: Achieving Pharmacare for All*, Advisory Council on the Implementation of National Pharmacare, June 2019.
[7] Parliamentary Budget Office, 2023.

The inconsistency in terminology throughout the Bill also raises additional questions about how the government intends to design and implement pharmacare. Section 1 of the Bill defines *pharmacare* as "a program that provides coverage of prescription drugs and related products". However, the Bill goes on to use several different variations of the term "pharmacare" or "coverage", all of which could have slightly different meanings. These include:

a) "pharmacare agreement",
b) "national universal pharmacare" (which is used five times),
c) "universal coverage of pharmaceutical products",
d) "universal, single-payer, public pharmacare" (which is used three times),
e) "universal, single-payer, first-dollar coverage" (which is used twice and only in reference to the covered products),
f) "first-dollar coverage" (which is used twice),
g) "prescription drug coverage plans", and
h) "national, universal, single-payer pharmacare".

As a result of inconsistent and undefined terms, the principles of statutory interpretation could result in a wide range of definitions being assigned to these undefined terms as the Act is interpreted. The inconsistent use of undefined terms makes it even more difficult to ascertain the government's intended approach to the pharmacare program with any clarity.

The final result could create practical and even legal barriers for patients or employers to purchase supplementary drug insurance for drugs on the national formulary. This presents significant risks to the prescription drug coverage currently enjoyed by 27 million Canadians through their workplace benefit plans – benefits that the Minister has stated an intention to continue.

In conclusion, despite comments from the Minister to the contrary, this legislation:

- Fails to explicitly acknowledge and ensure the continuation of workplace drugs plans alongside present and future public pharmacare programs;
- Presents significant risks to the 27 million Canadians who have access to prescription drug coverage through their workplace benefit plans; and
- Does not provide an appropriate degree of transparency and clarity on the government's intent.

Severely limits choice for Canadians

The proposed federal program will cover far fewer medications than are currently available to Canadians with private coverage. Existing workplace benefit plans provide coverage for a much broader list of medications than even the most generous public plans. For example, Health Canada published two backgrounders, *Universal Access to Contraception*[8] and *Universal Access to Diabetes*

[8] Universal Access to Contraception, Health Canada, February 29, 2024.

Medications, and Diabetes Device Fund for Devices and Supplies[9] that outline which specific drugs will be funded through these Funding Agreements. These cover only five classes of diabetes medications and generally do not include the majority of types of insulin and devices that workplace benefit plans cover.

Examples of types of insulin covered by workplace benefit plans, but not covered by the proposed federal program, include many of the more advanced types of insulin. These include injections that make life easier for diabetic children or patients with busy lives (e.g., weekly injections, fast-acting meal-time injections, insulins specific for diabetic coma etc.).

The impact on Canadians' access is illustrated clearly in Table 1 below. There are nearly four million Canadians who currently rely on their workplace benefit plans for their diabetes medications, contraceptives and related products. Of these, over two million Canadians are covered for medications and devices that would not be covered under the proposed federal program. This puts the coverage of two million Canadians into question. They may be required to switch medications and go onto the public plan or find another way to cover what they currently have.

Table 1: Analysis of Number of Claimants Covered by Workplace Benefit Plans for Diabetes Medications, Devices / Supplies and Contraceptives On and Not On the Federal List of Medications

Total Claimants (On and Not On the Federal List of Medications)				
Province	**Total Claimants**	**Claimants ON Federal List**	**Claimants NOT ON Federal List**	**% Not on Federal List**
AB	329,796	144,406	185,390	56%
BC	493,294	244,852	248,442	50%
MB	173,978	99,363	74,615	43%
NB	134,033	64,562	69,471	52%
NL	101,471	49,127	52,344	52%
NS	151,329	70,356	80,973	54%
ON	1,414,183	607,111	807,072	57%
PEI	23,328	10,814	12,514	54%
SK	115,259	66,133	49,126	43%
QC	1,057,969	549,372	508,597	48%
National	**3,994,640**	**1,906,096**	**2,088,544**	**52%**

Source: IQVIA, 2023

See the annex A for the number of claimants by diabetes medications, diabetes devices / supplies, and contraceptives.

[9] Universal Access to Diabetes Medications, and Diabetes Device Fund for Devices and Supplies, Health Canada, February 29, 2024.

Uses scarce federal fiscal resources to simply replace existing coverage

Adopting a single-payer model as contemplated in Bill C-64 will replace two million Canadians' current drug coverage and move them onto a new public plan. If the program is expanded, this number of Canadians with displaced coverage will grow. This does not increase access for those impacted Canadians and is an ineffective use of public resources because it spends resources on people who already have coverage.

Given the scarce fiscal capacity of federal and provincial governments, funding should be used to help those who need it (uninsured and underinsured), rather than simply replacing coverage that is already in place. In 2023, workplace benefit plans covered over $2.3 billion for diabetes medications, devices and contraceptives (see Table 2 below). This includes:

- Diabetes medications ($1.7 billion) – 85% of these costs ($1.4 billion) were for medications that will not be covered under the federal plan;
- Diabetes devices or supplies ($421 million) – currently none covered under the federal plan; and,
- Contraceptives ($217 million) – 21% of these costs ($45 million) was for contraceptives that will not be covered under the federal plan.

Table 2: Analysis of Total Costs Covered by Workplace Benefit Plans for Diabetes Medications, Diabetes Devices / Supplies, and Contraceptives On and Not On Federal List

Total Costs (On and Not On Federal List)				
	Total Cost	**Costs ON Federal List**	**Costs NOT ON Federal List**	**% Not On Federal List**
Diabetes Medications	$1,663,113,417	$252,887,766	$1,410,225,652	85%
Diabetes Devices & Supplies	$420,887,447	-	$420,887,447	-
Contraceptives	$217,274,346	$171,798,699	$45,475,646	21%
Total	**$2,301,275,210**	**$424,686,465**	**$1,876,588,745**	**82%**

Source: IQVIA, 2023

See annex B for a provincial breakdown.

The data highlights that covering the drugs outlined in the Health Canada background papers for those who already have coverage for those medications would cost over $424 million annually. This is before even one additional Canadian is provided access to any new medications. Simply paying to replace what already is in place does not help the government achieve its goal of expanding Canadians' access to medications.

Targeting scarce Federal resources to those without a plan, could give 220,000 Canadians comprehensive drug coverage

The 2024 Federal Budget committed $1.5 billion to the national pharmacare program over five years without any long-term funding commitment. As noted above, covering the drugs outlined in the Health Canada background papers for diabetes and contraceptives will cost over $424 million annually and merely replace coverage 2 million Canadians already have – while still leaving significant gaps. It would be far better to target those without a drug plan and to provide them with meaningful support, that covers medications beyond these two categories of drugs.

For example, the average cost for an Ontarian in 2022 on the Ontario Drug Benefit (ODB) was roughly $1,900 per year. Using the $424 million to target those without coverage, would provide roughly 220,000 Canadians with full, comprehensive drug coverage equivalent to the ODB. This would make immediate and deep impacts for the most vulnerable, without putting in jeopardy what is currently working well.

SECTION TWO: RECOMMENDED AMENDMENTS TO THE BILL

This section details our industry's recommended amendments to the Bill. We believe this legislation needs to be significantly amended to:

a) focus on ensuring universal coverage for all Canadians by addressing any gaps in drug insurance that currently exist;
b) provide the appropriate degree of transparency and clarity for stakeholders and the public to understand the intent of the government; and,
c) reflect the Minister's statement that Canadians can continue to access the coverage through their workplace benefit plans.

We call on this committee and the current government to introduce the necessary amendments below into legislation. They will provide explicit protections for workplace benefit and other plans, to make Minister Holland's statements during second reading debate, and PBO's costing (modelling an approach that permits the continuation of workplace benefit plans), a reality.

Comments on preamble – amend to remove references to CHA, ACINP and single-payer

1. Amend the Preamble to remove references to the Canada Health Act (CHA), the "Advisory Council of Implementation of National Pharmacare" (ACINP), and "single-payer"

We recommend the preamble be revised to remove references to the CHA, the "Advisory Council on Implementation of National Pharmacare" and "single-payer":

> ***Preamble***
> ***~~Whereas the Government of Canada recognizes that the Advisory Council on the Implementation of National Pharmacare as well as several studies have recommended establishing universal, single-payer, and public pharmacare in Canada;~~***

Whereas the Government of Canada is committed to continued collaboration with the provinces, territories, Indigenous peoples and other partners and stakeholders on the step-by-step implementation of national universal pharmacare, ***~~which is to be guided by the Canada Health Act and carried out in accordance with the recommendations of the Advisory Council on the Implementation of National Pharmacare;~~***

Comments on definitions: Define "universal" and "national"

Each of the following terms need to be properly defined under Section 3 to allow for the appropriate degree of transparency and clarity on the government's intent, and consistent interpretation of the Act in the future:

1. Define "universal"

"Universality" is referenced throughout the Bill but is not defined. Without a definition, there is a risk that the CHA principle of universality is adopted.

The CHA principle of universality requires a province to entitle all insured persons to the insured health services under a public insurance plan on uniform terms and conditions. Accepting this phrase risks importing all of the CHA principles into the future program, including potential prohibitions for private insurers to pay for drugs. This would also mean preventing the possibility of a future program that targets government supports to those without existing coverage.

Our industry supports universal access to prescription drugs. However, there is a need to define "universal" to mean providing all Canadians with access to needed medications but allowing that coverage to be provided through a public or private plan.

2. Define "national"

It is unclear whether "national pharmacare" is intended to describe a program administered directly by the federal government (eliminating provincial plans), federal funding to all the provincial drug insurance plans if they meet certain requirements, federal requirements on all provinces and territories to ensure access to drug insurance coverage (through public or private coverage) or another meaning.

We recommend that the definition of "national" be added and defined so as to allow coverage to be provided to Canadians either through a public or private plan

Comments on Section 4 (Principles): Remove references to CHA

To provide clarity and assurance that the CHA principles are not indirectly imported into a future pharmacare program or the funding agreements. We recommend the following amendments:

Recommended Amendments:

Principles
4 The Minister is to consider the following principles ~~***and the Canada Health Act***~~ *when collaborating with provinces, territories, Indigenous peoples and other partners and stakeholders with the aim of continuing to work toward the implementation of national universal pharmacare:*

(a) improve the accessibility of pharmaceutical products, including through their coverage, in a manner that is more consistent across Canada;

(b) improve the affordability of pharmaceutical products, including by reducing financial barriers for Canadians;

Comments on Section 5 (Funding commitment): remove call out to rare diseases

References to funding for rare diseases does not link to the rest of the Bill. Additionally, rare disease drugs are not funded through this Bill. We recommend this reference be removed to clarify the separate approaches to and funding for Rare Disease Drugs.

Funding commitment
5 The Government of Canada commits to maintaining long-term funding for the provinces, territories and Indigenous peoples to improve the accessibility and affordability of pharmaceutical products~~***, beginning with those for rare diseases***~~*. The funding for provinces and territories must be provided primarily through agreements with their respective governments.*

Comments on Section 6 (Payments): remove reference to "single-payer" and "first-dollar coverage"

To ensure the Bill reflects the Minister's statement that Canadians can continue to access their supplementary drug coverage and to focus any new program on those without drug coverage, we recommend the following amendments to Section 6:

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 provide public pharmacare coverage to residents without access to coverage for specific prescription drugs and related products intended for contraception or the treatment of diabetes under a private plan*** ~~***increase any existing public pharmacare coverage — and to provide universal, single-payer, first-dollar coverage —***~~ *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 to patients.***~~

Comments on Section 8 (National formulary) – introduce regulation making authority to govern the development and maintenance of the "National Formulary"

1. The national formulary should apply to both public and private plans

As mentioned above, our industry supports universal access to prescription drugs and believes that all Canadians should have access to the drugs they have been prescribed. The national formulary is a crucial component of this objective.

It is important that the national formulary is not only tied to public plans. The national formulary should apply to both public and private plans, establishing minimum requirements for these plans.

2. The Canadian Drug Agency (CDA) should be responsible for developing and maintaining the national formulary

In 2023, Health Canada announced that the creation of the CDA. Built from the existing Canadian Agency for Drugs and Technologies in Health (CADTH), the CDA will incorporate and expand on CADTH's mandate and expertise in the pharmaceutical sector. Given the CDA's future role to lead and coordinate within Canada's prescription drug system, they should be the accountable organization for the development and maintenance of the "national formulary."

3. CDA should publicly consult on the national formulary

We recommend it be made clear that the Minister or their delegate has an obligation to consult with stakeholders for the design of the national formulary and the process by which it will be revised and maintained.

4. Legislation should not come into force until the national formulary is approved

The CDA will need sufficient time to engage provinces, territories and other key stakeholders. As the national formulary is a key component of the national pharmacare program and its cost, the legislation should not come into force until the national formulary is approved and funding sources are identified.

As such, we recommend the following amendments to section 8 of the Bill:

> ***National formulary***
> *8(1) The Minister must, after discussions with the provinces and territories, request that the Canadian Drug Agency prepare, no later than the first anniversary of the day on which this Act receives royal assent, a list of essential prescription drugs and related products to inform the development of a national formulary that will establish the scope of prescription drugs and related products to which Canadians should have access under national universal pharmacare.*
>
> ***Discussions***

(2) The Minister must, after the list referred to in subsection (1) has been prepared, initiate discussions based on the list with provinces, territories, Indigenous peoples and other partners and stakeholders with the aim of continuing to work toward the implementation of national universal pharmacare.

Due process

(3) Subject to subsection (4), a universal pharmacare program must require the Minister to consult with the provinces, territories, Indigenous peoples and other partners and stakeholders on the process by which the national formulary will be designed and maintained, including any amendment to the list of essential prescription drugs.

Comments on Section 9 (National bulk purchasing strategy): amend to bring private payers into scope of any national bulk purchasing strategy

The CLHIA has long advocated that drug prices should be negotiated by the pan-Canadian Pharmaceutical Alliance (pCPA) on behalf of all Canadians, including those with public and private plan coverage, and Canadians paying out of pocket. The development of a national formulary and bulk purchasing strategy should leverage the purchasing power of the full system, including insurers, to obtain the best prices on behalf of Canadians.

As such, we recommend amending section 9 of the Bill to add:

National bulk purchasing strategy

9 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). ***The scope of the national bulk-purchasing strategy must include all payers in Canada – both public and private.***

Comments on Section 11 (Committee of experts): remove reference to single payer and adjust timeframe

1. Remove reference to single-payer

Section 11(1) of the Bill requires the Minister to establish a committee of experts to make recommendations and options for the operation and financing of a national universal single-payer pharmacare program. This Committee of experts is tasked with expanding single-payer pharmacare.

Given the reference to “single-payer,” it will likely preclude consideration of a future pharmacare program that supports a multi-payer approach. As mentioned above, we recommend that the reference to single-payer be removed.

2. The Committee of experts should be established before bilateral agreements with provinces are signed.

Section 11(2) of the Bill requires the committee advising on national pharmacare to provide its recommendations to the Minister within one year of the Act receiving royal assent.

However, there are many fundamental components of the program that are not yet clear (e.g., national formulary, coverage, how federal program will interact with provincial and territorial programs). The committee should first inform a consistent national program before negotiations with provinces and territories begin under those terms.

As a result, we recommend that the one-year timeframe be removed and the Bill be amended as follows:

> ***Committee of experts***
> *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* ***before negotiations with provinces and territories can begin****.*
>
> ***Report***
> *11 (2) The committee must, ~~no later than the first anniversary of the day on which this Act receives royal assent~~, provide a written report to the Minister setting out its recommendations.*

Suggested new Section 12 (Sunset provision)

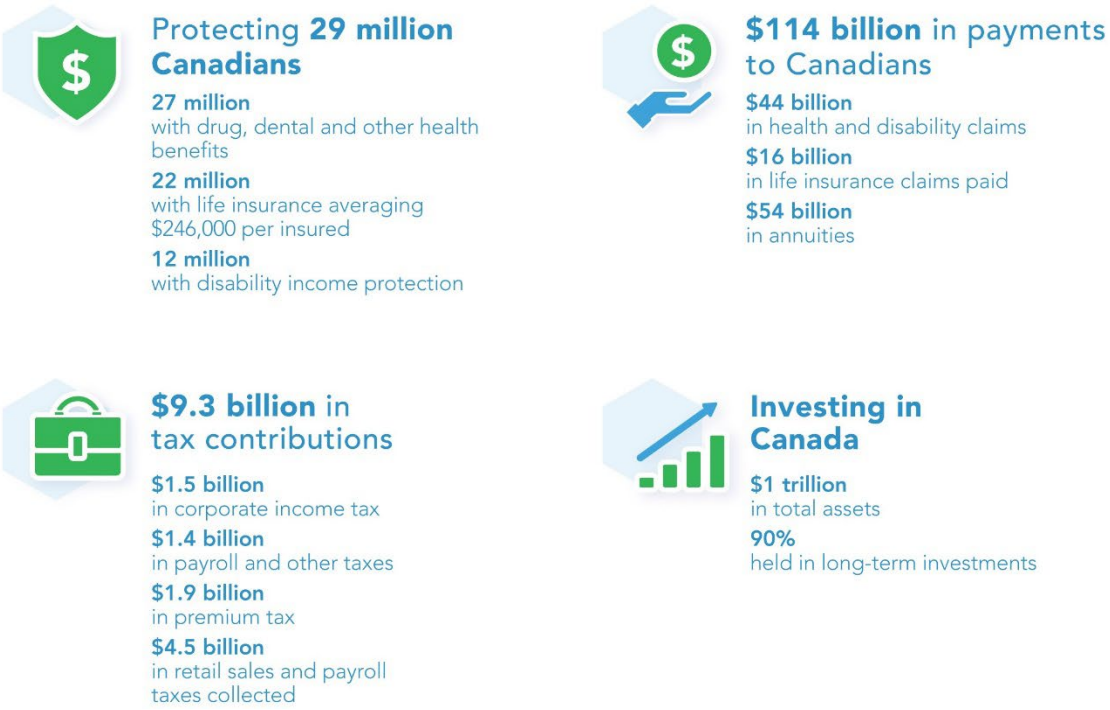
The committee of experts will be required to provide recommendations on the operation and financing of a program, and so there are considerable uncertainties on the design and implementation of any future pharmacare program. We recommend that the Government of Canada continue to be accountable to Canadians and allow for ongoing debate of the material provisions of the Act through using a sunset provision.

As a result, we recommend that the Act be reviewed and reconsidered within two years of it receiving royal assent through a new Section 12 as follows:

> ***Sunset provision***
> *12 Sections 4, 5, 6, subsection 8(2), and subsection 10(2) cease to apply on the second anniversary of the day on which this Act receives royal assent unless an extension is enacted by Parliament no later than six months prior to the expiry date.*

WHO WE ARE

The Canadian Life and Health Insurance Association (CLHIA) is the national trade association for life and health insurers in Canada. Our members account for 99 per cent of Canada's life and health insurance business. The life and health insurance industry is a key contributor to the health and well-being of Canadians and the healthcare system through the provision of supplementary health insurance. The industry also provides financial security to Canadians through a range of financial security products, such as life insurance and annuities.



CONCLUSION

The industry greatly appreciates the opportunity to provide comments on Bill C-64. Should you have any questions, you may contact Stephen Frank, CEO and President at sfrank@clhia.ca.

ANNEX A: CLAIMANTS COVERED BY MEDICATION CLASS

Total Claimants Covered by Health Benefit Plans (by Medication Class and by Province)							
Province	Diabetes Medications		Contraceptives		Diabetes Devices & Supplies	Total Claimants	
	Total Claimants	% Not on Federal List	Total Claimants	% Not on Federal List	Total Claimants	Claimants	% Not on Federal List
AB	174,699	55%	82,658	20%	72,439	329,796	34%
BC	318,085	40%	72,908	26%	102,301	493,294	30%
MB	99,991	33%	36,721	11%	37,266	173,978	21%
NB	78,264	50%	31,633	20%	24,136	134,033	34%
NL	54,338	39%	19,357	16%	27,776	101,471	24%
NS	75,460	50%	40,515	19%	35,354	151,329	30%
ON	744,867	57%	343,722	16%	325,594	1,414,183	34%
PEI	13,195	52%	5,177	15%	4,956	23,328	32%
SK	62,292	40%	32,077	11%	20,890	115,259	24%
QC	406,385	46%	422,968	22%	228,616	1,057,969	26%
National	**2,027,576**	**49%**	**1,087,736**	**19%**	**879,328**	**3,994,640**	**30%**

ANNEX B: TOTAL COSTS COVERED BY HEALTH BENEFIT PLANS BY MEDICATION CLASS

Total Cost Covered by Health Benefit Plans (by Medication Class and by Province)							
	Diabetes Medications		Contraceptives		Diabetes Devices & Supplies	Total Cost	
Province	Total Cost	% Not on Federal List	Total Cost	% Not on Federal List	Total Cost	Cost	% Not on Federal List
AB	$ 166,458,407	88%	$ 19,177,294	20%	$ 39,215,888	$ 224,851,589	67%
BC	$ 197,203,903	80%	$ 8,820,801	44%	$ 36,913,590	$ 242,938,294	66%
MB	$ 38,646,008	78%	$ 6,311,384	13%	$ 11,958,262	$ 56,915,654	55%
NB	$ 60,351,502	85%	$ 6,048,651	24%	$ 12,292,937	$ 78,693,090	67%
NL	$ 34,335,832	79%	$ 3,944,050	18%	$ 11,142,894	$ 49,422,775	63%
NS	$ 66,154,664	87%	$ 8,016,206	21%	$ 19,559,395	$ 93,730,265	70%
ON	$ 700,035,705	88%	$ 70,674,739	18%	$ 178,852,249	$ 949,562,693	72%
PE	$ 10,049,525	89%	$ 1,071,741	16%	$ 2,977,071	$ 14,098,337	71%
SK	$ 33,745,871	83%	$ 6,211,378	13%	$ 10,989,311	$ 50,946,560	67%
QC	$ 356,132,001	81%	$ 86,998,102	23%	$ 96,985,852	$ 540,115,954	69%
National	**$ 1,663,113,417**	**85%**	**$ 217,274,346**	**21%**	**$ 420,887,447**	**$ 2,301,275,210**	**71%**

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