National Pharmacare—Dead and Alive

National pharmacare is a policy zombie. It may be dead or alive—or somewhere in between. There have been a number of recent changes in drug plans and policy that suggest this persistent idea actually matters to the companies, trusts and unions that sponsor private drug insurance plans. Good health plan management and governance should not be limited to routine administration. Plan sponsors also should consider how to manage future risks and opportunities, and pharmacare presents both.

This article will review the key issues for private drug plan sponsors, describe the major types of universal systems and encourage private payers to understand and articulate their needs, priorities and preferences to governments.

Drug Policy: Boring but Now Necessary?

Private plan sponsors don't typically pay attention to arcane discussions of national drug policy. But maybe it's time to invest in some continuing education.

First, what is pharmacare? Already the adopted name for certain provincial drug plans (e.g., in British Columbia, Manitoba and Nova Scotia), *pharmacare* is a national approach meant to offer all Canadians consistent access to prescription drugs, usually with an undefined minimum standard of coverage in formulary and perhaps cost sharing. It is often meant to ensure no one is faced with financially catastrophic drug costs, and it sometimes means that coverage is provided with no out-of-pocket cost, at least for a small number of preferred or generic drugs. Pharmacare is a response to the

Given the complexity and costs involved in a national drug insurance program, it is important for plan sponsors, advisors and insurers to be engaged on this topic and to be able to understand and communicate their needs and goals.

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wide variety of provincial and private drug plans that provide coverage based on where you live or work rather than solely on medical need.

To do this properly, we should discuss and decide our national goals, including the definition of a minimum standard of adequate coverage, and the complex transition from many plans to (perhaps) one. How would a new universal plan be funded? While the insurance industry has described its policy preferences,[1] plan sponsors may have different priorities, and those should be considered. For example, small employers may be quite happy to transfer their increasingly complex and expensive drug plans to the government.

Not surprisingly, budget-driven governments have led drug policy and approaches to control drug prices. One example is the pan-Canadian Pharmaceutical Alliance (pCPA), which has created $1.3 billion in savings for public payers from 163 drug negotiations.[2] Meanwhile, private plans continue to pay retail for almost all new brand drugs and do not benefit from confidential pCPA rebates.

A Little History

Canada is the only nation in the Organisation for Economic Co-operation and Development (OECD) to have a universal health care system that does not include drug coverage. Currently, most Canadians have decent coverage provided through many sources, with the largest number covered through work-based health plans. Others get public coverage, and some get a combination.

Bringing prescription drug coverage into the Canadian medicare system has persisted since Supreme Court Justice Emmett Hall's 1964 Royal Commission. Fast-forward 53 years, and employers now fund about $11 billion in prescription drugs, and patients pay another $6 billion out of pocket. There is still a patchwork of coverage, and some Canadians—likely 2.5 to four million—have inadequate insurance or none at all.

Takeaways

- *Pharmacare* is a national approach that aims to provide access to prescription drugs to all Canadians.
- Health plan management and governance should include consideration of future risks and opportunities, including those presented by pharmacare.
- Recent developments suggest that changes to the Canadian drug insurance model are necessary to protect future access and quality.
- Pharmacare models include single payer and social insurance, and modern health systems are structured along a continuum between these two archetypes.
- Plan sponsors, advisors and insurers should investigate the potential impacts of universal pharmacare and be able to communicate their concerns, needs and goals to clients and governments.

Cost Drivers and Tipping Points

While the timing of a new national pharmacare plan is unclear, it is certain that private plan sponsors would be seriously affected. Recent announcements proposing new patented drug pricing regulations and new public drug coverage in Ontario show that governments can act quickly and sometimes without much consultation. As elections occur and new proposals appear, private payers must be prepared to offer constructive and principled advice about drug insurance. Otherwise, they may not like the decisions made by others in their absence.

Many developments suggest that changes to our current drug insurance model are necessary to protect future access and quality. After a brief respite from the so-called *patent cliff* (2011-2013), private drug plan costs are again escalating at multiples of the Consumer Price Index. Another factor is the concentration of risk in relatively small parts of the population (see the sidebar "Equity and High-Cost Claimants"). Uneven provincial coverage, especially for newer cancer drugs costing on average nearly $80,000 per course of treatment, leaves Canadians vulnerable to serious financial risk.[3] Funding orphan drugs for rare diseases presents a huge financial and ethical challenge. Other cost drivers include higher levels of chronic disease and rapid spending increases on specialty drugs, along with the failure of insurance industry pooling to protect many plan sponsors from high-cost claimants and double-digit annual cost increases.

There are other factors too, such as closing the gap between what public and private plans pay for drugs, pharmacy services and administration.[4] Will it be good or bad if more drug plans move to defined contribution models and if costs now paid by employers become voluntary benefits?[5]

There also has been a sustained and very public push by some academics to include drugs in medicare. At least two reports have used models to claim that billions of dollars could be saved annually with a single payer system, but the assumptions behind these claims would be extraordinarily difficult to achieve.[6]

These many factors require careful preparation as part of good management and governance. The ethical, financial and health outcomes of national pharmacare are complex and large, and the process is very uncertain.

Coming to Terms

My doctoral research investigates how we can achieve universal drug insurance, particularly through social in-

A Glossary of Pharmacare Models and Coverage

Single payer: Governments provide a standard plan as part of medicare. Examples: hospital and physician insurance.

Social insurance: A regulated plan to share funding between employers, plan members and governments. Examples: the Quebec drug plan and Canada Pension Plan.

Catastrophic: Governments provide full coverage once drug costs reach a particular threshold, generally a percentage of family income. Some private plans have annual dollar caps on personal costs. Examples: Provinces protect against high drug costs, but they do so at very different thresholds.

Essential drug list: A small number (e.g., 125) of common drugs are fully covered, but all others are available through public or private plans or at patient cost. There are no examples of this in Canada.

surance because there has been so little study of this model. My research participants are leaders in private and public drug plans. So far, they have made two things very clear. First, we need to define our terms. Second, we must carefully identify the problems we are trying to solve.

The most important term is *pharmacare* itself, which has changed in meaning over time. For this article, pharmacare means universal insurance, which in turn means adequate coverage of a comprehensive list of drugs that is available to everyone. A reasonable level of cost sharing would be included, with two caveats. First, out-of-pocket costs should be progressive, i.e., rise with family income, but they should be capped and should never deter access. Second, personal costs should be at a consistent (not necessarily identical) level across Canada, regardless of whether there is public or private insurance.

Once terms are defined, let's turn to defining the problem(s). That matters because the scope and severity of the problems will help scale and focus the optimal model. Do we need a completely new system, or can we improve the current shared-funding model to close gaps in coverage? The model should reflect national goals, but those have never been determined, an important flaw in any plan to improve the scope or quality of coverage.

Two Models

Either single payer or social insurance models can provide universal drug insurance. However, the scope of changes required—and therefore the feasibility of any change—varies significantly.

Single payer is the dominant model in research and is exemplified by coverage for hospitals and physicians in Canada, the new OHIP+ plan for children and young adults in Ontario and the four National Health Services in the United Kingdom. Everyone is covered, and most plans require modest cost sharing geared to utilization. Health services are funded through general taxation and perhaps other sources such as the employer health tax in Ontario, health premiums in British Columbia and drug premiums in Quebec. Costs are controlled by centralized administration, annual budgets and triaging, rationing or delaying care.

Social insurance is used to provide drug insurance in Quebec and support the Canada Pension Plan. The German and Netherlands health systems are other examples. Typically, there is a dedicated health fund with mandatory contributions, mainly by employers and plan members, and often now a top-up from general taxation. A competitive private insurance industry would be more tightly regulated to ensure it operates in the public interest. For example, no one could be declined coverage based on health status or age, there would be a minimum standard of coverage, and a national risk pool would enable insurers to equalize and stabilize coverage. Subsidies would help fund coverage for low-income or high-cost beneficiaries. Costs are controlled by government regulation, insurer negotiations with drug manufacturers and pharmacies and, as in Germany, physician incentives to improve prescribing.

Equity and High-Cost Claimants

In public drug programs, 2.1% of beneficiaries had annual drug claims of at least $10,000 and accounted for 33.5% of total public drug spending.

Similarly, one private payer reported that 0.8% of its claimants spent over $10,000 in 2016 and accounted for 29% of total drug claims.

For payers with limited resources, should everyone get the same coverage, or should those in greatest need get more help?

Sources: (i) Canadian Institute for Health Information. *Prescribed Drug Spending in Canada, 2016: A Focus on Public Drug Programs.* (ii) Express Scripts Canada. *Drug Trend Report 2016.*

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From the Bookstore

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Mark Zigler, D. Cameron Hunter, Murray Gold, Michael Mazzuca and Roberto Tomassini.

International Foundation. 2015.

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BIO

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The modern reality is that all health systems are structured and operate along a continuum between the two archetypes. Every country learns from others and adapts its model to reflect its national needs and priorities.

So Now What?

For plan sponsors—employers and unions—as well as advisors and insurers, the key is to investigate the potential impacts of a new universal pharmacare system on your drug benefit plan or on your broader business model. Consider the longer term, various scenarios and how to manage risk. Better quality health and financial outcomes will require systems thinking with explicit goals that serve everyone, regardless of where they live or work.

Plan sponsors might start by affirming the purpose and principles of their health and drug benefit plans. Many questions and choices must be weighed and decided:

1. How important is it to retain choice of plan design and provider and to operate independently to control costs or achieve other goals such as enhanced coverage or improved productivity?
2. How could a single payer public plan help or hinder those workplace considerations?
3. What is the value of emerging insurer technology to help members find lower cost, high-value pharmacies and drugs? What about insurer health promotion and disease prevention services? These options are not currently provided by governments.
4. How does reducing costs compare with other objectives? Public plans offer much better technology assessment for new drugs and potentially lower prices though pan-Canadian negotiations. Over time, a fully public plan should reduce operating and claims costs.

To support their clients, benefit advisors will need to do their own investigations and consider how and when to effectively communicate and engage their clients on these matters.

While a national drug insurance program may not be imminent, important changes have already occurred, and more are very likely in the next two to five years. Given the complexity and costs involved, this will take considerable time to assess and then develop constructive ideas for the private payer community and the governments that serve them. The time to start is now.

Endnotes

1. Canadian Life and Health Insurance Association, 2013. *CLHIA Report on Prescription Drug Policy*.
2. Council of the Federation, 2017. See www.pmprovincesterritoires.ca/en/initiatives/358-pan-canadian-pharmaceutical-alliance. The pCPA has operated since 2010, but its activities have accelerated recently after a new secretariat was established. Some private insurers and pharmacy benefit managers have only recently started to negotiate drug prices with manufacturers.
3. Bonnett, C. and A. Smofsky, 2017. Improving the Management of Cancer in the Workplace. Available at www.cancertaintyforall.ca/resources.
4. Law, M. R., J. Kratzer and I. A. Dhalla, 2014. The increasing inefficiency of private health insurance in Canada. *Canadian Medical Association Journal*, 186(12).
5. See www.mercer.ca/en/our-thinking/the-future-of-healthcare-infographic.html.
6. See, for example, Morgan et al., 2015. Estimated cost of universal public coverage of prescription drugs in Canada. *Canadian Medical Association Journal* (March). The assumptions are included in two appendices.