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Issues and Opportunities to Modernize Private Drug Plan Sustainability in an Evolving Market

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1. EXECUTIVE SUMMARY

As biopharmaceutical manufacturers launch new medicines in Canada - many being the first to meaningfully address critical or rare conditions - an increasing number of private drug plans experience claimants with higher costs. While these innovations represent improvements in the health status and labour force participation of Canadian plan members, they also present challenges for the design and sustainability of the existing private drug reimbursement infrastructure.

The private drug insurance market is approaching a crossroads. For a growing number of small, fully insured private plans, the current approach for high-cost claimants inefficiently distributes their associated costs on sponsors with these claimants. Increasingly sponsors opt to reduce employee coverage, leaving critical coverage gaps for their members and creating conditions of underinsurance. While the likelihood that smaller plans will encounter a claimant with high costs remains very low, the current model to distribute this risk is an increasing challenge for a growing number of plan sponsors, specifically in Ontario, Alberta, and the Atlantic provinces.

This research highlights the challenges and opportunities for stakeholders, including plan sponsors, benefits advisors, employees or plan members, insurers, government, and prescription drug manufacturers. It discusses options for these stakeholders to collaborate on solutions that optimize Canadians' access to innovative medicines while balancing the need for affordability and sustainability of the insurance infrastructure.

A Path Forward:

Change is needed to ensure effective distribution of risk that enables affordable and broad participation for private plan sponsors. A modified pooling approach will support fully insured sponsors with members experiencing high costs to receive the medicines their members require, while equitably and effectively sharing risks and ensuring that all sponsors can continue to offer competitive and comprehensive benefits programs to their members.

A more efficient and equitable risk-sharing approach could also provide more affordable options for medium-sized employers that purchase administrative service only (ASO) or Refund Accounted plan types with stop-loss pooling currently ineligible for the Canadian Drug Insurance Pooling Corporation (CDIPC). While our investigation focused on CDIPC-eligible fully insured plans, the pooling challenge is also felt in ASO plans that may face similar situations.

Our research explored the principles of effective risk pools through the lens of the plan member and plan sponsor rather than the insurer. Implementing change from this perspective is a critical success factor to evolving our private drug insurance model. To ensure the needs of plan sponsors and plan members are met, an effective risk pool will address the following principles:

Scale / Participative: Enlarge the size of the risk pool by increasing plan sponsor participation. A larger pool will allow variable thresholds for different employer sizes, smaller employers with lower thresholds carry less risk, larger employers with an an option to accept higher thresholds and greater risk. Consider inclusion of ASO/ Refund Accounted plan types to expand the potential pool.

Affordable: Sponsor premiums should not be directly impacted by costs associated with high-cost claimants. Consider employer size ratings for pooling thresholds.

Transparent: Publish cost reports that justify cost increases with standardized pooling premium rate guidance.

Consistent / Comprehensive: Standardized formularies and treatment criteria across all insurers participating in the pool.

Available: An effective solution will distribute chronic recurring costs to ensure common availability of coverage and seamless transferability for employees between employers and sponsors between insurers.

2. INTRODUCTION

According to the final report of the Advisory Council on the Implementation of National Pharmacare, Canada has more than 100,000 private insurance plans.[3] IMC estimates that small plans - with fewer than 50 claimants - account for more than 80 per cent of private insurance plans in the country.[4] Yet these approximately 80,000 private plans only account for 10 per cent of private insurance claimants in Canada.[4] This imbalance underscores the plan sponsors' risk: a smaller pool of claimants cannot adequately spread the risks associated with a high-cost claimant in their plan, especially in the context of the current insurance industry approach to risk distribution for both fully insured and more broadly smaller ASO plans. Currently, CDIPC is designed to manage smaller fully insured plans. However, many smaller plans (less than 250 plan members) also face difficult plan design decisions and increasing costs associated with stop loss when their members experience high costs.

Private drug insurance pooling mechanisms in Québec through the Québec Drug Insurance Pooling Corporation (QDIPC) and other provinces through CDIPC were designed to address sustainability, affordability, and risk dispersion of high-cost claimants. This report explores the concept of pooling in greater detail to consider whether CDIPC and QDIPC solutions continue to adequately address the evolving needs of the Canadian private drug reimbursement market.

Generally, small plan sponsors provide fully insured private health plans which depend on CDIPC and / or QDIPC for pooling the premium risk associated with encountering high-cost claimants. To maintain a healthy private market that continues to attract innovation, it is imperative that an affordable and viable approach to risk pooling remains available for Canadians. The need and timeline to address existing system limitations is an emerging priority given the ongoing introduction of more complex and innovative therapies. According to the National Prescription Drug Utilization Information System (NPDUIS) Meds Pipeline Monitor 2022, the trend of increasing specialty medicines anticipated to enter the Canadian market shows no signs of abating in the coming years, with increasing numbers of drugs for rare disease (DRDs), cell and gene therapies and novel oncology medicines dominating the pipeline.[5]

Considering this trend, this report discusses opportunities for stakeholders to ensure long-term sustainability and equity in the provision of private drug reimbursement to Canadians. It is intended to encourage a conversation about the limitations, advantages, enablers, and barriers associated with the implementation of potential solutions – from industry-initiated to government-mandated initiatives.

With federal solutions such as the National Strategy for Drugs for Rare Diseases still taking shape, and the introduction of National Pharmacare legislation, this research highlights the importance of mobilizing the relevant private industry stakeholders to collaborate towards achieving more immediate solutions. These solutions can preserve the important role private plans play in serving Canadians and their plan sponsors with robust and timely coverage for new medicines. Waiting for government solutions will not serve the private market well since they may not meet the needs of employer sponsored drug benefits. Instead, industry-led solutions will better secure the role of our existing private reimbursement infrastructure while modernizing the private drug insurance system to support Canadians' affordable access to innovative medicines in the years to come.

3. OBJECTIVE

This report was developed to provide information about the current private drug benefits landscape. Specifically, it illustrates the challenge and impact of high-cost claimants on the sustainability of private drug insurance for members, plan sponsors and insurers, within the context of existing pooling infrastructure. It explores private drug plan sustainability (i.e., to remain affordable and effectively distribute risk) and considers potential updates to support the more than 27 million Canadians

estimated by the Canadian Life and Health Insurance Association (CLHIA) with access to private drug plans. This report discusses opportunities for the insurance industry to ensure continued sustainability and equity in the provision of drug reimbursement to Canadians. It highlights limitations, advantages, enablers, and barriers associated with the implementation of potential solutions – from industry initiated to government mandated initiatives.

4. METHODS

PDCI completed secondary and qualitative primary research on the Canadian private payer marketplace between November 2023 and March 2024.

PDCI interviewed leading and well-recognized experts on plan pooling, plan design and risk sharing within the private insurance industry. This included discussions with insurers (payers), plan advisors (benefit consultants and insurance brokers), and plan sponsors (employers, industry associations and trusteed plans) to explore current issues, trends, and opportunities related to the private market's sustainability in the context of increasing numbers of complex medicines of high value to Canadians entering the market.

PDCI's secondary research included a review of historical literature and legislation on Canadian private plan pooling. Additional published reports on health spending trends, CDIPC spending, and benefit trends from Canadian pharmacy benefit managers and other sources were reviewed.

PDCI presented the preliminary findings of our research for feedback at three industry events:

- Benefits Canada Canadian Leadership Council on Drug Plan Partnerships May 7, 2024, Toronto, Ontario;
- IMC Private Market Policy Summit May 29, 2024, Toronto, Ontario; and
- The Benefits Breakfast Club Event: Pulling Back the Curtain: Drug Trends, Risk, Pooling and PLAs June 20, 2024, Oakville, Ontario.

Feedback from these events have been considered in the final version of this report.

5. BACKGROUND

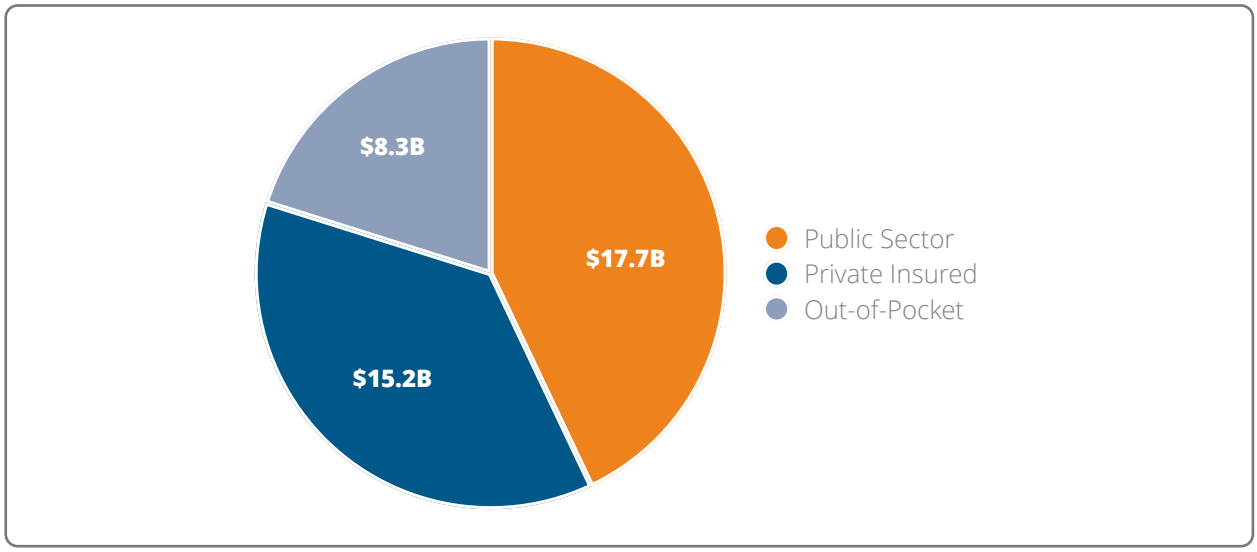
Canada's prescription drug market operates in a dual private/public system of coverage, consisting of multiple private insurance plans, cash (patient out-of-pocket) and public drug programs implemented through varied approaches across the country. This dual system is heavily influenced by the structure of provincial drug reimbursement programs.

As the delivery of healthcare services is under provincial jurisdiction, a variety of public drug programs exist across the country to meet the needs of each health system and population. British Columbia, Saskatchewan, and Manitoba operate as Pharmacare-style provinces wherein the public drug programs pay for claimants once income-based deductibles are reached. This approach generally minimizes the need for a private plan pooling mechanism. In contrast, residents in Ontario, Alberta, and the Atlantic provinces, are more dependent on private insurance for drug coverage. These provinces offer various catastrophic plans and specialized programs which provide some reprieve to the impact of high-cost claimants, but significant reimbursement gaps remain within these public programs.

Since the Act Respecting Prescription Drug Insurance was implemented in 1996 in Québec, by law all residents must be insured by either the provincial public plan (i.e., Régie de l'assurance maladie du Québec (RAMQ)) or a private insurance plan. Additionally, all plans are required to pool risks associated with the costs of pharmaceutical reimbursement through QDIPC. Québec's approach ensures all its residents have access to medicines by requiring minimum coverage consistent with the public plan's RAMQ formulary.

CDIPC, a non-profit corporation, is an industry-led pooling solution implemented in 2013 aimed at addressing the increasing risk of high-cost claimants foretold at that time. It is a pooling mechanism for fully insured plans operating outside of Québec to distribute the risk of high-cost claimants and thereby mitigate the effect a high-cost claim could have on the plan sponsor's ability to provide drug benefits. According to a 2017 analysis published by CDIPC, approximately 16 per cent of all private claims were paid through Extended Healthcare Policy Protection Plan (EP3) Pools representing fully insured plans, while Administrative Services Only (ASO) and Refund Accounted plans paid for more than 80 per cent of the private market.[6] This is particularly important for small or medium employers which would be unable to absorb the cost of an unlikely but impactful high-cost claim.

Figure 1: Prescribed Drug Spending

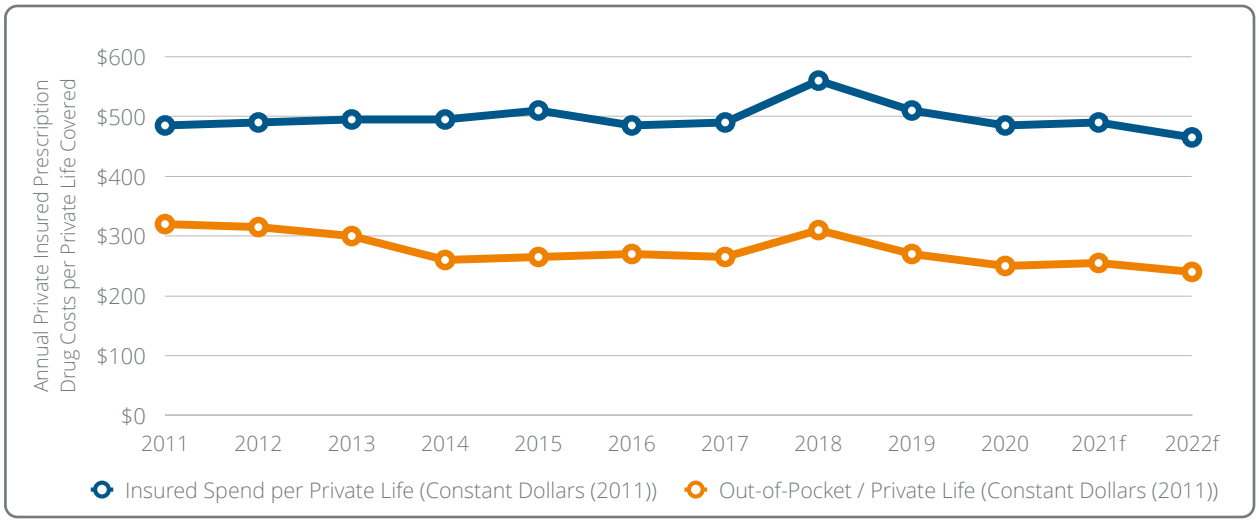


According to the Canadian Institute for Health Information (CIHI) projections (Figure 1),[7] In Canada, $41.1 billion was spent on prescription medicines in 2023. The private insurance sector paid out $15.2 billion in private insured payments. Overall, private spending remains consistent on an inflation and per life covered adjusted basis.[8]

Additionally, spending on prescription medicines as a proportion of private health expenditures remains relatively constant over time. As shown in Figure 2 on a per private life covered, inflation-adjusted basis, spending on prescription medicines has remained unchanged and even declined slightly since 2011.

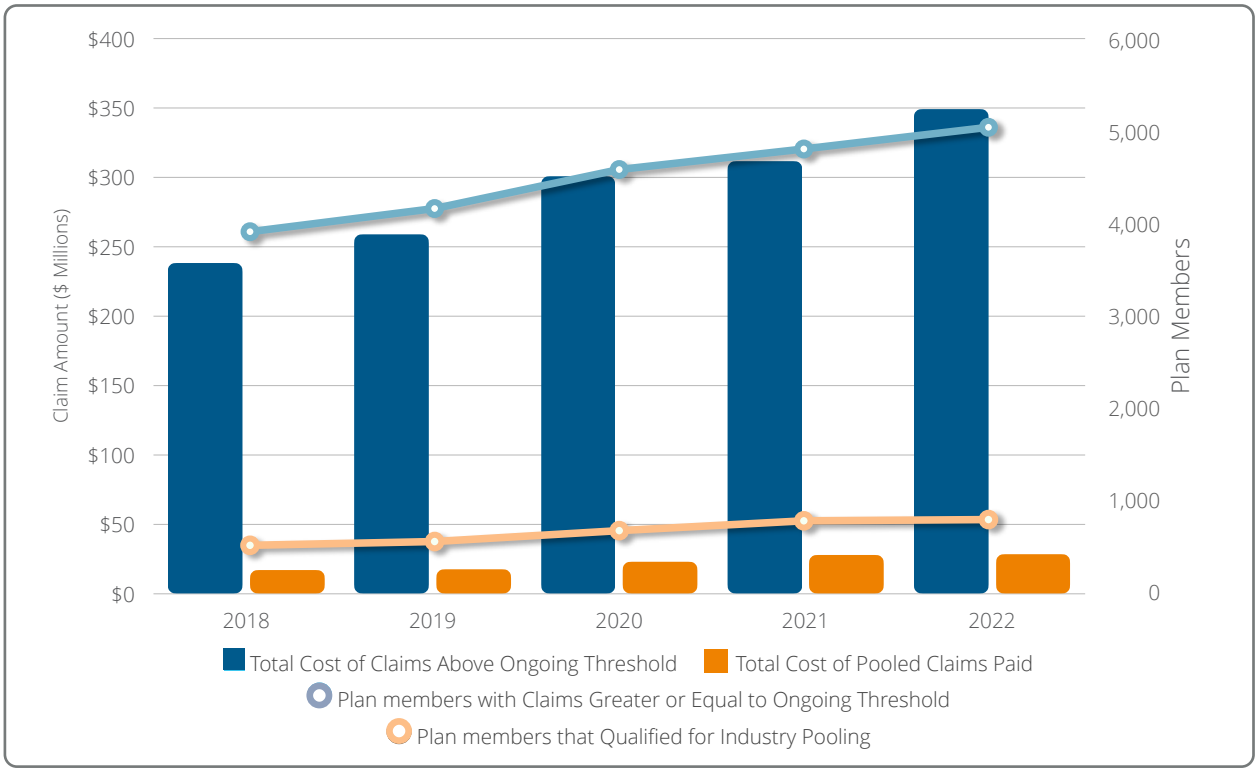
CDIPC premiums are not experience rated. According to CDIPC's latest data,[9] despite consistent overall spending, during the period from 2018 to 2022, the number and costs of high-cost claimants (>$10,000 per year) increased by 40.7 per cent (Figure 3). Of these claimants, CDIPC experienced a 24.9 per cent increase in the number of claimants with paid claims greater than or equal to the Ongoing Threshold (OT) ($32,500 per year) representing paid claims of $349.2 million. Of the paid claims above the OT, 763 claimants qualified for industry pooling with about 10 per cent ($35.5 million) of their costs paid by the CDIPC pool. The remaining 90 per cent of costs were paid by the EP3s of individual insurers. Plan sponsors are subject to their insurer's EP3 experience ratings based on the insurer's combined EP3 costs and their insurer's individual approaches to plan design and premium determinations.

Figure 2: Inflation-Adjusted Private and Out-of-Pocket Spending Remains Consistent



Source: Henricks, Paul, Health Spending Perspectives – Beneath the Surface; PDCI Market Access INSIGHTS Journal, Volume 3 Issue 2; 2023[1]

Figure 3: CDIPC Pooling Results 2018-2022



Source: Ferguson, Bryan, Can we Learn from Canadian Drug Insurance Pooling Corporation's Data on Prescription Medicine Cost Pooling? PDCI Market Access INSIGHTS Journal, Volume 4 Issue 2; 2024[2]

According to PDCI's research, when faced with rising premiums, some plan sponsors opt to redesign their plans (e.g., by introducing plan maximums which cap the annual or lifetime expenditures allowed for a claimant under a plan) to avoid incurring higher premium costs to cover potential high-cost claimants. This reduced coverage leaves plan members underinsured for high-cost claims. These claimants are offloaded to public catastrophic programs, or various financial assistance or compassionate access programs that may be offered by pharmaceutical manufacturers.

> *"We do not have a problem with the cost of drugs, we don't even have a problem with the cost of new drugs in the big picture, we have a lack of insurance problem."*
>
> **Plan Advisor**

> *"Insurance is made to handle risk. We've stepped away from insurance in most medical benefit plans. For years we've taken that insurance element out to basically a cash-flow management and education role. Now insurance is becoming important again."*
>
> **Actuarial Consultant**

Ensuring the private market remains sustainable requires careful consideration of the evolving total market needs. Recent increases in the costs and frequency of high-cost claimants and their impact on private drug plan affordability suggest an assessment of the current pooling system is now warranted. Pooling mechanisms are intended to distribute risk across a sufficiently broad group to facilitate individual affordability. As the frequency of high-cost claimants increases, current pooling approaches may present limitations or unintended consequences which require re-examination in the context of evolving market needs.

6. CURRENT APPROACHES TO HIGH-COST CLAIMANTS

The current risk pooling approach for fully insured plans with a member experiencing high costs can dramatically increase the plan's future premiums. As more innovative, specialized, high-value medicines are made available to Canadian patients, the chance of a plan sponsor encountering a high-cost claimant and a corresponding rise in premiums is increasing. To avoid increased premiums, plan sponsors may consider plan redesigns which result in critical coverage gaps for claimants with specialized medicines needs.

CURRENT PLAN DESIGNS

Many private health insurers operating throughout Canada offer plans with varying levels of coverage for Canadians. The three largest national group insurance carriers collectively manage approximately 58 per cent of all insured lives[a].

Many approaches to cost management in drug benefits are offered across Canada to optimize value and affordability of drug plans for plan sponsors. Among others, these include:

- Copayment / Coinsurance
- Generic substitution
- Prior authorization
- Annual and life-time maximums
- Biosimilar switching
- Plan Maximums
- Preferred provider networks
- Mandatory Deductibles

EXPERIENCE RATINGS

Insurers use experience ratings to calculate the cost of insurance for different people or groups. It is based on the concept that people who have similar characteristics or past experiences with insurance claims tend to have similar future risks. Experience ratings play a role in establishing the cost of private health benefits plans to small to medium sized plan sponsors who purchase fully insured, premium-based coverage.

a. *Source: PDCI Market Access, Census of Insurers*

Insurers examine a plan's claim and cost history to assign an experience rating to the plan sponsor which contributes to calculating the plan's premiums (i.e., the cost of the plan to the plan sponsor). Inherently, plan sponsors that do not experience high costs through their health benefits plans are assigned lower premiums compared to plan sponsors which do experience high costs.

While experience ratings can help to lower the cost of providing drug benefits for plans which do not experience high-cost claims, the consequence is that they impose higher premiums on plan sponsors with high-cost claims experience.

To illustrate this in non-benefit terms, consider a safe driver being insured amongst other safe drivers versus paying the premium for unsafe drivers pooled with other unsafe drivers. If you have been put into the high-risk driver category due to your experience with frequent accidents, you will understand the extreme cost burden of attaining affordable insurance. For those in this category, insurance options become limited, and many are forced to stop driving.

In the Canadian prescription drug insurance market, generally insurers experience rate sponsor claims for costs up to $10,000 per claimant. For claimant costs above this threshold, the approach is not entirely transparent.

Claimant costs over $10,000 that are not eligible for CDIPC pooling are paid by the insurer. These costs fall into the insurer's EP3 Pool and are pooled at the insurer level. The insurer determines how to distribute these costs through experience ratings based on group ratings.

For costs above the CDIPC OT and eligible for CDIPC pooling, all participants in the pool share the combined eligible costs paid by the pool. These CDIPC costs are not experience rated and are shared equally based on insurer market shares.

'Incredibly shocking': health premiums for Yukon gov't workers to increase 52.8 per cent.'

As reported by CBC News March 25, 2024, members of the Yukon Government's health benefits plan for its employees and retirees recently faced a challenging increase to the premiums paid by both the plan sponsor and its members to continue participation in the plan in light of its experience-rated post-pandemic increase in benefits utilization.

Because of experience ratings, following a high-cost claim event, a plan sponsor would typically face a significant increase in premium costs. To avoid higher premiums, sponsors and plan advisors may seek solutions to mitigate or otherwise eliminate the high-cost claimant experience by promoting a change to the benefit plan design that would make future premiums more affordable.

RISK POOLING

As claim costs for individuals rise, to share costs equitably across plan members, sponsors, and insurers require an increasing number of members to participate who are *not* experiencing these costs.

To mitigate high-cost claimant risk and distribute costs, insurers form risk pools. Pools must be of a sufficient size to effectively distribute risk in a way that ensures all participants feel they receive value for the premium paid.

"When your pool shrinks in size, then your financial experience suffers and just makes things more expensive and less effective over the years - it's a general insurance concept."

Plan Advisor

An essential component of risk sharing is participation, if 20 per cent of the population elects not to participate, the burden of risk is shared among a smaller group (i.e., the remaining 80 per cent). When the costs for an uncontrollable event are high, those not experiencing such events must share the cost amongst the remaining participants. Broad participation in pooling is a fundamental principle to developing a sustainable pool.

Experience ratings from EP3 pools are creating a situation where plan sponsors choose not to provide insurance for high-cost claimants due to high premiums, leaving the risk pool predominantly composed of plans with high-cost claimants. This is creating a cycle of increasing premiums, making it even more challenging for plans with high-cost claimants.

To promote fairness and equitable access to private prescription drug insurance in Canada, it is important to address this challenge and explore alternative approaches that consider the needs of individuals with conditions experiencing high-costs and mitigate the impact of uncontrollable factors on premium calculations.

7. ELEMENTS OF EFFECTIVE RISK POOLING

To be effective, a risk pool needs to be of sufficient size such that the impact of a rare but high-cost event can be efficiently distributed amongst participants. Those not experiencing high-cost events must believe that the cost to insure themselves against the event is reasonable based on the probability they might encounter the event. Otherwise, they will be incentivized to leave the pool.

In his 2022 whitepaper,[10] Tim Clarke, President, tc Health Consulting Inc, identified five key principles needed for a robust and comprehensive funding model. Among these, the paper identified that voluntary insurance will not result in comprehensive coverage. Conversely, this principle is reflected in Québec's mandatory participation model. All Québec residents must purchase private drug coverage that is at minimum equivalent to the provincial program or enroll in the provincial program directly.

According to Cronk et al. (2021), who explored risk pools from an agricultural grain pool perspective, risk-pooling systems are most effective when their participants adhere to several principles (See Figure 4)[11]:

1. Available: Participants agree the pool is for needs that arise unpredictably, not routine, predictable needs;
2. Affordable: Giving to those in need should not create an obligation for them to repay;
3. Comprehensive: Participants should not be expected to help others until they have taken care of their own needs;
4. Consistent: Participants should have a consensus about what constitutes need;
5. Transparent: Resources should be either naturally visible or made visible to ensure fairness;
6. Participative: Individuals should be able to decide which partners to accept; and
7. Scale: The scale of the network should be large enough to cover the scale of risks.

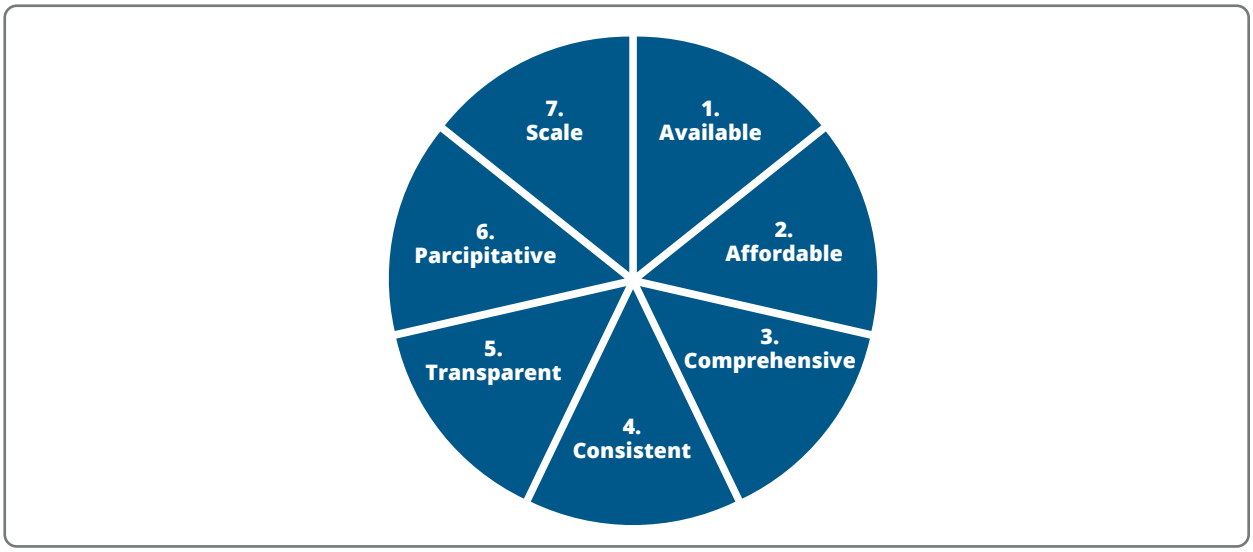
8. QDIPC – QUÉBEC'S MANDATED SOLUTION TO POOLING

The 1996 Act Respecting Prescription Drug Insurance implemented in Québec required a system to pool the risks assumed under the new plan. To meet this requirement Québec's insurers established QDIPC in 1997.

8.1. QDIPC PRINCIPLES

As part of the research, PDCI investigated elements of the Québec pooling system and compared its approach to the rest of Canada. The core QDIPC principles are summarized in Figure 5.

Figure 4: Principles of Effective Risk Pooling Systems[11]



QDIPC FEATURES FAVOURING SUSTAINABILITY

Minimum coverage means no Québec resident is without coverage for medicines covered by RAMQ.

Because coverage is mandatory, all Québec residents must have coverage from either the Québec RAMQ drug plan or a private insured plan. The private insured plan must at minimum provide an equivalent level of coverage to the Québec public plan (RAMQ Formulary). Therefore, in Québec, there is consensus on what constitutes need, and the plan is sufficient in scale to distribute risk effectively.

QDIPC recommended pooling premiums are clearly defined and outlined based on plan sponsor size.

Transparent and clear reporting allows employers to isolate premiums for high-cost claimants from the costs for other elements of their prescription drug benefits. QDIPC ensures sufficient scale by setting a minimum number of lives represented by a plan that are required to participate in QDIPC. Sponsors with less than 6,000 lives must participate in QDIPC.

A key characteristic of the QDIPC model is that pooling thresholds change by plan sponsor size. This ensures small employers are fairly treated with lower pooling thresholds based on their limited ability to assume high-cost claimant risk and larger employers with higher pooling thresholds pay a higher portion of costs based on their plan's experience.

> ***"The difference is having a solution that works for a society rather than an individual. If our goal is to have a drug coverage system that works for society, its not going to work for some individuals. The way that it doesn't work for those individuals is you'll be low risk and overpay, but the person who is high risk and high need will actually get what they want or what they need. This is what insurance is for, it's to protect people.***
>
> **Actuarial Consultant**

In contrast, this is a critical limitation of CDIPC. The typical employer size for fully insured plans represents fewer than 50 claimants and CDIPC's OT is consistent regardless of plan size. According to **IMC's 2023 Cost Drivers Report**, while small plans represent more than 83.7 per cent of plans, the percentage of private claimants in those plans is only 9.4 per cent[4]. This greatly limits the scale of CDIPC's pool.

QDIPC DRAWBACKS

QDIPC's approach is not without its drawbacks. Most notably, there are limited incentives to encourage claim management approaches to ensure high-cost claimants are properly managed and minimize the potential for waste. In Québec, insurers have limited incentive to limit or minimize costs qualifying for the pool.

Figure 5: QDIPC Principles

Pooling is Mandatory in Québec

Under the Act Respecting Drug Insurance, pooling is mandatory and applies before any other form of reinsurance, including pooling under CDIPC and private reinsurance.

Industry set up a risk-sharing (Pooling) system

All insurers and administrators of employee benefit plans are required to pool the risks inherent in the costs of pharmaceutical services and medications of Québec residents according to mutually agreed upon criteria. To fulfill this obligation, the industry set up a risk-sharing (Pooling) system, administered by QDIPC, the sole body recognised by the Québec government for this purpose.

Pooling thresholds and factors dependent on group size

QDIPC Terms and Conditions are revised annually with broad industry input establishing pooling thresholds and factors dependent on group size. Pooling factors are re-evaluated at the time of compensation, based on the actual experience of paid drug claims, to ensure full compensation of all sums involved so that no surplus or deficit is ever created.

Private plans must include the minimum coverage criteria

Individuals meeting the eligibility criteria to belong to a Group must be covered by this plan unless they hold coverage under another private plan.
All private plans must include the minimum coverage criteria provided by the Act.

LEARNINGS FROM QDIPC

For those in Pharmacare provinces (British Columbia, Manitoba, Saskatchewan), few claimants reach CDIPC thresholds as claimants experiencing high costs generally receive automatic coordination of benefits with provincial reimbursement programs.

Some of the principles supporting QDIPC provide an opportunity for consideration that may benefit sponsors dependent on CDIPC. The specific elements of QDIPC that may offer insight into the characteristics of a more effective approach for plan sponsors include:

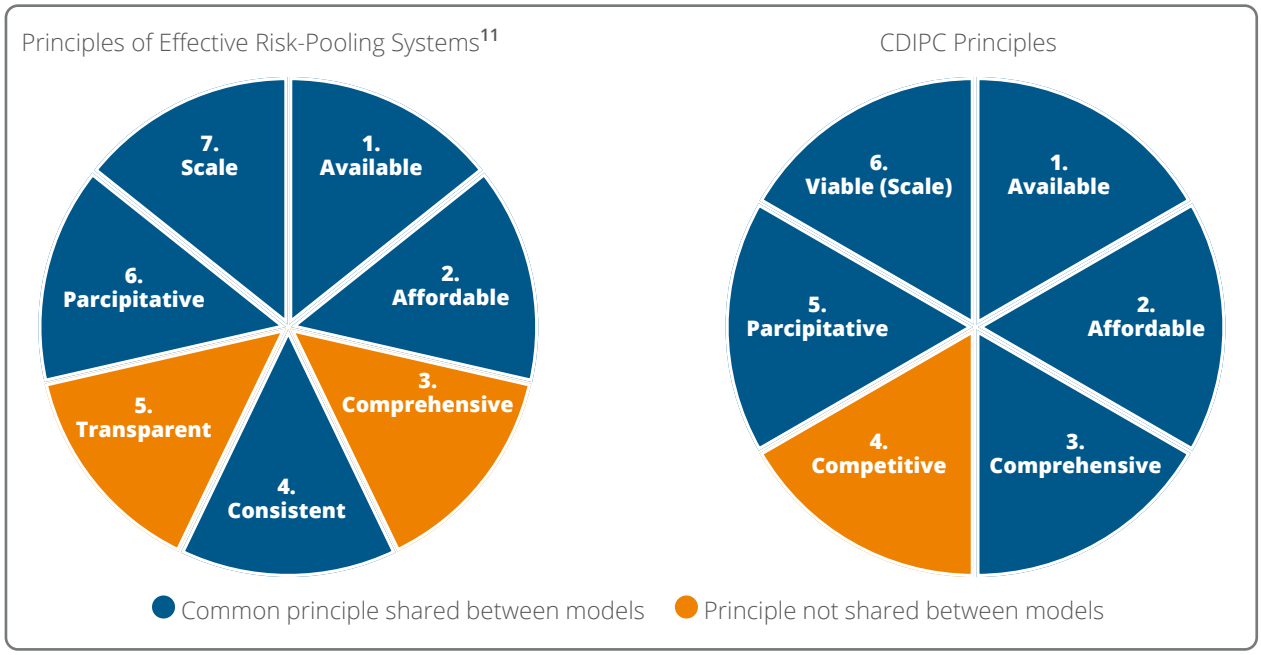
- Experience ratings do not penalize sponsors for rare and high-cost claimants;
- No waiting period or maximums;
- Mandatory coverage;
- A common minimum standard across private plans (at minimum equivalent to the provincial plan);
- Pooling premiums and pooling thresholds based on employer size; and,
- Cost transparency.

9.CDIPC – AN INDUSTRY INITIATED APPROACH TO RISK POOLING

9.1. CDIPC PRINCIPLES

CDIPC was established with the key principles described in Figure 6 which mostly align with the Cronk et al. (2021), principles.[11] Notably, comprehensive, and transparent are two principles for effective risk pooling identified by Cronk et al. (2021), that are not reflected in the CDIPC principles. Instead, within its six principles CDIPC has included competitive.

Figure 6: Principles of Effective Risk-Pooling Systems contrasted to the CDIPC Principles



9.2. ARE CDIPC RISK SHARING ELEMENTS EFFECTIVE?

1. Available: Chronic treatments for less common conditions align with unpredictable, not routine costs

Of the elements Cronk et al. (2021), identified, the first, available for unpredictable, not routine costs, is notable in that it may not align with some payer/advisor perspectives of what benefit plans are intended. Many emerging medicines are chronic or life-long medicines with increasingly high annual costs for rare or less common

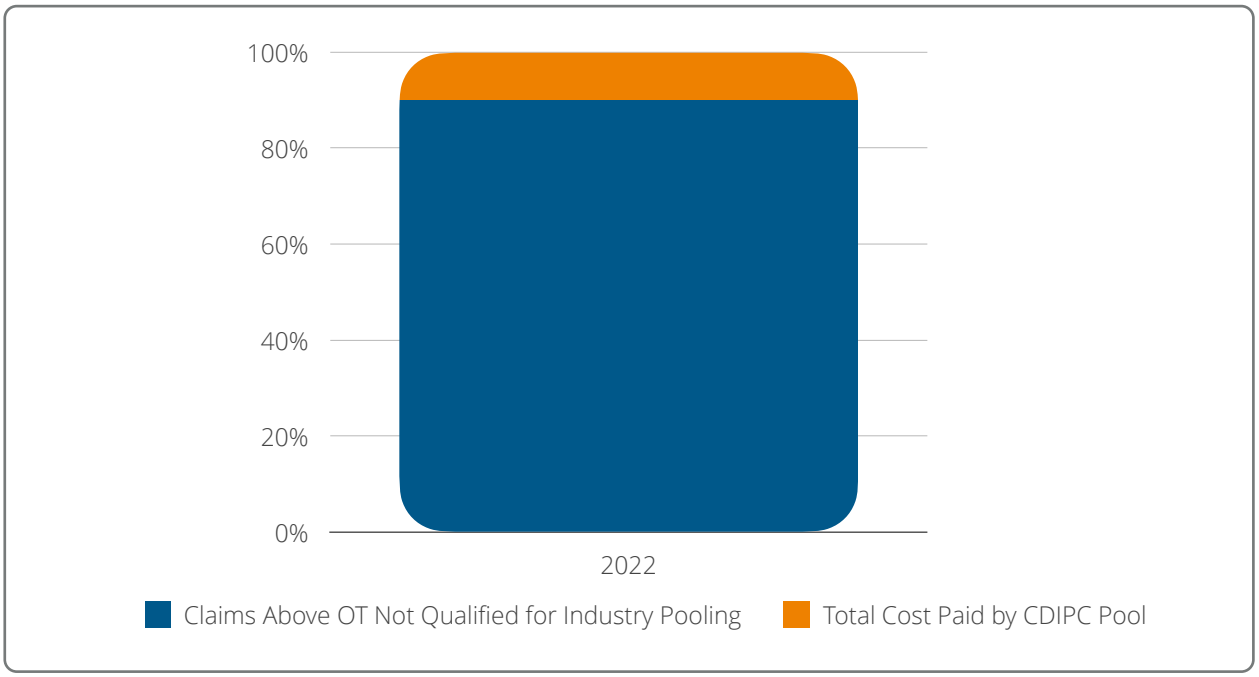
conditions. From the payer lens, chronic conditions are perceived as inconsistent with "needs that arise unpredictably, not routine predictable needs." CDIPC was not designed to manage long-term predictable high-cost claimants, but rather unpredictable, acute expenditures. This does not mean that CDIPC cannot adjust its application of this principle in the context of the evolving patient needs for advanced therapies. Instead, new policy should consider predictability from the perspective that an individual being diagnosed with a rare disorder or condition requiring high-cost medicines is unpredictable and therefore not routine. This perspective is aligned with QDIPC which covers all eligible costs above the threshold ensuring protection for smaller employers from recurring costs.

2. Affordable: Experience based premiums represent an obligation to repay

Under the second principle, affordable "no obligation to repay" may be interpreted to relate to experience rated premiums and future premiums for those that experience need. The obligation to pay a higher premium due to high-cost claimant experiences is not directly related to CDIPC. CDIPC is clear that its costs are not experience based. So participating plans pay the same premium per life regardless of experience.

Where this principle breaks down is for costs below the CDIPC OT and costs that are above the OT but not qualified for CDIPC. These costs fall within an insurer's EP3 Pool and are experience rated by the insurer. With a limited insurer pool, these costs rise quickly due to a limited group of plans experiencing high costs. As discussed earlier, just 10 per cent of the total costs of high-cost claimants were paid by CDIPC and the remaining 90 per cent falls under the insurers' EP3 experience rated pools (Figure 7). Therefore, the current pooling structure does not meet the needs of plan sponsors facing increasing premiums. Ensuring plan premiums for costs above specific thresholds are effectively distributed across all plans regardless of experience will reduce plan premium volatility due to high-cost experience.

Figure 7: Claims Paid by CDIPC Above the Ongoing Threshold[9]



3. Comprehensive: Benefit plans must offer comprehensive and equitable benefits

The third principle, comprehensive, suggests the plan design needs to reflect the needs of all employees. Employees seek comprehensive benefit plans to cover their medicine needs when, and if, costs arise regardless of if the costs are recurrent or unexpected. When an employer's plan covers only select high-cost medicines, it can create inequity among employees, particularly those who require medicines not covered by the plan's formulary. An employee can not be expected to contribute to a plan if it does not address their needs. Unequal access to necessary treatments can disproportionately affect individuals with certain medical conditions or rare diseases.

By not covering all high-cost medicines, the employer's plan may inadvertently discriminate against employees who rely on the excluded medications for their health and well-being. This can lead to adverse consequences, such as employee turnover, reduced productivity, increased health complications, and potential discrimination claims.

To ensure employment equity, it is important for employers to carefully evaluate and consider the coverage of high-cost medicines in their prescription drug plans. Employers should strive to provide comprehensive coverage that considers the diverse medical needs of their employees. This can help promote a fair and inclusive workplace environment where all employees have access to the medications they require, regardless of the cost or rarity of their treatments.

4. Consistent: Standardized formularies and treatment criteria provide consensus of what constitutes need

The fourth principle, consistent or "consensus about what constitutes need" is also somewhat in conflict with the current market. In essence, consensus is formed through the adoption of prior authorization criteria where the insurer agrees to pay for patients meeting certain criteria.

> ***"The fact they pulled together all the companies to agree to something when they are so diverse. How you put them in the same pool and expect them to share equally is very difficult."***
>
> **Plan Advisor**

This may conflict with individual needs that don't meet the specified criteria set by their insurer, or when the insurer has not set criteria or agreed to pay for a specific medicine. Importantly, in the current market, the "consensus" (i.e., prior authorization criteria), may be inconsistent between insurers participating in the CDIPC pool. This inconsistency in criteria across insurers may result in some insurers contributing more claims to the industry pool than insurers with more strict criteria for the same drug. The current approach to establishing what constitutes need is implemented inconsistently between payers resulting in coverage gaps and reduced transferability for patients. The inconsistency of criteria across insurers represents a stressor for the system as sponsors may grow frustrated when they face pooling charges for the pooled claims of high-cost medicines that are not covered in the same way under their own plan. The criteria should be consistent across the entire industry for a particular medication. Typically, a drug that has a prior authorization process (PAP) with one insurer will have PAP across many.

QDIPC has taken an alternate approach to meeting this principle by establishing the minimum requirement that private insurers must offer all drugs listed on the provincial RAMQ formulary. An insurer can offer more options or flexibility than the minimum required, but not less.

5. Transparent: Current CDIPC reporting is not sufficient to provide confidence pooling costs are distributed fairly

The fifth principle relates to transparency. Perhaps one of the most consistent comments received from plan

advisors was that the method of calculating plan premiums associated with pooling costs are neither clear nor transparent. Following high-cost claimant experience, sponsors are not able to determine how their premiums are generated and are only aware that their premiums increase substantially. Transparency in the calculations of pooling charges helps protect plan sponsors from additional costs, provides greater cost predictability, enhances sponsor freedom to move between insurance providers and encourages competition in the market.

> ***"There is a big black box called CDIPC. I see that of the health premium dollar a percentage is going to CDIPC or pooling but do not see any CDIPC calculations, references, or explanations."***
>
> **Plan Advisor**

Furthermore, the concept of transparency may be inconsistently applied due to the recent introduction of confidential rebates to insurers through confidential manufacturer product listing agreements (PLAs). It is unclear how and if rebates received from a manufacturer are reflected in claims pooled to CDIPC. Given that PLAs are a cost-containment tool employed by private insurance in recent years, it is almost certain manufacturer PLAs were not contemplated when CDIPC was first established.

6. Participative: Free to decide which partners to accept.
The sixth principle, participative, is best illustrated by considering the example of flood insurance. Those living on a floodplain are likely to be grouped with other floodplain residents. It is unlikely that those living in an area without risk of flooding would want to accept floodplain-residents in their risk pool. If flood insurance premiums are high and a resident doesn't live in a high-risk floodplain their decision to abstain from this coverage is easier. Each time a low-risk participant chooses to opt-out of this coverage the pool becomes more centralized on those at greater risk, making the costs of insuring against that risk relatively higher per participant.

> ***"Optionality gives individuals choice to participate but it affects the aggregate."***
>
> **Actuarial Consultant**

In the current context, this principle leads to sponsors electing not to participate in pooling ("we don't need to cover those drugs"). While participation in CDIPC is mandatory for smaller fully insured plans, sponsors which elect to not be fully insured or which implement designs with maximums below the OT do not participate. In essence, sponsors setting maximums below the OT elect not to accept those that wish to pay for potential high-cost claimants as "partners". As participation declines through the implementation of plan maximums and other risk mitigation tools, the base for risk distribution declines.

> ***Key finding: Québec requires that employers with up to 6,000 members must participate in QDIPC. Resulting in fewer ASO plans, limited plan maximums and more fully insured plans. This broadens the pool and spreads the risk across a larger number of participants.***

7. Scale: Must be large enough to cover the scale of risks.
The largest portion of the Canadian private insured population and the majority of plan sponsors are within Ontario, Alberta and the Atlantic provinces. With adequate participation, the potential patient pool is more than sufficient to cover the scale of risks associated with high-cost claimants. However, smaller plans that rely on CDIPC only represent approximately 20 per cent,[4] of private insured lives and individually are less likely to encounter high-cost claimants. With the current pooling approach, fully insured plans with high-cost claimants face high premium increases due to combined CDIPC and EP3 pooling charges distributed across a small pool of lives insufficient to cover the scale of risks.

Maximizing the size of the pool is a basic tenet of insurance that protects plan sponsors and consumers from unpredictable risk of high-cost claimants. CDIPC's design allows insurers to avoid the risk associated with high-cost claimants through plan redesign; but reduces participation in the pool, and in turn, compounds the issue for plans that continue to participate in the smaller pool.

9.3. CDIPC LIMITATIONS

CDIPC's website acknowledges it is "not a perfect solution".[12] Since CDIPC's establishment in 2013, the market has evolved such that its approach to distributing risk among the rising numbers of high-cost claimants no longer adequately addresses rising plan sponsor needs for coverage of claimants experiencing high-costs. In contrast, the impact of these same claimants appears more sustainable in Québec and the Pharmacare provinces, despite substantial differences in their approaches to supplemental public reimbursement between these regions.

> ***"The whole idea that coverage was transferable. If you have a high-cost claim that you are going to be able to move from company (insurer) to company (insurer) is 100 per cent wrong. Everybody will decline it, that's their right because they don't want it in their EP3 pool, they don't care about the CDIPC pool."***
>
> **Plan Advisor**

TRANSFERABLE – HIGH-COST EXPERIENCE AND PLAN MOBILITY

Over the course of our research, an important finding emerged. While the CDIPC pool is not experience rated, the costs not paid by the CDIPC pool, (i.e., the EP3 costs) for plan sponsors, are experience rated at the insurer level. While not specific to the plan itself, ratings may be grouped based on similar plan designs, for example, plans experiencing high costs.

Our research found that to move plans or insurance carriers when a plan sponsor has high-cost claimant experience is increasingly difficult. The most common approach today for plan advisors is to "go back to the drawing board" on the benefits plan design. Advisors will often requote the business with adjustments to the plan and provide a way out of the high-cost claimant; usually by ensuring the claimant secures reimbursement through other sources of reimbursement (for example the Trillium Program in Ontario).

> ***Key Finding: CDIPC was designed to protect insurers from risk. From this perspective, the system is meeting its goals of distributing the costs from high-cost claimants across the insurance industry. CDIPC was not designed to protect individual plan sponsors and consumers from the costs of high-cost claimants***

The lack of transferability is especially pronounced in Ontario, Alberta, and the Atlantic provinces. Whereas Québec pooling through QDIPC pools all costs above thresholds and experience rating is based on the provincial experience and is set by QDIPC. In contrast, Pharmacare provinces take on costs above income thresholds, which typically fall below CDIPC and EP3 thresholds, unless the province does not reimburse the claimant's costs. It is important to note that in the Pharmacare provinces many private drug plans now follow the provincial formulary to avoid these costs. This trend will erode a key value proposition of the private market of providing more generous coverage with more treatment options.

AFFORDABLE – INCREASING PREMIUMS FOR THOSE PARTICIPATING

According to our research, rising premiums due to pooling charges are increasingly cited by plan sponsors and

advisors when plan design reviews are completed. Many are looking to new methods to limit exposure to rising premiums through the introduction of restrictive plan designs including plan maximums below CDIPC thresholds.

PARTICIPATIVE – PLAN MAXIMUMS LEAD TO REDUCED PARTICIPATION

Reducing participation threatens the sustainability of fully insured private drug plans. Options such as lifetime drug spend caps have been constructed that allow advisors to guide sponsors away from the CDIPC and EP3 liability. This leads to reduced participation and increased risk borne by those experiencing high-cost claimants. According to our research there is a growing trend towards introducing plan maximums to reduce premium costs for plan sponsors.

> ***"Once people get to the brink of the cliff, they'll come up with a solution more quickly to ensure its sustainable because nobody wants these things to fall apart."***
>
> **Actuary**

VIABLE – SOLUTIONS NEEDED TO ENSURE VIABILITY AND MEET EVOLVING MARKET NEED

The compromises made by the insurance industry that contributed to the design and introduction of CDIPC in 2013 were a significant achievement. The industry's collaboration and ability to independently design a solution that improved the sustainability of the private drug insurers at the time was substantial and serves as a model for any future modernizations of the system.

However, 12 years after its creation, these compromises are not keeping pace with the innovation seen in the prescription medicine market. The industry providing private drug benefits, must also innovate to meet the needs of patientsthe needs of patients seeking reimbursement for disease treatments that were unimaginable when CDIPC was first conceived.

In summary, a reevaluation of the CDIPC principles from a consumer and plan sponsor perspective is needed to support the evolving needs of patients and the private insurance market today. Deferring to public solutions is unlikely to satisfy many Canadians currently benefiting from private sources of reimbursement. Solutions that continue to support a healthy and adaptable private market are critical for continued sustained access to highly innovative medicines.

10. THE WAY FORWARD

In the last decade, we have witnessed a substantial evolution in the pipeline of new and highly innovative medicines offering high-value improvements to patients and plan sponsors. While evaluating existing pooling mechanisms, it became clear there are opportunities to identify solutions that ensure the sustainability of a robust private insurance market, equity of access to highly innovative medicines across private drug plans, and the effective distribution of the risk associated with high-cost claimants across plan sponsors and consumers.

Any path forward must reflect on key barriers to change including:

- **Insurer willingness to innovate**

  A significant barrier appears to be insurer resistance to change. Insurers, that may benefit from a larger book of business and associated risk pool, can optimize plan designs and fee schedules to effectively avoid risk from high-cost claimants and may be less likely to collaborate across the industry. A comprehensive risk sharing approach may reduce flexibility for insurers to create plans excluding high-cost claimants to reduce sponsor costs. From industry discussions it seems insurers may prefer to wait for government mandated approaches to impose solutions on them.

- **Sponsor willingness to cover high cost claimants and incorporate risk into plan design premiums**

  Improved risk-sharing approaches need to consider potential sponsor resistance to change. The impact on premiums must be affordable and consistent with the value of risk being assumed by the sponsor.

There are several approaches to address the evolving private market needs associated with high-cost claimants. In practical terms, the solutions require multiple stakeholders across the health system to develop a collaborative and sustainable solution. A solution may be a hybrid of the following potential approaches – or a completely new model.

NATIONAL PHARMACARE

A national single payer pharmacare program is touted by some policymakers and stakeholders as a solution to address private drug plan sustainability and the budget risks highlighted in this paper. The proposed solution: eliminate private drug plans and replace them with one publicly-funded pharmacare program. In our current public/private system, provincial governments provide solutions for those with higher prescription medicine needs and limited ability to pay. On the private side, many employers offer private extended health benefit plans to provide employees with tax-deductible health benefits, to remain competitive in the labour market, and to mobilize a healthy and productive workforce.

The solutions embedded provincially, combined with private insurance and existing federal programs, create an environment where few Canadians experience gaps in coverage. In many cases, these gaps are due to income-based deductibles and copayments in public plans that compete for patients' often scarce disposable income when faced with high medical burden.

The current proposed implementation of National Pharmacare takes on a very small segment of prescription medicines, carving out a limited set of diabetes medicines and contraceptive products. Several provinces have indicated they will opt out of the proposed federal solution signaling that as proposed, it does not meet the prescription drug coverage needs of Canadians.

At this stage in the political and legislative processes, it remains unlikely that a comprehensive national pharmacare strategy aimed at rectifying the issues we have described here could reasonably be implemented in the foreseeable future. Further, implementing a public funded system is unlikely to improve access and more likely any public solution will not be comprehensive and continue to rely on private supplemental benefits[b]. Other more immediate and viable solutions to address the issues presented in this research are required. Implementing a broader privately supported risk management approach would reinforce the sustainability and value of the private market and demonstrate that insurers can innovate to meet the evolving needs of Canadians.

> ***"One of the risks when we start talking about national pharmacare in general is if the government does something that is too good, employers can back out of their responsibility. So, you have to make sure that everybody accepts what their role is and stays in their lane."***
>
> **Actuarial Consultant**

PAN-CANADIAN ALIGNED APPROACH (ON, AB & ATLANTIC)

Within Ontario, Alberta and Atlantic provinces, an independent solution can be formulated for the largest portion of Canada with the greatest unmet need.

The advantage of implementing a solution for these six most impacted provinces is that they already operate public drug plans with similar basic structures. While differences are notable, a combined solution for claimants experiencing high costs could provide similar benefits and costs to all the provinces in this group. The combined group would represent a sufficient size for pooling. Leveraging Ontario's broad population and including smaller provinces such as Prince Edward Island would distribute risk more equitably for all participants.

b. **National Pharmacare announcement.** *It is notable in Health Canada's February 2024 announcement for universal access to diabetes medications that Glucagon-like peptide-1 (GLP-1) analogues were excluded from the program.*

FEDERALLY LEGISLATED APPROACH – DRUGS FOR RARE DISEASES STRATEGY

As part of the National Strategy for Drugs for Rare Diseases **announced** in March 2023, the Government of Canada established an Implementation Advisory Group to form the national governance structure of the strategy to help improve consistent access and affordability of effective DRDs across the country. The group provides recommendations to Health Canada and facilitates stakeholder feedback towards implementation of the strategy and will be operational through 2026.

As details of how the federal and provincial governments will introduce DRD funding formulas unfold. It remains unclear how this initiative will impact private coverage.

A solution at the national level needs to be overlaid with existing provincial private and public structures. In July 2024, British Columbia was the first province to sign a three-year bilateral agreement with the federal government securing funding for a select list of DRDs under the National Strategy for Drugs for Rare Diseases. British Columbia's DRD program and provincial pharmacare structure facilitated this bilateral agreement. Implementing similar agreements across Canada and in particular in Ontario and the Atlantic provinces will involve additional barriers and complexity.

Given, the need for change and the uncertainties with respect to public sector initiatives, private insurance stakeholders should not delay exploring industry-led solutions in the hopes that government solutions will address private drug plan issues.

CONSUMER AND INSURANCE INDUSTRY DRIVEN SOLUTIONS

Markets have a tremendous ability to rapidly influence change. The pandemic demonstrated the health industry's ability to innovate, launch and transform itself.

- A mandatory federal approach seems unlikely, as does a pan-Canadian approach. Provinces will continue to retain responsibility to administer provincial health care and a federal approach needs to recognize their role when setting a provincially manageable standard.
- Industry led improvements through self-regulation to better reflect consumer needs and core pooling principles could make strides towards improved risk sharing and participation.
- A combined provincial policy from Ontario, Alberta and the Atlantic provinces could establish a minimum coverage standard.
- While the DRD strategy may address some equity issues, it remains unclear the quality and timeliness of coverage which would be offered.

11. CONCLUSIONS AND RECOMMENDATIONS

Evolution of high-cost claimant pooling strategies is needed to address sustainability risks for the private insurance market. By collaborating with IMC and innovative medicine manufacturers, private healthcare stakeholders can develop a new approach to pooling to ensure the long-term sustainability of private benefit plans and equitable, affordable coverage of high-cost claimants.

Change is needed to ensure effective distribution of risk that enables broader participation from private plan sponsors. A modified pooling approach, that reflects the principles from a consumer and sponsor lens, will support fully insured sponsors with members experiencing high costs to receive medicines their members need, while equitably and effectively sharing risks and ensuring all sponsors continue to offer competitive and comprehensive benefits programs to their members.

While our research focused on CDIPC eligible fully insured plans, a more efficient and equitable risk-sharing approach could also provide more affordable options for small to medium sponsors that currently rely on non-CDIPC eligible ASO or Refund Accounted plan types with stop-loss pooling.

ELEMENTS OF AN EFFECTIVE RISK SHARING POOL FOR CANADIANS

Following the principles of an effective risk pool through the lens of the patient and consumer – not the insurer - will be a critical success factor. Consumers (i.e., plan members) of extended health benefit plans seek choice, flexibility and barrier-free access to innovation that supports their medical needs when required. Plan sponsors seek to minimize costs and maximize profit balancing their investment in benefits against their ability to attract and retain the best talent for their business. To ensure both needs are met, an effective risk pool will ensure the following:

Scale / Participative: Implement employer size thresholds or other mechanisms to ensure the pool is sufficient in size to effectively distribute high-cost claimant risk. Enhance plan sponsor participation through innovative incentives to encourage participation. Consider inclusion of ASO / Refund Accounted plan types to expand the potential pool.

Affordable: Sponsor Premiums should not be impacted by utilization. Eliminate experience rating of EP3 paid costs. Consider employer size ratings for pooling thresholds (similar to Québec model).

Transparent: Publish combined cost reports that justify premiums and cost increases; standardization of rates.

Consistent / Comprehensive: Standardized formularies and treatment criteria.

Available: An effective solution will distribute chronic recurring costs to ensure common availability of coverage and seamless transferability for employees between employers and sponsors between insurers.

It is recommended that all stakeholders including consumers, plan sponsors, plan advisors, manufacturers and insurers work collaboratively to develop a new framework for managing high-cost claimants. Introducing fundamental change to pooling will be challenging. IMC and its members will support collaborative conversations to build solutions to serve patients, plan members, plan sponsors, and the insurance industry.

PDCI welcomes dialogue with all stakeholders to support improvements to the drug benefit plan pooling infrastructure to ensure the continued value and long-term sustainability of our private drug insurance industry in Canada. A failure to innovate in the face of important and evolving market circumstances will undermine the ability of private insurance to provide meaningful value to Canadians through robust access to the highly specialized medicines of tomorrow.

BIOS

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With 30 years of industry experience in market access and strategic planning Paul's cross-functional expertise is foundational to his client advice and to the innovative reimbursement solutions he leads across private and public drug markets. Paul was instrumental in the development and launch of PDCI's Market Access Toolkit, a suite of services supporting market access strategies for the biopharmaceutical industry.

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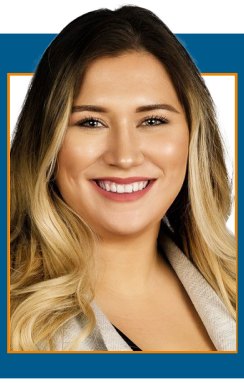

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Laura guides PDCI clients through optimization of their Canadian market access strategies. She leads cross-functional projects including market access assessments, payer advisory boards, and net pricing analyses to prepare for payer negotiations. She also provides strategic expertise on regulated pricing, market forecasting, and product launch planning.

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13. GLOSSARY OF TERMS

Administrative Services Only (ASO) – usually larger plans that use insurers to administer their prescription claims and other benefits for a fee.

Advisor – is a consultant or insurance broker engaged by a plan sponsor to provide expert advice in the selection, ongoing management, and renewal of a contract/agreement with a private payer. They are compensated on a fee for service or commission basis.

Broker – is a licensed advisor usually compensated through commissions paid by the private payer for their services.

CDIPC – Canadian Drug Insurance Pooling Corporation

Consultant – is a licensed advisor usually compensated on a fee for service basis by the plan sponsor.

DRD – Drug for Rare Disease

EP3 – Extended Healthcare Policy Protection Plan

Fully Insured - A traditional type of insurance option sponsored by an employer. The employer pays premiums to the insurance company, with fixed annual amounts based on how many employees are enrolled in the health plan.

IMC – Innovative Medicines Canada

Ongoing Threshold – the threshold amount set by CDIPC above which claimant costs incurred above the threshold become eligible for CDIPC pooling up to a maximum amount.

Plan Member – individual who is enrolled and eligible for reimbursement under an employer, association, or trusteed plan. This can include the primary individual enrolled under the plan, their spouse, and dependent children.

Plan Sponsor – an employer, association or trusteed plan who has entered into a contract/agreement with a private payer to adjudicate claims for a list of services and products based on specific eligibility criterion.

Private Healthcare Stakeholders – is a collective term for advisors, brokers, consultants, private payers, and plan sponsors.

Private Payer – An insurance company or other third-party payer that has a contract/agreement with a plan sponsor for adjudicating claims for a list of services and products based on a specific eligibility criterion.

QDIPC – Québec Drug Insurance Pooling Corporation

Refund Accounted Plans – A plan type where if at the end of the policy year, premiums exceed costs, the surplus can be applied to increase reserves or refunded to the plan sponsor. If costs exceed premiums, the deficit is collected through a premium increase.

Stop-Loss Pooling – also known as large claim pooling, is purchased by ASO and Refund Accounted plans to protect sponsors from catastrophic or high-cost claimants.