Drug Plan Reform in Canada—
The New Rules and the Renewed Reaction

In an effort to control the soaring cost of prescription drugs, provinces have initiated reforms in medication pricing and drug plans. In some cases reform has caused a shift in costs to private sector plans, creating a two-tiered pricing system. This article provides a perspective on ongoing reform efforts and touches on opportunities plan sponsors and designers might consider to make plans more efficient and sustainable.

by Marc Kealey
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Canada contributes to the world significantly in terms of politics, comedians, natural resource management, innovation in health system design and, of course, the game of hockey. A G-20 nation, Canada often compares itself to and competes with its closest neighbor and trading partner, the United States.

However, when it comes to prescription drugs and their prices, Canada as a nation is compared to countries like Sweden—a bitter pill to swallow for Canadians, who represent 2% of the world’s population.

This article outlines the rationale behind and the reactions to prescription medication and drug plan reform currently underway in Canada. It also provides a brief historical perspective on the reform environment and offers insights into opportunities for plan sponsors, designers and plan members to maximize reform outcomes.

A Perspective

Pricing for prescription medication in Canada is different from U.S. pricing.

The Canadian constitution gives provinces the power to create their own laws and regulations to manage and govern their health care systems, including prescription drug benefits. Each province has its own formulary and drug benefit plan and has regulatory colleges that govern the activities of health care providers like physicians, nurses and pharmacists.

The sum total of all provincial drug benefit programs is about $12 billion (Can$) per year.

In Canada, medications—both prescription and over the counter, and specifically those approved for human consumption—are granted approval through Health Canada. Any pharmaceutical manufacturer wishing to “launch” a
medication in Canada undergoes a rigorous approvals process. Patent laws govern the allowable time that a branded medication (like Lipitor™) can be sold without competition—about 20 years. After the patent term expires, the law provides that generic manufacturers—those approved to manufacture a copy of the branded molecule—can produce and sell their version of the branded medication at a reduced price. Generic versions of any branded medication are approved and dispensed to patients through licensed pharmacies at a significantly lower price than that of the branded medication.

In the current environment of economic challenges, provincial drug benefit programs have little choice but to make changes to improve the financial position of their plans. The cost of drug programs is rising, and the public has little appreciation of those increases. Provincial drug benefit plans across Canada are making tough decisions. Generic drug prices, which seem unnecessarily high and are fueled by what are known as promotional allowances or rebates for retail pharmacies, are the targets of the reform. As frustrated private sector plan sponsors and designers experience similar rising costs, they also are undertaking this same assertive reform. Of course, this reform has created its own sense of frustration among pharmacy owners.

Canada spends about $25 billion (Can$) a year on prescription medicines. The split between public sector drug benefit plans (such as the Ontario Public Drug Program) and the private sector is about 45% public sector and 55% private sector. It should be noted that rising costs in drug plans have largely accrued from increased drug utilization—for instance, more patients needing medications for chronic illnesses—and actual increases in the cost of medications. In the last ten years, provincial drug benefit programs have witnessed annual increases of anywhere from 8% to 15%. Private sector drug plan sponsors have listed similar annual cost increases.

These issues are not endemic solely to the current economic climate; increases have been commonplace year over year for quite some time. While there appears to be no magic bullet for the future, with some innovative thinking, ingenuity and courage, they can be mitigated and managed.

A Historical Perspective

In the late 1960s, Canada's federal government limited patent terms on brand medications and allowed for greater manufacture of generic medicines in Canada. Those broad-reaching legislative initiatives opened the door to realized savings for drug benefit plans as they allowed patented medicines to be copied by generic manufacturers when patents expired.

This legislation did not, by any stretch, threaten the existence of brand manufacturer in Canada. The brand pharmaceutical sector remains a vibrant part of Canada’s socio-economic fabric, providing clinical research for new therapies, clinical programs and education opportunities for patient groups, hospitals and medical providers including physicians, nurses, pharmacists and others. In fact, the 1990s and the early 2000s were good years for brand manufacturers with blockbuster medications to manage high cholesterol, hypertension, diabetes, mental health, sexual health issues and cardiovascular disease. Brand-named drugs were listed on formularies across the country.

Clinical research among brand manufacturers continues today for the next disease management tool, such as biologics, a new class of medications that is made from living organisms. Biologics are used to combat cancer, rare diseases and genetic disorders where no other treatment is available.

The patent legislation of the late ‘60s spawned a robust and vibrant generic manufacturing sector that continues to grow in Canada. Generic manufactured medicines account for over 50% of all medicines dispensed in plans across Canada. The legislation giving generic manufacturers the right to copy the active ingredient in a previously branded medicine and sell to patients through a pharmacy has meant savings in drug plans. Generic medicines cost less because manufacturers do not incur the cost of drug discovery; that effort has already been done by brand manufacturers. Similarly, generic manufacturers do not have to incur the cost of what is commonly known in pharmaceutical industry parlance as safety and efficacy because brand manufacturers have already done these studies. In the last five years, the patents on a number of blockbuster medicines—brand names sold at higher prices in pharmacies to patients—have expired. Generic versions of medicines such as Altace™, Biaxin™, Zyprexa™, Pantaloc™, Pariet™, Actos™, Pravachol™ and Vasotec™ are now for sale at a lower price. In the next three to five years it is expected that more branded medicines will hit the patent expiration cliff.

Prices for brand medicines, set in Canada by a panel known as the Patented Medicines Price Review Board (PMBRB), were about 30% to 40% higher than prices for their generic versions.

At the same time the movement from brand name to generic versions of drugs was taking place, community pharmacy, as a sector, began to consolidate. Throughout the 1970s and 1980s Canada witnessed the firm establishment of chains or banners or buying groups intended to ensure cost-effectiveness and profitability for the retail sector. As a consequence, there appear to be few real independent, community-based retail pharmacies in Canada. The retail community pharmacy universe, therefore, has become a significant force as a distribution channel.

This movement in pharmacy seems to have spawned a philosophical difference of opinion between pharmacy as retailer and pharmacist as health professional. The retail pharmacy, by virtue of its ubiquity and strength, appears to have emerged as the more powerful entity in this reform world.

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 Competition for shelf space in community retail pharmacy prescription medicine is fierce. Generic medicine manufacturers used to compete against each other for pharmacy’s business through programs aimed at pharmacists and small-ticket items like handheld information technology devices. Now, they compete solely through cash rebates or free goods to the community pharmacy or chain head offices, which make the buying decisions and allow a manufacturer’s medicine to be dispensed at a local pharmacy or through a matrix established by the pharmacy chain. This scheme produced the unintended consequence of making generic drug prices, although still cheaper than brand medicines, more expensive in Canada than in comparator countries. It’s widely noted that Canadians pay the highest drug prices for generic medications. Here’s why: Historically, as retail purchases of generic medications grew, so did the “allowances” to pharmacies from manufacturers to have pharmacies stock a particular manufacturer’s products. The prices that pharmacies charged to public and private plans did not take into account the rebates or allowances the retail pharmacy received from manufacturers. This practice inflated the price or the actual cost of the ingredient (not the fee) paid by the consumer and third parties.

Public sector drug plans recognized that rebates or allowances to retail pharmacies ranged from 40% to 80% of the invoice price of medications. The provinces of Ontario and Quebec, convinced that this practice was having an impact on their plans, introduced legislation to curb the practice. In 2006, Quebec passed Bill 130, the Act Respecting Prescription Drug Insurance. The act introduced various cost-containment provisions, including establishing a set price for generic drugs (54% of the brand), and strived to limit allowances paid by manufacturers to retail pharmacy. The act did not affect private sector plans.

In 2006, Ontario launched Bill 102, the Transparent Drug System for Patients Act, which introduced broad-ranging changes for manufacturers and pharmacy. The act went much further than Quebec’s Bill 130; it amended the Ontario Drug Benefit Act as well as the Drug Interchangeability and Dispensing Fee Act, which governs the private sector. It established a firm limit on “allowances” to be paid to retail pharmacies doing business in the public sector only (the Ontario Public Drug Program). It also set generic drug prices only in the public sector at 50% of the brand. Because plans in both the public and private sectors like to emulate changes like this, a 50% limit became the new price in Canada for generic drugs.

In other ways, the bill gave special recognition to the profession of pharmacist. It moved to increase the role of pharmacists as a part of the health team through commitments for increased scope of practice, the ability to advise the public drug program through the Pharmacy Council and a fee-for-service initiative known as Meds Check.

Bill 102 was passed into law in late summer of 2006 amid a backlash from retail pharmacy, which was collectively upset over the impact of the act’s limit on allowances. One of the most significant and unintended consequences of the passage of Bill 102 was a shift in costs of prescription medications and fees for pharmacy service from the newly legislated public sector to the seemingly untouched private sector. Since the passage of Bill 102 in Ontario, drugs sold in pharmacies to consumers are sold under what is now referred to in Canada as a two-tiered drug-pricing system. Patients in the public program pay a lower price for drugs than patients in the private drug benefit sector.

Before the passage of Bill 102, there was little distinction between public sector drug plans and private sector drug plans regarding fees paid to pharmacy and ingredient costs. In fact, private sector plans often mimicked any changes that were realized by changes in public sector plans. Since the passage of Bill 102, however, private sector plans pay about 50% more for prescription and fees than plans in the Ontario Public Drug Program.

Other provinces, watching closely what was transpiring in Ontario, soon followed suit with reform measures to protect their public drug plans. Most notable were the provinces of British Columbia and Alberta.

British Columbia (BC) established its Pharmaceutical Task Force and tried to address the issue of what it deemed “the hidden cost of generic medications” and what it viewed as a growing trend in “frequent prescribing.” After a protracted consultation period, the province reached an agreement with the BC Pharmacy Association with what it cited as “interim changes” to the province’s PharmaCare program. It was interesting to note that the province gave appropriate recognition to the value of pharmacists and, in 2009, invested in patient care options.

In 2009, Alberta introduced its reform measures through its Pharmaceutical Strategy. This two-phased reform measure began in early 2009 with a legislated change to the price of any generic that would be newly introduced on the public drug plan from the previous 75% to 45% of the branded medicine’s price. The province committed to further lowering the cost of generics that were already on the plan. Early this year, the province announced a commitment to a price of 56% of the brand price for these medications.

The province also announced that it would invest in a fee mechanism for pharmacists to provide a cognitive service, best described as an intervention from a pharmacist to a patient that produces a health outcome. It is similar to the program earlier described as Meds Check Ontario. These announced reform measures in Alberta seemingly will not benefit private sector plans.

In the summer of 2009, the province of Ontario’s minister of health began consultations with pharmaceutical stakeholders to create longer term sustainability on its recently reformed public drug program. The minister recently announced that it would begin bilateral discussions with pharmacy on approaches to eliminating allowances or
rebates altogether. The province will likely settle on a generic drug-pricing scheme similar to or perhaps lower than the province of Alberta’s scheme. At the same time, Ontario has further recognized the value of the pharmacist as a part of the integrated health team. Ontario offered the profession scope of practice enhancements, through prescribing authority and other clinical enhancements, to ensure greater access for patients in the health care system.

**The Road Ahead**

Private sector plan sponsors, designers and consultants have been keenly interested in the outcomes of recent reform measures introduced by provinces. Private sector sponsors are unhappy with the two-tiered drug cost system and have expressed concern and frustration about the practice of generic allowances to pharmacy. Plan sponsors have tried to instill some discipline in plan design to combat increases in prescription drug costs and fees associated with traditional community pharmacy.

Provinces in Canada remain bullish on the need for reform. The Competition Bureau in 2008 suggested that the practice of allowances or rebates to pharmacy from generic manufacturers resulted in $800 million that could be used to reduce the prices Canadians pay for prescription medications, diverted into chronic disease management programs, or used to lower taxes or benefit plan costs.

Besides public efforts at reform, the private sector is seizing this opportunity to promote drug cost management. Many are looking closely at the prices of prescriptions and trying to find ways to direct plan members to opportunities for good outcomes at lower costs. Some are capitalizing on public sector reforms and implementing those changes. Others are considering innovative and alternative distribution of prescription medicines. Some are encouraging cooperatives with other plans. Most are calling for better drug prices, exclusive listing agreements on their formularies and clinical programs for their plan members.

Private sector plans are encouraged to engage more in the public sector reform debate and become knowledgeable about public policy initiatives underway on the sustainability of public sector plans.

Plan sponsors and plan designers may embrace alternative delivery mechanisms, a simplified prescription process, better interaction with pharmacists, lower dispensing fees, lower prices for drugs and optimization of the dispensing practice (from monthly to every three months for chronic medication regimens) when they witness the actual savings they can realize.

This transparency will maximize drug benefit plan efficiency and promote better outcomes for private sector plan sponsors and holders. This, in turn, will create greater access, greater benefit and, most of all, sustainability going forward.

**Endnotes**

1. Canadian Institute for Health Information research.
3. IMS Canada.
5. Bill 130, the National Assembly.
7. IMS Canada research.
8. Province of British Columbia Health Ministry.

Marc Kealey is the chief advocate of Kealey & Associates Inc., a health advocacy organization. The company works with health organizations, disease and patient groups across North America. He lectures frequently on the issue of drug plan sustainability and is a tireless advocate for the role of the pharmacist in integrated health. From 2004 to 2007 he was the CEO of the Ontario Pharmacists’ Association. He works closely today with private sector employer groups and benefit plan designers to develop innovative alternatives to their existing drug plans to produce better cost savings.

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by Michael C. P. McCreary and Carrie L. Clynick

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