Canadian Institute of Actuaries / Institut canadien des actuaires

Pharmacare: Is There a Pill for That?

February 2021

Executive summary

The Canadian Institute of Actuaries believes all Canadians should have access to affordable prescription drugs. Canadians currently have varying levels of prescription drug coverage under a mix of public and private plans. Yet, some are still unable to afford certain medications. And some have no coverage at all.

The Government of Canada is considering potential options for universal drug coverage, such as a single-payer federal Pharmacare program. We agree that no Canadian should be left without prescription drug coverage. However, we believe the best way to achieve increased health outcomes across the country is through a Canada-wide framework with elements managed by the federal government, provincial/territorial governments, and private insurance. It would enable:

+ Pooling of costs at the highest level where risk can be better absorbed

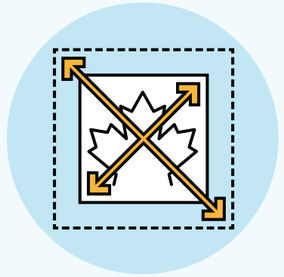
+ Negotiating prices using the greater weight of the whole country

+ Making sure that all Canadians can access the same medicines, fairly and equitably

In an actuarial context, prescription drug coverage for all Canadians is very appealing. We anticipate that such a framework would enhance life expectancy and, more importantly, would enhance *healthy* life expectancy. We anticipate improved worker productivity, longer labour force participation, and more economic growth. And we see less use of more expensive elements of our limited health care resources such as hospitals.

We believe the introduction of a prescription drug framework does not need to mean wholly replacing what we have now with something new. The current private and public programs are working well in many ways; a new framework should focus on helping them work better together and on filling the gaps. Our proposed structure would also cost taxpayers significantly less than the proposal in the Hoskins Report.

Proposed framework



Provincial flexibility

+ Provinces and territories should be afforded the flexibility to design their own public prescription drug plan and create a structure for the coordination of their public plan with the existing private drug insurance marketplace.

Oversight

+ An overseeing body comprised of decision-makers from federal, provincial/territorial, and private plans and other relevant experts should be established to negotiate drug prices on behalf of all public and private plans across Canada. This body should also explore how to implement optimal evidence-based prescribing and public health alternatives to pharmaceuticals.

Coverage

+ A national formulary should be established by the overseeing body, to define the core and specialty medicines that will be covered.

+ Both public and private plans should cover, at a minimum, all drugs included in the national formulary, to guarantee consistency across the country. Any plan could be allowed to cover drugs beyond those listed in the formulary if they wish.

+ The cost borne by the patient as deductible, coinsurance, or copayments should be limited to an affordable amount.

Insurance and reinsurance

+ Private plans should continue to cover costs up to a certain limit based on each plan's risk appetite, using a mix of self-insurance, insurance, and reinsurance. Industry organizations could continue to share costs across insurers.

+ Provincial and territorial plans should cover up to a certain limit of an individual's aggregate costs.

+ The federal government should pay for costs beyond the defined limit.

+ High-cost drugs on the national formulary, including those for orphan diseases, should be reinsured by the federal government on an individual basis for both public and private plans. They would first have to be listed in the formulary based on evidence of efficacy and negotiated price.

+ There would be no premiums for this federal reinsurance.

This framework would offer two clear advantages to the provinces/territories and employers: their total costs would be capped by the basic coverage limit (after which the federal reinsurance kicks in), and the volatility of the costs would be much lower, that is, year-to-year costs would be more predictable. For the federal government, this framework gives them a level of participation and a say in how it is run. For individuals, their costs would simply be covered, and they would not need to be involved in any level of reinsurance.

Any new framework should be introduced in stages to bring refinements and improvements over a number of years for greater sustainability as the framework matures and as costs and savings are better defined and projected.

We urge convening a task force of medical professionals, pharmaceutical experts, insurance leaders, private plan sponsors, government representatives, and actuaries to identify more accurate, consistent data on the costs and potential savings of the framework, and to perform a financial analysis over a long-term horizon.

Looking ahead by, for example, 20 years, this task force would explore and clarify projected changes in prescription drug needs as the population ages; changes in treatments that will be available and their costs; and the different costs and savings currently cited by varying sources.

We believe a well-managed prescription drug framework can result in lower overall costs and better health outcomes and contribute to the long-term economic recovery from COVID-19. The pandemic has shone a bright light on problems in our health care system. Investments today in the system – including prescription drug coverage – would benefit both today's Canadians and the generations to come.

Introduction

Canada is one of the few OECD countries that has universally paid physician and hospital coverage but limited and inconsistent coverage for prescription drugs. The important and complex questions around how to strengthen and standardize access to and improve the affordability of prescription drugs for Canadians has gained significant momentum in recent years, leading to the federal government's creation of the Advisory Council on the Implementation of National Pharmacare. Their Final Report (herein referred to as the "Hoskins Report") was issued in June 2019.

As a reference point, the Hoskins Report recommends the implementation of a universal, single-payer Pharmacare program following these principles:

- Structure legislation within the same fundamental principles of the Canada Health Act, including universality, comprehensiveness, accessibility, portability, and public administration.
- Provide coverage for a national list of prescription drugs and related products (a national formulary) to ensure all Canadians have equitable access to the medicines they need.
- Keep out-of-pocket costs for all products listed on the formulary to no more than $5.00 per prescription, with a copayment of $2.00 for essential medicines and an annual maximum of $100 per household per year.
- Allow private coverage to supplement coverage under the Pharmacare program.

To highlight gaps in the current system, the Hoskins Report includes various statistics:

- Prescription drugs represent the second-largest cost in Canadian health care, after hospitals and ahead of physician services.
- Approximately 7.5 million Canadians (19% of the population) either do not have prescription drug insurance or have inadequate insurance to cover their medication needs (Advisory Council 2019, p. 41).
- Among these persons, approximately 2 million Canadians (5.2% of the population) have no drug insurance coverage (Advisory Council 2019, p. 41).
- About 21 million Canadians (60% of the population) are covered under private plans, usually requiring premiums along with some copayment (Advisory Council 2019, p. 9).
- The costs that people with private plans pay – between copays and deductibles – is increasing, from 10% of their drug costs in 2005 to 15% in 2017 (Advisory Council 2019, p. 45); as well, the overall share of private health insurance premiums paid by employees has risen rapidly from 26% in 2010 to 40% in 2016 (Advisory Council 2019, p. 45).

We urge caution in the acceptance of some of these counts (i.e., there is no general consensus with respect to the number of Canadians without prescription drug coverage), however it remains clear that millions of Canadians are either uninsured or underinsured. Our report offers some considerations on addressing this issue.

It is impossible to publish this report without acknowledging the effects of the COVID-19 pandemic. Federal, provincial, and territorial governments are facing unprecedented deficits to fight its effects and to protect and revive the economy. The pandemic is shining a spotlight on many aspects of the health care system, such as the importance of essential workers, the preparedness (or lack thereof) for pandemics, the gap in treatment and coverage for mental health conditions, the tragic circumstances that have unfolded in Canada's long-term care institutions, and the risk posed to Canadians who have lost their supplementary medical coverage or prescription drug insurance due to job loss.

We believe implementing a well-managed prescription drug framework can result in lower overall costs and better health outcomes and contribute to the long-term economic recovery from COVID-19. We note its inclusion as a priority in the September 2020 Speech from the Throne (Governor General of Canada 2020). A private member's bill (C-213) has been presented in February 2020 (Parliament of Canada 2020) that calls for federal transfers to provinces that would establish a single, publicly administered, universal, and comprehensive prescription drug insurance program.

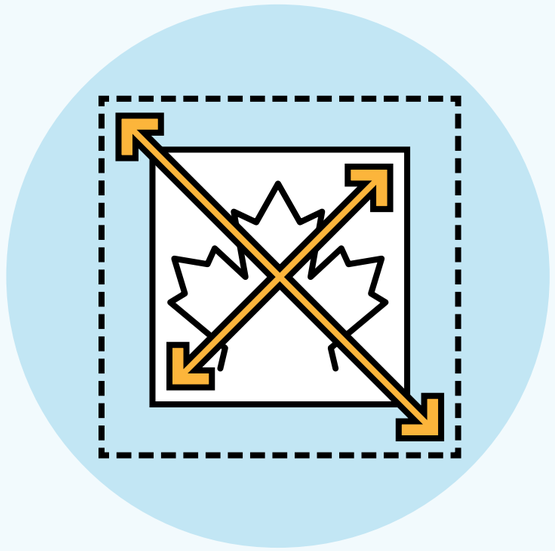
Note on terminology

People use the word "pharmacare" in varying senses, but in most cases they are referring to a universal, single-payer program such as that proposed by the Hoskins Report.

We have chosen not to use the word "pharmacare" at all in reference to our proposed framework to avoid the assumption that this is what we mean as well.

However, in the end, the word doesn't matter; what matters is achieving the important goal of providing prescription drug coverage to all Canadians in the best way possible.

Provincial flexibility



+ Provinces and territories should be afforded the flexibility to design their own public prescription drug plan and create a structure for the coordination of their public plan with the existing private drug insurance marketplace.

A national prescription drug framework should begin by building on successes within both private insurance and provincial/territorial programs, with a focus on filling the immediate needs of Canadians without coverage.

We believe this framework should allow provinces/territories and private plan sponsors enough flexibility to continue to offer programs beyond the core formulary that reflect the realities of their own populations. Different provinces have different challenges with respect to available budgets, population demographics, existing prescription drug programs, and pharmacy regulations.

Several provinces already have systems in place, which have been tailored to the needs of their jurisdictions and governance structures. Examples include the following:

+ Under Quebec's universal mandate, employers who provide accident and/or sickness benefits to their employees are required (until age 65) to provide prescription drug coverage that meets or exceeds the level of coverage provided by the province's public drug plan.
+ Under BC PharmaCare (Morgan et al. 2006), Saskatchewan Pharmacare (Saskatchewan Government 2020), and Manitoba Pharmacare (Manitoba Government 2020), residents are covered for eligible prescriptions under several plans, and some have low or no deductibles. The effective impact is that prescription spending by individuals and families is limited to a percentage of income; this amount is frequently covered by private plans.

As it stands today, private plans pay 36% of Canada's total spending on prescription drugs each year, and employers usually pay at least 50% (and often a much higher percentage) of this cost. The private insurance system also undertakes important activities, including:

+ developing valuable intellectual capital with respect to the criteria used for adding new drugs that are expected to have a positive impact on the individual as well as on the employer's productivity and the health outcomes of Canadians;
+ managing access to higher-cost drugs through prior authorization and step therapy; and
+ delivering individual and aggregate stop-loss insurance products and industry-wide pooling (which spread the risk of high-cost claims, reducing the impact on any one plan sponsor/employer).

Canada's prescription drug framework should preserve the advantages of these existing public and private plans.

Oversight

+ An overseeing body comprised of decision-makers from federal, provincial/territorial, and private plans and other relevant experts should be established to negotiate drug prices on behalf of all public and private plans across Canada. This body should also explore how to implement optimal evidence-based prescribing and public health alternatives to pharmaceuticals.

We recommend establishing an overseeing body tasked with, among other roles, negotiating wholesale drug prices and rebates with manufacturers. Much of this work is already being accomplished under the pan-Canadian Pharmaceutical Alliance (pCPA) – through which the provinces are working together to negotiate drug prices. Rather than start from scratch, we recommend building on this existing groundwork. **The overseeing body would be cooperative, including representatives from the federal, provincial, and territorial governments, the insurance industry, and other experts**.

This price negotiation would also include high-cost drugs and rare disease treatments, such as those for orphan diseases – diseases that are so rare that medication to treat them can cost more than $1 million per patient annually. According to Telus Health, in 2018, specialty drugs, including those for chronic and rare diseases, were claimed by just 1.1% of claimants, but accounted for 29% of total drug costs. This has increased significantly over the past ten years; in 2009, specialty drugs accounted for 0.5% of claimants and 12% of costs (Telus Health 2019). This trend is expected to continue as even more expensive therapies come to market, including drugs for rare and targeted cancers and gene therapy.

Improved protocols and public health use

We call for more research in other areas to reduce overall cost increase. Increasingly, patients expect that medication of one form or another is the solution to their ailment. In many cases, that may be true because the condition has advanced to that state. However, along with prescription drugs, other areas of medical care, public health, and health promotion need increased investment, such as lifestyle changes and therapy that can lead to improved physical and mental health (Harvard Medical School 2009). The overseeing body would research improved protocols for more effective use of pharmaceuticals and to reduce the mix of prescriptions to the elderly – who are among those most prescribed (CaDeN 2019). This will help limit cost increases and may also improve health outcomes (McDonald et al. 2019).

Dispensing fees

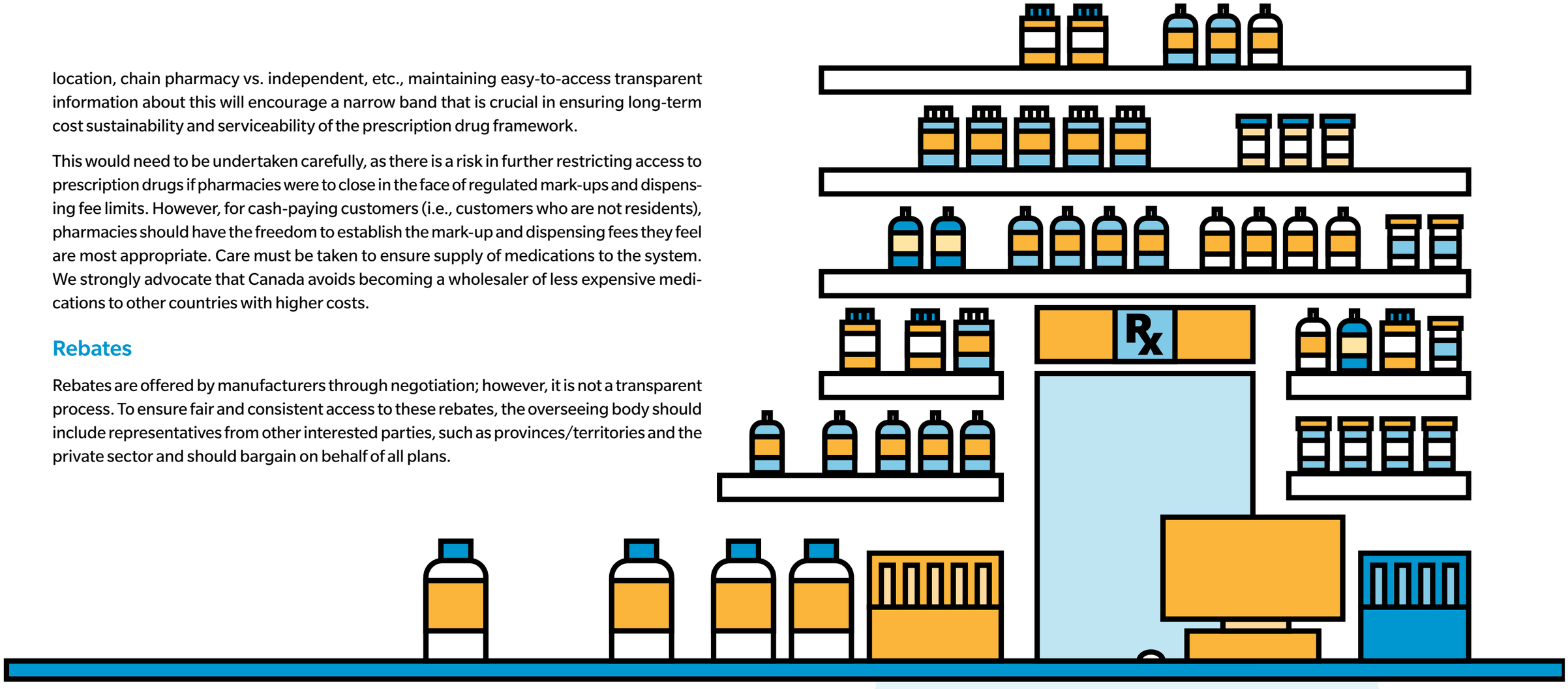
Given the role we envision for the federal government as a reinsurer for provincial/territorial and private plans, the Canadian overseeing body could also engage with pharmacies concerning allowable mark-ups and dispensing fees. Even though mark-ups and dispensing fees will likely vary based on criteria such as geographic

location, chain pharmacy vs. independent, etc., maintaining easy-to-access transparent information about this will encourage a narrow band that is crucial in ensuring long-term cost sustainability and serviceability of the prescription drug framework.

This would need to be undertaken carefully, as there is a risk in further restricting access to prescription drugs if pharmacies were to close in the face of regulated mark-ups and dispensing fee limits. However, for cash-paying customers (i.e., customers who are not residents), pharmacies should have the freedom to establish the mark-up and dispensing fees they feel are most appropriate. Care must be taken to ensure supply of medications to the system. We strongly advocate that Canada avoids becoming a wholesaler of less expensive medications to other countries with higher costs.

Rebates

Rebates are offered by manufacturers through negotiation; however, it is not a transparent process. To ensure fair and consistent access to these rebates, the overseeing body should include representatives from other interested parties, such as provinces/territories and the private sector and should bargain on behalf of all plans.



Coverage

- **A national formulary should be established by the overseeing body, to define the core and specialty medicines that will be covered.**
- **Both public and private plans should cover, at a minimum, all drugs included in the national formulary, to guarantee consistency across the country. Any plan could be allowed to cover drugs beyond those listed in the formulary if they wish.**
- **The cost borne by the patient as deductible, coinsurance, or copayments would be limited to an affordable amount.**

The formulary must be consistent across all provinces and territories, as portability – one of the fundamental principles of the Canada Health Act – cannot be achieved if there are differences in the formulary between jurisdictions. **Therefore it will be very important to have representation from all jurisdictions and private payers in the selection of the national formulary and to ensure transparency and avoid unintended consequences**.

Formulary inclusions

We foresee a challenge with respect to prescription drugs Canadians are currently taking that may not be listed on the national formulary. Differences between the national formulary and existing public formularies should be reviewed for gaps. We recommend starting with a core formulary that would be built up over time based on evidence of efficacy.

The Régie de l'assurance maladie du Québec (RAMQ) formulary, which includes approximately 900 different molecules (totalling 8,500 drugs compared to open formularies for private plans which can exceed 10,000 drugs), covered 86% of all drug spending and 87% of all prescriptions.

Another important element to consider is the introduction of new, very expensive drugs, such as biologic drugs and similar therapies. To the extent that these drugs will be deemed useful and that their coverage under the framework will be considered necessary, we should expect these drugs to have a significant impact on the annual increase of drug cost per capita in Canada. Based on recent data, the Drug Spending Model (DSM) assumes that new drugs add 4.5% per year to overall projected prescription drug spending.

According to the Canadian Institute for Health Information, greater demand and the rapidly rising number of high-cost drugs on the market have combined to take our spending on prescription drugs from its 1985 level of $2.6 billion or 0.5% of Gross Domestic Product (GDP) to $34 billion or 1.6% of GDP in 2018.

We agree with the principle of biosimilar substitution, to support the use of biosimilars and encourage patients and prescribers to choose the most cost-effective therapies to ensure the sustainability of the framework. Biosimilars made up less than 7% of Canada's biologic market in 2017, while the OECD average was more than 30%.

Cost-sharing

Mechanisms such as premium contributions, deductibles, coinsurance, or copayments, under which patients pay a small portion of the cost of their medication, are used in nearly all OECD countries (Barnieh et al. 2014) and remain a standard feature of the vast majority, if not all, existing prescription drug plans in Canada. However, there is conflicting evidence about their efficiency as cost-control devices, at least for chronic conditions among at-risk populations. While one study shows that increasing copayments significantly reduces the average annual drug spending, another study shows that it significantly reduces drug usage and compliance to medication treatment, leading to greater use of more expensive publicly funded medical services.

In view of this evidence and considering the current prevalence of cost-control mechanisms, we believe the prescription drug framework should initially consider using traditional insurance cost-sharing mechanisms (premium contributions, deductibles, coinsurance, or copayments) and that the impact of such mechanisms on medication compliance and health outcomes on Canadians be closely studied and monitored. The cost borne by the patient as deductible, coinsurance, or copayments should be limited to an affordable amount.

Quebec has achieved universal drug coverage, mandating that its residents without group coverage participate in its RAMQ plan. The plan features all the traditional insurance mechanisms, but the cost increases incurred by RAMQ insureds have far exceeded general inflation. This has also been the case with most public and private drug plans over the same period. It simply shows the impact of the powerful drivers underlying such increases; they are unavoidable, and any prescription drug system needs to be prepared for them. From 1997 to 2020, Quebec residents have seen their:

- annual premiums increase from $175/adult (equivalent to $265 in 2020) to $648/adult, a 145% increase over inflation;
- annual deductibles increase from $100/year (equivalent to $151 in 2020) to $21.75/month (equivalent to $261/year), a 72% increase over inflation;
- share of drug costs, upon satisfying the deductible, increase from 25% to 37% (a 48% increase over inflation); and
- annual out-of-pocket maximums rise from $750 (equivalent to $1,135 in 2020) to $1,143 (a 1% increase over inflation).[1]

The above figures provide an important lesson: Despite the efforts made by Quebec to contain the cost of its universal program (e.g., lower dispensing fees, negotiations with the pharmaceutical industry, controlled list of medications), it has been impossible to keep cost increases aligned with, or even close to, general inflation.

This situation does not mean that there has been a lack of control on cost increases for prescription drugs. In fact, the increased drug coverage in Quebec has likely led to significant savings in the costs of hospital, physician, and nursing care. However, these savings cannot be determined accurately because other forces (salary increases to physicians, variations in the number of and use of health care providers, etc.) have had a strong impact on the cost of publicly provided health care.

To alleviate the burden, Quebec decided to keep the out-of-pocket maximum in pace with inflation at the expense of huge increases in the premiums, the deductible and the share of costs borne by the insured. This decision aimed at recognizing the fact that high out-of-pocket costs present barriers to access for low-income earners. (Social assistance recipients and seniors receiving the Guaranteed Income Supplement have either a lower or zero out-of-pocket maximum and are less affected by general level of the out-of-pocket maximum.)

In creating leverage and incentives, we must see the entire system: the drug manufacturers, the physicians, the pharmacists, and the patient/client. Without careful assessment and planning, we could create unintended results, such as non-usage where needed, which could lead to later visits and/or hospitalizations that would not have been needed otherwise through to death, as opposed to lower costs in the long run.

1 Equivalents for 2020 are based on the variation of the general CPI for Canada (Series 1810000401 from Statistics Canada).

Insurance and reinsurance

- **Private plans should continue to cover costs up to a certain limit based on each plan's risk appetite, using a mix of self-insurance, insurance, and reinsurance. Industry organizations could continue to share costs across insurers.**
- **Provincial and territorial plans should cover up to a certain limit of an individual's aggregate costs.**
- **The federal government should pay for costs beyond the defined limit.**
- **High-cost drugs on the national formulary, including those for orphan diseases, should be reinsured by the federal government on an individual basis for both public and private plans. They would first have to be listed in the formulary based on evidence of efficacy and negotiated price.**
- **There would be no premiums for this federal reinsurance.**

Private plans and provinces/territories should act as primary insurers and cover the first tier of costs, with the federal government "reinsuring" the costs beyond a defined limit. In this way, the annual cost to be paid by the patient could be quite low or be a function of taxable income in the previous year. Provinces and territories could choose that people receiving social assistance, government disability benefits, or the federal Guaranteed Income Supplement benefit could be made exempt from copayments and/or deductibles. This is especially important for vulnerable or at-risk populations, including seniors. Over time, these mechanisms could be adjusted subject to evidence-based decision-making.

Risk pooling

A key principle underlying insurance is the law of large numbers; as the size of a group grows, the more certainty there is around a particular outcome. Due to the infrequent nature and size of specialty drug claims, many plan sponsors and provinces have experienced significant volatility in the costs of their drug plans. This has led to the introduction of drug caps or maximums, delays in listing certain drugs, or even ceasing drug coverage altogether.

The costs for these large and infrequent drug claims are most appropriately pooled at the largest group level available in the Canadian market – the federal government. Further, costs for more frequent, predictable, and lower-cost drugs can continue to be, and are appropriate to be, insured at the provincial/territorial or private plan sponsor level aligned within the national framework.

The federal government will have an important role to play in building a risk-based framework to hold together the various public and private plans. **The federal government should act as a reinsurer to all drug insurance plans in Canada, public and private**, as follows:

- Specialty or high-cost drugs, including drugs for orphan diseases, should be reinsured on an individual basis by the federal government for all drug plans in Canada, public and private. This would use a formulary-based approach, in which costs for drugs on the formulary over a specified dollar threshold would be paid for by the federal government. This would remove significant cost volatility from provincial/territorial and private plans.

This type of risk-sharing framework already exists within Canada, created by governments looking to more appropriately share costs across a broader base:

- The Quebec Drug Insurance Pooling Corporation (QDIPC) was established in 1997 following the adoption of the Prescription Drug Insurance Act, which sought to provide all Quebec citizens with coverage for the cost of pharmaceutical services and medications. All insurers and administrators of employee benefits plans share the risk of high-cost medications (QDIPC 2020). QDIPC administers this pooling system, and is the only body recognized for this purpose by the Quebec government.
- The Canadian Mortgage and Housing Corporation (CMHC) is a federal crown corporation that, as one of its main activities, provides mortgage insurance to homebuyers to help stabilize the housing market. This mortgage insurance protects lenders against the risk of borrower default. For higher risk loans, those where the down payment is less than 20% of the purchase price, lenders are required to purchase mortgage insurance from the CMHC or a private insurer, and the cost is passed on to homebuyers (CMHC 2020). To ensure market stability, CMHC acts as a reinsurer for 90% of the risk of the private sector lenders.

This framework would offer two clear advantages to the provinces/territories and employers: their total costs would be capped by the basic coverage limit (after which the federal reinsurance kicks in), and the volatility of the costs would be much lower, that is, year-to-year costs would be more predictable. For the federal government, this framework gives them a level of participation and a say in how it is run. For individuals, their costs would simply be covered, and they would not need to be involved in any level of reinsurance.

Planning for the future

✚ We urge convening a task force of medical professionals, pharmaceutical experts, insurance leaders, private plan sponsors, government representatives, and actuaries to identify more accurate, consistent data on the costs and potential savings of the framework, and to perform a financial analysis over a long-term horizon.

The task force formation would be initiated by the federal government, but provinces/territories and employers would also participate in its formation. While the task force would be busiest in the development of the initial framework, its role would continue as the framework evolves and morphs and it would ultimately report to the overseeing body. Any expenses incurred by the task force would be paid by the federal government.

We see this as being analogous to the CPP Committee of Officials (but with the addition of an employer representative). The officials are usually at the level of Assistant Deputy Minister, reporting to the Deputy Minister and then to the Minister of Finance.

Looking ahead by, for example, 20 years, this task force would explore and clarify projected changes in prescription drug needs as the population ages; changes in treatments that will be available and their costs; and the different costs and savings currently cited by varying sources. Some initial work has been done by actuaries (Grignon 2018). An appropriate projection time frame could be decided by the task force. If adequate long-term funding can be demonstrated, taxpayers will have greater confidence in the financial reality of such a framework.

To support these projections, we suggest reviewing historical experience data from large, existing prescription drug plans whose provisions are as closely aligned as possible with the plan design being considered, for example, drug experience from the Public Service Health Care Plan (TBS 2015).

For the purpose of modelling short-term costs and the pent-up demand associated with Canadians who currently cannot afford the medications they require, other sources of data can be considered. For example, the OHIP+ plan, which came into effect on January 1, 2018, provided all Ontario residents below the age of 25 with full coverage for the 4,400 drugs listed on Ontario's formulary (Ontario Government 2020). This has since been modified to include a stipulation that the resident must not be covered by a private plan. While the OHIP+ plan only covers people under the age of 25, it can help to provide some indication for the short-term pent-up demand that exists.

Whether the short-term or long-term projections are being considered, the projection model can also incorporate the anticipated additional purchasing power that the overseeing body would obtain through negotiations with drug manufacturers on behalf of Canadians.

Funding

The Canada Health Act does not outline, let alone guarantee, a funding formula for health care. This has proved to be very expensive for the provinces and territories, who have seen federal funding for hospital and physician costs decrease from 50% to less than 25%.

We believe participation by the federal government would need to be guaranteed to ensure the participation of the provinces/territories. Both federal and provincial/territorial jurisdictions would need to consider how best to fund their respective portions of the costs. While a well-run prescription drug framework, including well-designed provincial/territorial components, can have a meaningful impact on cost inflation, it is reasonable to assume that prescription drug cost inflation will continue to outpace GDP growth. In the face of this reality, how federal and provincial/territorial governments will fund the costs of the program in the long term is an important discussion addressed only philosophically in the Hoskins Report.

The Parliamentary Budget Officer (PBO) calculated that if it had been implemented in 2016, a universal Pharmacare program – based on Quebec's public formulary – would shift over $19.3 billion annually from provincial/territorial budgets and private-sector payers to the federal budget and would impose over $7.3 billion per year in additional costs for taxpayers. This was after accounting for $10.8 billion of "savings" from formulary restrictions, mandatory generic substitution, and extreme price regulation.

However, using the same model with a different set of assumptions, Canadian Health Policy Institute estimated that the minimum net additional federal cost would have been $26.2 billion (36% higher than the PBO's model) and the taxpayer cost nearly $12.3 billion annually (68% higher than the PBO's model).

This demonstrates the wide range of possible experience and the need for more consistent cost projections. However, it is clear that our "reinsurance" model would cost taxpayers a lot less than the Hoskins Report's proposal for Pharmacare.

Reporting on performance

Canada's prescription drug framework should feature comprehensive objectives to get better value for cost, including assisting both the public and the medical community to improve health outcomes. Importantly, the framework should undertake periodic reporting on achievement of its objectives with benchmarking against the best performers globally. And specifically, it should have transparent reporting to Canadians on overall health costs versus life expectancy. All of this should be supported through the development of a cost-effective information system to feed into the reporting on objectives, efficacy of the framework, and development of information.

Given the importance of the sustainability of such a program, consideration should be given to the mechanisms used to ensure sustainability in other long-term plans – such as the CPP and the Employment Insurance program. Periodic actuarial valuations similar to a pension valuation should be done and a report prepared for the public. We believe there would be a role for a health actuary in the Office of the Chief Actuary at OSFI.

Conclusion

The health care landscape in Canada is continuously evolving, and – as we have seen from the effects of the COVID-19 pandemic – the importance of making improvements to increase our nation's health outcomes cannot be underestimated. **The next step in improving Canada's health care system is to ensure access to affordable prescription drugs for all Canadians**.

We believe a prescription drug framework should build on what works within the private and public programs and make them better, by pooling costs at the highest level where risk can be better absorbed, by negotiating prices using the greater weight of the whole country, and by making sure that all Canadians can access the same medicines, fairly and equitably.

There is still important work to be done in analyzing and understanding the long-term projections to ensure the framework is sustainable. There are many questions to answer around incentives, mechanisms, funding, and administration. However, steps should be taken to start gaining improvements right away; Canadians should not have to wait for the "perfect plan."

We will watch with interest as these questions are tackled and offer our support of actuarial expertise to help find the answers.

We believe a well-managed prescription drug framework can result in lower overall costs and better health outcomes and contribute to the long-term economic recovery from COVID-19. This would benefit both today's Canadians and the generations to come.

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CIA membership supports this statement through a robust process that identifies topics of importance to Canadians where actuarial expertise can contribute to public discourse. Actuaries with diverse backgrounds and views participate in the assembly of relevant research and in drafting the statement. CIA members not involved in drafting the statement are invited to provide input to ensure that the drafters consider all views and that the statement is supported by a reasonable degree of consensus.

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