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The Quebec Act Respecting Prescription Drug Insurance and its Impacts on Private Group Insurance Plans

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The Act respecting prescription drug insurance in Quebec came into full force on January 1, 1997, and has been a major force in reshaping group insurance plans in the Province. This Act and the universal plan that it created have been gradually modified over time.

This Act mandates prescription drug coverage for all Quebec residents, adults and children. All persons who are eligible for coverage, either as a participant or as a dependent, under an eligible private group insurance (or under an individual insurance contract concluded on the basis of one or more of the distinctive characteristics of group insurance) plan must join such plan or any other similar plan to which they may be eligible. All other persons are covered under a public plan run by the Régie de l'assurance maladie du Québec (RAMQ – The Quebec Health Insurance Board). The only exception to this rule is for residents aged 65 or more, who may choose between a private group plan (if they are eligible to such a plan) or the public plan. The Act also prescribes eligibility conditions and maximum cost sharing for private plans, along with an obligation to pool large claims.

The Initial Context

When the Quebec Health Insurance Plan was implemented in 1970, it included first-dollar coverage of prescription drugs (without coinsurance) for people receiving social assistance benefits. With the passage of time, this approach was felt increasingly inequitable for low paid workers since the transition between social assistance (with free prescription drugs) and low paid jobs (with no prescription drug coverage or with a contributory prescription drug plan) was not supported.

In 1977, Quebec introduced free prescription drug coverage under the Quebec Health Insurance Plan for all residents upon reaching age 65. During the 1990s, with the aging of the population and the increase in the cost and utilization of prescription drugs (due to the shift to ambulatory care and the development of new, expensive drugs, among other things), the cost of this program was increasing much faster than the revenues of the province and was expected to increase even faster in the future.

As a corollary to the shift to ambulatory care and to incite people to be treated at home whenever possible, the Quebec government had started paying prescription drugs for persons who were previously treated in hospitals on an outpatient basis and who were now treated at home, since it would have paid for these drugs anyway if they had continued to receive their treatment in the hospital. This program (known as "Malades sur pied" – Ambulatory patients), became increasingly expensive and exceedingly complex while causing growing dissatisfaction, mostly among patients who were not eligible to it, because the government paid only a limited number of drugs, and only for certain specific conditions.

As a result, the government considered abolishing the "Malades sur pied" program and, in 1993, set up a committee to analyze the problems related to it. In its report, the committee recommended a very different solution: the implementation of a universal prescription drug program. A new committee was then set up in 1994 to report on the feasibility of such a universal program. This committee, in turn, reported that a universal program run by the government was both feasible and desirable.

The Political Context

In the meantime, there had been a provincial election and the party that came into power had promised it would implement a universal prescription drug program if it were elected. Then, in 1995, the Federal government launched the National Forum on Health to report on the state of health care in Canada, including the accessibility and affordability of prescription drugs. At approximately the same time another committee, chaired by Claude Castonguay, was set up in Quebec to report on the various options that could lead to equitable prescription drug coverage for the whole population. This report was tabled in 1996.

Quebec was concerned that the Forum would recommend including prescription drugs in the provincial Medicare programs through the requirements of the Canada Health Act. Quebec saw this eventuality as a threat since the Federal government would then be imposing new uncontrollable expenses on the

province without necessarily providing adequate funding. It must not be forgotten that the Canada Health Act mandates first-dollar coverage, with no user fees, for all medical expenses that fall within its scope.

This whole context prompted Quebec to move swiftly. Only a few weeks after the report of the Castonguay committee was released, in early April 1996, a bill was tabled in the Quebec legislature. The bill was discussed during a round of public hearings and was substantially modified before being passed in June 1996.

A few months later, the National Forum on Health tabled its report, which actually included a recommendation that publicly funded services be expanded to include all medically necessary services and, in the first instance, home care and prescription drugs. In particular, the report recommended that medically necessary prescription drugs be made available to all Canadian residents, without deductibles or co-payments. Thereafter, in its 1997 electoral program, the Liberal party, which was then re-elected to form the government of Canada, pledged to work with the provinces to ensure that all Canadians have access to medically necessary drugs within the public health care system. By swiftly implementing its own legislation regarding prescription drug coverage, the Quebec government tried to put the federal government before a fait accompli and hopefully prevent it from expanding the scope of the Canada Health Act and requiring the Province to bear the full cost of prescription drugs for its residents.

With the passage of time, the interest for a national requirement that prescription drug coverage be included in the scope of the Canada Health Act cooled off considerably until it was revived in the February 2018 spring budget, when the federal government announced the creation of the Advisory Council on the Implementation of National Pharmacare. Then, in June 2019, this council tabled a report (known as the Hoskins Report) saying how universal Pharmacare should be implemented in Canada. The recommendations included, among other things, the application of the requirements of the Canada Health Act to Pharmacare and some form of federal funding. At the same time, the federal government refused to increase from 22% to 35% its share of the funding of provincial Medicare plans, as asked by the provinces. Such funding was initially set at 50%. In 2023, the federal funding of provincial Medicare plans was increased to approximately 24%.

This illustrates a major concern with federally-funded mandatory universal Pharmacare based on the principles of the Canada health Act: the federal share of the cost of such a program could be expected to decrease over time, leaving the provinces with an ever-increasing share of the cost of the program, while not being able to implement cost containment features, at a time when their current Medicare plans are underfunded. In February 2021, the Canadian Institute of Actuaries issued a Public Statement in February 2021 entitled ***Pharmacare: Is There a Pill for That?***. This statement suggests that the best way to achieve increased health outcomes across the country is through a Canada-wide framework with elements jointly managed by the federal, provincial/territorial governments and private insurance. Such an approach would eventually bear some similarities with the Quebec program.

Scope of the Quebec Act Respecting Prescription Drug Insurance

Every Quebec resident (except Indians covered by the Federal government and persons living in a recognized long-term care facility “CHSLD”) is required to participate in a prescription drug insurance plan. However, the Act does not create a single universal plan, like the Quebec Health Insurance Plan, but rather a legal framework governing private group prescription drug insurance plans and a public plan run by the Régie de l’assurance maladie du Québec for people who do not have access to a private group insurance plan.

The Public Plan

The public plan covers Social Assistance recipients, residents under age 65 who are not eligible for coverage under an eligible group insurance plan and residents aged 65 or over who have not joined an eligible group insurance plan. Persons 60 to 64 years of age who have severe employment constraints and receive the Old Age Security Spouse’s allowance are treated as Social Assistance recipients with

severe constraints. Table 1 on the next page summarizes the main provisions of the plan for the period from July 1, 2016, to June 30, 2017.

Important Features

List of Medications – Covered Drugs

Covered drugs are all drugs prescribed by a physician and mentioned on a list updated periodically by the Quebec government ("List of Medications"). The list not only includes nearly all drugs usually covered under typical group insurance plans but it also includes smoking cessation drugs (such as Zyban™, Nicorette™, Habitrol™ and Nicoderm™) for up to 12 consecutive weeks in a 12-month period. Special drugs are covered only for certain conditions. Physicians are well aware of the list and tend to prescribe only drugs that are on this list. The patient presents the prescription at the pharmacy (along with the health insurance card) and only has to pay the deductible and coinsurance, if any. The RAMQ reimburses the pharmacist for the portion of the cost which is covered by the plan. The premium is not subject to the Quebec taxes on insurance premiums, by contrast with the premium paid under a private group insurance plan.

Table 1

Plan Conditions (July 2023 – June 2024)	
Deductible	
– Dependent children (below age 18 or aged 18 to 25 if students)	$0
– Social Assistance recipients	$0
– Persons aged 65 or over receiving at least 94% of the **maximum** Guaranteed Income Supp.	$0
– Other persons aged 65 or over	$22.90 / month
– Other adults of any age	$22.90 / month
Coinsurance borne by the insured	0%
– Dependent children (below age 18 or aged 18 to 25 if students)	0%
– Social Assistance recipients	0%
– Persons aged 65 or over receiving at least 94% of the **maximum** Guaranteed Income Supp.	33%
– Other persons aged 65 or over	33%
– Other adults of any age	
	$0
Maximum amount borne by the insured	$0
– Dependent children (below age 18 or aged 18 to 25 if students)	$0
– Social Assistance recipients	
– Persons aged 65 or over	$56.17 / month
• *receiving at least 94% of the maximum guaranteed income supplement*	$99.65 / month
• *receiving a partial guaranteed income supplement*	$99.65 / month
• *not receiving the guaranteed income supplement*	($1,196/ year)
– Other adults of any age	$0
	$0
Premiums	
– Dependent children (below age 18 or aged 18 to 25 if students)	$0
– Social Assistance recipients	$0 to $731
– Persons aged 65 or over	$0 to $731
• *receiving the maximum guaranteed income supplement*	$0 to $731
• *receiving a partial guaranteed income supplement*	
• *not receiving the guaranteed income supplement*	
– Other adults of any age	

The amounts in the above table are updated annually.

Pharmacists' Fees

Moreover, the pharmacists' fees are negotiated with the RAMQ; these fees (varying between $9.49 and $10.61 for 2023-2024, to be increased by 2% for 2024-2025) are significantly lower than those charged to persons covered under private plans (average of about $20).

Lowest-Price Policy

Another feature of the public plan is the lowest-price policy. If a generic substitute exists for the medication prescribed by the physician, the public plan will only pay based on the price of the generic product, unless the physician has specified "no substitution". Until 2013, brand name drugs that had been on the RAMQ list for less than 15 years were exempted from this rule. This exemption ceased on January 13, 2013. From January 14, 2013 on, no drugs are exempted from the lowest-price policy.

Exceptional Medications

The public plan covers, under certain conditions, those drugs listed in the "Exceptional Medications" section of the List of Medications. The "Institut national d'excellence en santé et services sociaux" assesses the clinical advantages and the cost of certain drugs and recommends to the Minister of Health and Social Services whether or not they should be covered as exceptional medications, along with the conditions for their eligibility. Several exceptional medications are coded, which means that doctors enter a code on these prescriptions so that the drugs will be automatically insured. Insured persons with coded prescriptions may then go to a pharmacy and obtain the prescribed drugs. In the case of non-coded prescription drugs, doctors must send the RAMQ a payment authorization request. Once authorization is granted, insured persons can obtain the prescription drugs at a pharmacy.

Exceptional Patient Measure

For treatment of a serious medical condition, the exception patient measure may cover, on an exceptional basis, certain drugs, for instance, drugs not appearing on the List of Medications. In such cases, however, certain criteria must be fulfilled. The decision to cover these drugs is made on an individual basis for each patient, based on the patient's exceptional need for this medication, and depends upon meeting four conditions:

- The medication must be eligible to this particular measure;
- The medical condition of the patient must be chronic (palliative care non-ambulatory patients are excluded);
- The medical condition of the patient must be serious;
- The medication asked for must be a last resort treatment for the patient.

Tax Situation

Premiums paid to the public plan are not subject to the 9.00% group insurance premium tax, nor are they subject to the 3.00% Part VI tax ("tax on capital" commonly known as "premium tax") nor to the 0.30% Part IV.1 tax ("compensatory tax" commonly known as an add-on to the 3.00% tax).

Evolution of the Plan

The initial maximum annual premium was set at $175/year for political reasons, the actuaries at RAMQ being aware that this amount was too low. It remained at this level until June 2000, despite rapidly increasing costs. It was doubled in July 2000, reaching $350 on an annual basis.

It later increased to $385 in January 2001. No other change took place until July 2002, when an extensive review of the program was made. The deductible and maximum borne by the insured were raised; the coinsurance borne by the insured was increased for all except children, Social Assistance recipients and seniors receiving the maximum Guaranteed Income Supplement (GIS). A requirement that the coinsurance and maximum annual cost borne by the insured be reviewed as of July 1st of each year was added to the law.

On March 1, 2003, the maximum cost borne by seniors receiving at least 94% of the maximum GIS was lowered to the level applicable to those who receive the full GIS. On July 1, 2005, the deductible and coinsurance were abolished for seniors receiving the maximum GIS but not for those who receive between 94% and 99% of the maximum GIS. Finally, on July 1, 2007, the deductible and coinsurance were abolished for seniors receiving at least 94% of the maximum GIS and for all social assistance recipients, regardless of whether they have severe constraints preventing them from working or not.

In December 2005, Quebec passed Bill 130, with provisions being gradually enacted from 2006 through 2009. Major features of this Bill were:

- A provision stipulating the circumstances where individual health insurance policies constitute a group plan within the meaning of the Act Respecting Prescription Drug Insurance;
- A provision creating the obligation, for the employer, to charge its group insurance premium for prescription drugs coverage to any employee eligible to such coverage, unless the employee demonstrates that he/she is covered under another group insurance plan covering prescription drugs;
- A provision tightening the definition of an “Association Group” (applicable since August 30, 2006);
- A provision clarifying the requirements regarding the coverage of spouse and children (applicable for the most part since October 1, 2007);
- Provisions regarding the verification of private group plans, along with related fines (applicable since January 1, 2009).

Initially, since the pharmaceutical industry maintained an important number of jobs in the Province of Quebec, it was decided that the public plan would reimburse the cost of the brand name drug (approximately 60 drugs, such as Crestor and Celexa) for 15 years following the inscription of that drug on the Quebec Plan list even though a generic exists. Over time, the number of jobs in the pharmaceutical industry in Quebec declined considerably. As a result, on January 13, 2013, the Quebec government announced that, effective immediately, these drugs would be covered only up to the cost of their generic version.

The following table shows the evolution of the major features of the program:

Table 2

Date	Maximum Annual Premium	Monthly Deductible*	Coinsurance*	Maximum Amount Borne by the Insured
Jan 1, 1997	$175	$8.33	25.0%	$62.49 /m = $750 / y
July 1, 2000	$350	$8.33	25.0%	$62.49 /m = $750 / y
Jan. 1, 2001	$385	$8.33	25.0%	$62.49 /m = $750 / y
July 1, 2002	$422	$9.13	27.4%	$68.50 /m = $822 / y
July 1, 2003	$460	$9.60	28.0%	$69.92 / m = $839 / y
July 1, 2004	$494	$10.25	28.5%	$71.42 / m = $857 / y
July 1, 2005	$521	$11.90	28.5%	$71.42 / m = $857 / y
July 1, 2006	$538	$12.10	29.0%	$73.42 / m = $881 / y
July 1, 2007	$557	$14.10	30.0%	$75.33 / m = $904 / y
July 1, 2008	$570	$14.30	31.0%	$77.21 / m = $927/ y
July 1, 2009	$585	$14.95	32.0%	$79.53 / m = $955/ y
July 1, 2010	$600	$16.00	32.0%	$80.25 / m = $963 / y
July 1, 2011	$563	$16.00	32.0%	$80.25 / m = $963 / y
July 1, 2012	$579	$16.25	32.0%	$82.66 / m = $992 / y
July 1, 2013	$607	$16.25	32.0%	$82.66 / m = $992 / y
July 1, 2014	$611	$16.65	32.5%	$83.83 / m = $1,006 / y
July 1, 2015	$640	$18.00	34.0%	$85.75 / m = $1,029 / y
July 1, 2016	$660	$18.85	34.5%	$87.16 / m = $1,046 / y
July 1, 2017	$667	$19.45	34.8%	$88.83 / m = $1,066 / y
July 1, 2018	$616	$19.90	34.9%	$90.58 / m = $1,087 / y
July 1, 2019	$636	$21.75	37.0%	$93.08 / m = $1,117 / y
July 1, 2020	$648	$21.75	37.0%	$95.31 / m = $1,144 / y
July 1, 2021	$710	$22.25	35.0%	$96.74 / m = $1,161 / y
July 1, 2022	$710	$22.25	35.0%	$96.74 / m = $1,161 / y
July 1,2023	$731	$22.90	33.0%	$99.65 / m = $1,196/ y

* For those to whom the deductible and coinsurance apply

Source: Régie de l'assurance maladie du Québec

Evolution of Cost

If we consider that the initial premium was arbitrarily set at a level that was unsustainably low, the first few years of operation of the program do not give meaningful information regarding the evolution of its cost.

From 2002 on, RAMQ started varying the deductible coinsurance percentage and maximum amount borne by the insured on a yearly basis.

It took until 2009, approximately 12 years after the inception of the program, before the cost was brought reasonably under control. Over the 7-year period from 2002 to 2009, the premium increased by 38.6%, the deductible increased by 63.7% and the maximum borne by the insured increased by 16.2%. During the same period, coinsurance passed from 27.4% to 32%, a 16.8% impact on the cost borne by the

insured. This shows that the RAMQ prioritized keeping the maximum amount borne by the insured at an affordable level at the expense of the deductible and, to a lesser amount, coinsurance and premium.

Over the next 14 years (twice the period mentioned above), the premium increased by 25%, the deductible increased by 53.2% and the maximum borne by the insured increased by 25.2%. During the same period, coinsurance passed from 32% to 33% (even though it had reached 37% in 2019 and 2020), a minimal impact on the cost borne by the insured. This shows that the cost containment measures (not only the adjustment to the financial parameters of the plan but also the lowest price policy, the limitation on pharmacists' fees, etc.) implemented by the Quebec government and RAMQ have been effective so far.

The annual increase in deductible is by far the strongest modification to the parameters of the program and aims at controlling the erosion of deductibles that plagues private plans that have a fixed deductible. In private plans, when the cost of covered expenses increases, the increase is magnified by the presence of a deductible. The higher the deductible, the stronger the impact. Table 3 illustrates this concept. For the sake of simplicity, let us assume that we have a group with five persons insured and that their claims increase by 10% from year X to year X+1:

Table 3

	Amount Claimed	
Certificate holder	Year X	Year X+1
Elizabeth	$100.00	$110.00
Daniel	$250.00	$275.00
Justin	$400.00	$440.00
Thomas	$500.00	$550.00
Stephen	$600.00	$660.00

If the deductible is $25 per certificate and is not indexed, the amount that can be reimbursed (assuming 100% coinsurance) will be $1,725 in year X and $1,910 in year X+1, a 10.7% increase. Erosion of the deductible would drive the cost of insurance 0.7% higher. Now, if the deductible is $500, the amount that can be reimbursed (assuming 100% reimbursement) will be $100 in year X and $210 in year X+1, a 110% increase! Here the erosion of the deductible would drive the cost of insurance up by more than 100%. In the RAMQ plan, the deductible increased by 4.4% on average over the last 21 years. This had a significant impact on the cost of the program.

From an actuarial point of view, it is interesting to note that the maximum premium doubled in the first three-and-a-half years of existence of the program. This may be the combination of four different things:

- A possible initial underestimation of the cost of the program;
- High inflation and increased utilization of prescription drugs;
- Shift in the prescription pattern of doctors;
- Erosion of the deductible.

The first two items are quite straightforward. Estimating the cost of covering people who are not already covered by a group prescription drug plan is rather challenging, to say the least. It was assumed that the persons newly covered by the program would cost approximately the same amount per capita as the persons covered under a private plan. This may not have been exactly correct as this population may

have a different age/sex/health blend from the typical group insured population (for example, persons who retired before reaching age 65 ended up massively on the public plan).

High inflation on prescription drug plans in the 1990s and early 2000s is a well-documented phenomenon. However, what causes an inflation rate to be significantly higher on prescription drugs than on the overall basket of goods and services is not so well documented and remains a challenge for pricing actuaries and consultants.

One phenomenon that we observe to some extent is the shift in the prescription pattern of doctors. As time passes, doctors tend to prescribe newer, more expensive (and hopefully more efficient) drugs. The following table shows what happens in a universe where there are only four generic antibiotics that can be used to treat an upper respiratory tract infection:

Table 4

	Year X		Year X+1	
Drug used	Cost per treatment	% of prescriptions	Cost per treatment	% of prescriptions
Drug A	$18	55%	$18	45%
Drug B	$29	30%	$29	30%
Drug C	$43	10%	$43	15%
Drug D	$106	5%	$106	10%

In year X, the average cost/treatment will be $28.20. Now, there is no inflation. However, the cost in year X+1 will be $33.854, a 20% increase! An interesting feature of this example is the fact that no new medication was introduced in X+1. Similarly, we implicitly assume no increased utilization as we are comparing the cost of one treatment.

In this example, we may either think that some Drug A prescriptions were replaced with Drug C and Drug D. More probably, some Drug A was replaced with Drug B, some Drug B was replaced with Drug C and some Drug C was replaced with Drug D.

Private Group Insurance Plans

Mandatory Coverage

All Quebec residents below age 65 who can be covered (either as a participant or as a dependent) by an eligible private group insurance plan (or by an individual insurance contract concluded on the basis of one or more of the distinctive characteristics of group insurance) covering prescription drugs must be covered under such a plan. Persons who may be covered under two or more eligible plans simultaneously need only to be covered under one plan.

Eligible Groups

To be allowed to provide prescription drug coverage, a group insurance plan must cover a group of persons formed for purposes other than contracting insurance coverage for its members. Moreover, the group must be determined on the basis of current or former employment status, or be composed of persons who belong to:

- a professional order; or
- a professional association whose membership consists of members of one or more professional orders; or
- an association whose membership consists of persons engaged in the same trade or occupation; or
- a union or association of employees.

However, the law does not force people who can enroll into such an association but who have not done so to actually enroll in it. On the contrary, Section 42.1 does not allow anyone to offer private prescription drug insurance to these persons. Hence, they must be covered under the RAMQ plan as long as they do not enroll in the association.

All other types of group or individual insurance plans are prohibited to cover prescription drugs, unless their coverage is limited to the amounts that are not paid by the public plan (deductible, coinsurance and drugs not on the list). Based on case law, members of an association-type group must share the same type of employment. For example, an association of business persons was denied the right to private coverage, because its members were engaged in a diversity of jobs. On the other hand, an association of persons related to plumbing (regrouping not only plumbers but also people working on pipes such as refrigeration system technicians) was allowed to provide private prescription drug coverage to its members.

Mandatory Provisions

Even though no employer or association is under the obligation to provide group insurance coverage to its employees or members, a group insurance plan (including a self-insured plan and a group of individual policies sold to members of an eligible group) providing any type of accident and sickness benefits to a group of persons determined on the basis of current or former employment status, profession or habitual occupation must cover prescription drugs. For example, an employer cannot offer short-term or long-term disability insurance on a group basis without providing prescription drug coverage to both its employees and their dependents. However, a plan covering travel insurance only or a paid sick leave bank does not require the plan sponsor to offer prescription drug coverage.

Being a hybrid between life insurance and accident and sickness insurance, accidental death and dismemberment insurance (AD&D) poses a unique problem. The RAMQ considers AD&D as a form of disability insurance. As a result, even an AD&D plan that is part of the same group insurance policy as the life insurance benefit and that is incidental to this benefit (e.g., an AD&D benefit expressed as a percentage of the life insurance benefit) causes the plan sponsor to be required to provide prescription drug coverage to the persons who are eligible for the AD&D coverage, and to their dependents. On the other hand, if the AD&D benefit is replaced with an accidental death benefit only (no dismemberment or loss of use benefit), it does not cause an obligation to provide prescription drug coverage.

Coverage of Dependents

Coverage may not be limited to the employee or participant only. The spouse (if living with the participant) and dependent children must also be covered for prescription drugs (unless they are covered under another eligible group insurance plan). The definition of dependents must be at least as generous as that provided under the Act and include the spouse, dependent children and persons with a functional disability.

The spouse is a person legally bound to the participant through marriage or civil union or living with the participant for at least 12 months in a common-law relationship. Because of the provincial law on non-discrimination, a spouse who is of the same sex as the participant must be covered under the participant's plan. A spouse who has been living with the participant for less than 12 months also qualifies as a spouse if a child was born to them or adopted by them during their relationship. A spouse who does

not have the same domicile as the participant must not be covered by the participant's group insurance plan.

A dependent child is a person under 18 years of age, who is not married nor part of a civil union, and is subject to parental authority, or a person less than 26 years of age, who is single, who attends an educational institution on a full time basis as a duly registered student and who is domiciled with a person who would exercise parental authority were the child a minor. A person with a functional disability is a person who has reached the age of majority, does not receive social assistance payments, has no spouse, has a disability included in regulations and that arose before age 18 and is domiciled with someone who would exercise parental authority if that person was a minor. This person is considered as a dependent child.

Regarding children of separated spouses, the parent with whom the child is domiciled has the obligation to cover the child under a private group plan, if the parent is eligible for such plan. If the parent is not eligible for such plan, the other parent must cover the child under his/her own group plan, even though the child does not live with this other parent, provided that this other parent is eligible to such a plan. If neither parent has access to a private prescription drug group plan and the parent with whom the child domiciled is covered as a dependant under the plan of his/her new spouse, this new spouse must cover both the parent and the child in his/her own plan, even though there is no filiation relationship between the new spouse and the child.

Eligibility Rules

Plan sponsors must determine eligibility rules, within the requirements of the Act. For example, a plan may have a waiting period (a period during which a person is not yet covered). An employer may also decide to offer coverage only to certain groups of employees such as full-time employees. (In this situation, if the employer decides not to cover its part-time employees for prescription drugs, then they may not be covered for any other type of accident and sickness benefits such as dental, hospital or disability income.)

It is expressly forbidden to define a group using criteria based on the members' age, sex or state of health. This requirement is far-reaching since it departs from some usual practices in the field of group insurance. For example, an insurer may not exclude a person (participant or dependent) who does not present satisfactory evidence of insurability. Also, a plan that used to cover employees or retirees until age 65 may no longer invoke this age criterion to terminate their coverage. It must continue to offer coverage to active employees and retirees beyond their 65th birthday. However, there is no need to cover retirees before the age of 65 if none of the older retirees is covered. Terminating coverage once an employee reaches a specific total of age and service is also forbidden. Regarding retirees, the employer has the choice between offering coverage for prescription drugs to all of them, regardless of age, or to none of them. If the employer chooses not to offer prescription drug coverage to its retirees, then it cannot offer them any other form of accident and sickness insurance (including supplementary health, dental, AD&D etc.) except out-of-province travel insurance.

Turning 65

Upon reaching age 65, employees or retirees who are eligible for coverage under a private group plan covering prescription drugs remain eligible for coverage under this plan since it cannot exclude persons on the basis of their age. However, persons who turn 65 are automatically registered for the public plan administered by the RAMQ.

Hence, they have a choice to make. They may decide to be insured:

- only by the public plan, administered by the RAMQ;
- by the public plan (first payer) and by a private plan offering supplemental coverage (second payer); or
- only by a private plan offering at least the basic coverage.

Supplemental coverage does not replace the basic coverage of the public plan, but may add to such coverage, for example, by paying the cost of drugs not insured or the portion of costs not reimbursed by the public plan. When a person has supplemental coverage for prescription drugs, RAMQ acts as the first payer; the private plan then acts as the second payer.

Since older persons tend to have a higher cost of coverage than younger persons and since the premium charged by the public plan does not vary according to age, by contrast with private plans that may price coverage according to risk, the public plan offers subsidized coverage to persons aged 65 and older. As a result, employers are reluctant to have these persons fully covered for prescription drugs in their private plans. However, employers cannot terminate the coverage of employees or retirees because of age. What they do is to charge a very high contribution (significantly higher than the premium of the public plan) to the employees and retirees who wish to have full prescription drug coverage in the private plan after reaching age 65. Upon being informed of that contribution, these persons normally decide to remain in the public plan.

When a person, upon reaching 65, decides to remain covered in a private plan, his/her dependents must also be covered in the private plan (except for a spouse aged 65 or older, who has decided to be covered in the public plan). Conversely, if, upon reaching 65, the person decides to be covered in the public plan, his/her dependents become ineligible for coverage under this person's private plan and must be covered in the public plan or in another private plan to which they are eligible.

Drugs Covered and Pharmacists' Fees

A plan covering prescription drugs must cover all the drugs on the "List of Medications" covered by the public plan and may not have any exclusion. For example, if a participant or a dependent is injured while committing a crime or attempting to commit a suicide the plan may exclude all medical expenses, except prescription drugs.

The list includes two types of medications: Regular Medications and Exceptional Medications. A private plan cannot restrict the coverage of regular medications, except when the list allows some limitations (for example, on anti-smoking treatments). Exceptional medications must be covered by private plans at least on the basis of the criteria that appear on the list (same criteria as for the public plan), but the plan may require a pre-authorization. The list also describes conditions and circumstances where unlisted medications and exceptional medications prescribed according to other criteria than those on the list, must be covered by private plans. This is mostly for exceptional situations such as last resort treatments; pre-authorization may be required by the plan in these circumstances.

A major difference with the public plan is the fact that the "lowest-price policy" does not apply to private plans. This situation, along with the fact that brand-name drugs are on the list published by the Minister prevents private plans to require systematic generic substitution. Hence, a private plan may limit the reimbursement to an amount based on the cost of the generic substitute, but only if the reimbursement represents at least 67 % of the cost of the brand-name drug that was prescribed by the physician, after the deductible.

This is seen as an irritant by private plans, as they cannot benefit from the same cost-containment measure as the public plan. However, this irritant is mitigated by the fact that the pharmacist's fees tend to be significantly higher on generic drugs, prompting pharmacists to propose generic drugs whenever possible. Also, a private plan can encourage the use of generics by varying the percentage of reimbursement between brand name drugs and generics (for example, a plan may reimburse 85% of the cost of generic drugs but only 75% of the cost of brand name drugs).

Some drugs available over the counter are included on the list and must be covered by private plans. As a result, it is no longer possible to have a general exclusion for drugs available over the counter. Moreover, certain drugs (such as AIDS medication) that used to be provided free of charge by the Quebec government under special programs before 1997 must be covered under private plans, a situation of cost-shifting from the government to private plans.

In Quebec, before September 15, 2017, pharmacists' fees were blended with the cost of ingredients into a single price for a prescription. As a result, there was no way to know what part of the cost of a particular

prescription represents the dispensing fee. This situation has changed and now pharmacists' fees are shown on the receipt produced by the pharmacy. Pharmacists in Quebec tend to charge higher fees on generic drugs than on brand name drugs. This sometimes creates a weird situation: if a private plan pays 85% of the usual and customary cost of generic drugs and 80% of the cost of brand name drugs, the reimbursement often ends up being 67% of the cost of the generic and 80% of the cost of the brand name drug, because the usual and customary cost of generics can be much lower than the amount charged by the pharmacist, resulting in 67% of the pharmacist's price being higher than 85% of the usual and customary price. This can result in a significant communication challenge for the plan sponsor.

Deductible, Coinsurance and Maximum Annual Contribution

A private plan must reimburse at least 67 % of the cost (over and above the deductible) of prescription drugs on the Minister's list. Furthermore, the amount (deductible + coinsurance) borne by an adult and his or her dependent children may not exceed $1,196/year.

Plans may include a deductible that applies to prescription drugs, in whole or in part. Unlike the plan provided by the Board, the deductible for private plans may apply not only to adults but also to children. The deductible does not need to be applied on a monthly basis and it may be as high as $1,196/year if that is the wish of the parties to the insurance contract. (In such an extreme example, the plan would have to reimburse 100% of the cost above the deductible since the deductible would then be equal to the maximum amount that can be borne by an adult under the law).

Co-payments are considered as a per prescription deductible. As a result, national plans that cover only the cost of ingredients outside Quebec tend to apply a co-payment, typically around $10 to $15, even though a higher co-payment is legal, as long the total amount paid by an adult (and dependent children) as cost-sharing does not exceed $1,196/year.

Plan Termination

A group prescription drug insurance coverage may be terminated by the insurer on a date other than the renewal date only if that date falls 30 days after sending a notice of intent, and then only for non-payment of premiums. In the event of a strike or lockout, the insurer or administrator of a self-insured plan must maintain coverage for a period of at least 30 days from the date on which the work stoppage began. When the insurer or the policyholder terminates a group plan covering prescription drugs, they must send a notice of non-renewal to the participant with a copy to the RAMQ.

Special Situations

When a person moves from one private plan to another or between a private plan and the public plan within a calendar year, the $1,196 limit is not carried over automatically. The person must ask the former insurer a statement of the expenses counted toward the $1,196 maximum (the former insurer has the obligation to provide such information). The person must then submit the information to the new insurer, who must use it in determining amounts to be reimbursed until the end of the year.

Under Section 44.1 of the Act respecting Prescription Drug insurance, when an employee who has not demonstrated that he/she is covered under another group insurance plan is eligible to a contributory group plan, the employer is under the obligation to charge the premium for the prescription drug insurance portion of the group plan on this employee's pay without having to obtain the employee's consent.

Persons younger than 65 years of age who have access to a private group plan covering prescription drugs must join that plan.

Certain persons mistakenly believe that by paying a premium through their income tax they are automatically registered for the Public Prescription Drug Insurance Plan, or that they can cancel their registration for the public plan simply by indicating on their income tax return that they are covered by a

private plan. Actually, the only way to register or cancel one's registration for the public plan is to contact the RAMQ directly.

Mandatory Pooling

All insurers, including administrators in the case of self-insured plans, must pool the risks arising from the mandatory coverage, according to terms and conditions to be agreed up on among themselves and of which the Minister of Health and Social Services must be informed by November 1 of each year at the latest. In the absence of an agreement, the Minister may determine the pooling terms, by regulation.

Forms of Pooling

In group insurance, there are traditionally three different forms of pooling:

- Pooling within the group, which is achieved by charging the same premium rates to all participants who have the same major characteristics (employment status, single or family coverage);
- Pooling within an insurer's portfolio (this is done mostly for smaller groups for which the premium rates are based at least partially on the combined experience of several groups);
- Pooling among different insurers, traditionally done through reinsurance arrangements.

The Act does not define what it means by "pooling". As a result, when the insurance industry set up the Quebec Drug Insurance Pooling Corporation (the "Society"), it came up with its own definition of pooling and its own pooling mechanism, specific to prescription drug coverage in Quebec. This pooling mechanism aims at satisfying the government's objectives as well as respecting, as much as possible, the free market conditions that prevail in the insurance industry.

Government's Objectives

In meetings with the representatives of the insurance industry, the Quebec government advanced the following objectives:

- Prescription drug insurance should be affordable to all residents of Quebec, and
- The members of a group should not be penalized by any large claim arising from one person.

It must be remembered that private plans now have to provide prescription drugs to severely ill participants and dependents, including persons who formerly had their medication paid by the government under special programs. As a result, it is quite possible to have a recurrent claimant receiving $50,000 worth of prescription drugs in a five-employee group. If such a claim had to be entirely supported by the group, the resulting premium would not be socially acceptable. Pooling is then the solution to this type of problem by allowing the claim to be spread over a much larger number of persons.

Interpretation by the Insurance Industry

In designing the pooling process required by the law, the Society had to determine what exactly was to be pooled (or what is an excessive risk) and how it was to be pooled (the pooling mechanism itself).

The Society initially interpreted an excessive risk as the risk that a group might suffer a 20% rate increase over and above the trend factor (that is, inflation and general utilization), just because of only one person with a large claim. (The 20% is a ballpark figure that may vary somewhat over time.) This concept has been accepted both by the industry and by the government. Such a concept implies that the impact of a large claim varies according to the size of the group.

Even though this pooling affects drugs claimed by Quebec residents, the size of a group, for pooling purposes, is based on the total number of certificates within the group, including employees who live outside Quebec. Over time, the size of groups subject to pooling and the pooling thresholds have evolved

significantly, in response to the changing environment of prescription drug coverage (emergence of new, very expensive drugs, experience of the insurance industry with the pooling mechanism, changes in the level of comfort of the insurance industry toward inter-company pooling, etc.).

The following tables show the evolution of the size of groups subject to inter-company pooling, along with the evolution of the pooling thresholds:

Table 5

Pooling Threshold according to Group Size (Smaller groups) [1]					
Year	Group Size				
	< 10	10 to 24	25 to 49	50 to 124	125 to 249 [2] [3]
1997	$ 750	$ 1,200	$ 3,000	$ 6,000	not applicable
1998	$ 750	$ 1,200	$ 3,000	$ 6,000	not applicable
1999	$ 750	$ 1,200	$ 3,000	$ 6,000	$ 50,000
2000	$ 850	$ 1,500	$ 3,750	$ 7,500	$ 50,000
2001	$ 1,000	$ 1,750	$ 4,400	$ 8,750	$ 50,000
2002	$ 1,200	$ 2,000	$ 5,000	$ 10,000	$ 50,000
2003	$ 1,500	$ 2,500	$ 6,000	$ 12,000	$ 20,000
2004	$ 1,700	$ 2,500	$ 6,000	$ 12,000	$ 20,000
2005	$ 2,000	$ 2,900	$ 6,900	$ 13,800	$ 23,000
2006	$ 2,000	$ 3,000	$ 7,500	$ 15,000	$ 25,000
2007	$ 2,100	$ 3,300	$ 8,500	$ 17,000	$ 28,000
2008	$ 2,400	$ 3,800	$ 9,800	$ 19,000	$ 32,000
2009	$ 4,400 [4]	$ 4,400	$ 11,300	$ 21,000	$ 37,000
2010	$ 4,800	$ 4,800	$ 12,400	$ 23,000	$ 37,000
2011	$ 5,000	$ 5,000	$ 13,000	$ 24,000	$ 39,000
2012	$ 5,100	$ 5,100	$ 13,500	$ 24,000	$ 39,000
2013	$ 5,100	$ 5,100	$ 13,500	$ 25,000	$ 39,000
2014	$ 6,000	$ 6,000	$ 15,500	$ 27,500	$ 42,000
2015	$ 7,500	$ 7,500	$ 17,000	$ 30,000	$ 45,000
2016	$ 8,000	$ 8,000	$ 18,000	$ 32,500	$ 47,500
2017	$ 8,000	$ 8,000	$ 18,000	$ 32,500	$ 47,500
2018	$ 8,000	$ 8,000	$ 18,000	$ 32,500	$ 47,500
2019	$ 8,000	$ 8,000	$ 16,500	$ 32,500	$ 47,500
2020	$ 8,000	$ 8,000	$ 16,500	$ 32,500	$ 47,500
2021	$ 8,000	$ 8,000	$ 16,500	$ 32,500	$ 47,500
2022	$ 8,000	$ 8,000	$ 16,500	$ 32,500	$ 55,000
2023	$10,000	$10,000	$ 18,000	$32,500	$72,000

Source: Quebec Drug Pooling Insurance Corporation – Terms and Conditions for Pooling (annual)

[1] Pooling based on the private plan's list of medications.

[2] Before 2003, there was a single band for group with 125 certificates or more.

[3] Before 2011, self-insured groups did not participate in this stratum.

[4] Since 2009, the 0-10 and 10-24 strata are merged.

Table 6

Pooling Threshold according to Group Size (Larger groups) [1]					
Year	Group Size				
	250 to 499	500 to 999	1,000 to 1,499	1,500 to 2,999 [2]	3,000 [3] to 6,000 [4]
1997	not applicable	not applicable	not applicable	not applicable	not applicable
1998	not applicable	not applicable	not applicable	not applicable	not applicable
1999	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
2000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
2001	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
2002	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
2003	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
2004	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
2005	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
2006	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
2007	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000
2008	$ 60,000	$ 60,000	$ 60,000	$ 60,000	$ 60,000
2009	$ 60,000	$ 60,000	$ 60,000	$ 60,000	$ 60,000
2010	$ 60,000	$ 60,000	$ 60,000	$ 60,000	$ 60,000
2011	$ 60,000	$80,000	$ 100,000	not applicable	not applicable
2012	$ 60,000	$80,000	$ 100,000	not applicable	not applicable
2013	$ 60,000	$80,000	$ 100,000	$ 100,000	not applicable
2014	$ 60,000	$80,000	$ 100,000	$ 100,000	not applicable
2015	$ 65,000	$ 85,000	$ 110,000	$ 110,000	not applicable
2016	$ 67,500	$90,000	$ 115,000	$ 115,000	not applicable
2017	$ 72,000	$ 95,000	$ 120,000	$ 120,000[2]	not applicable
2018	$ 72,000	$ 95,000	$ 120,000	$ 120,000	not applicable
2019	$ 72,000	$ 95,000	$ 120,000	$ 120,000	not applicable
2020	$ 72,000	$ 95,000	$ 120,000	$ 120,000	$300,000
2021	$ 72,000	$ 95,000	$ 120,000	$ 120,000	$300,000
2022	$80,000	$105,000	$130,000	$130,000	$300,000
2023	$80,000	$105,000	$130,000	$130,000	$300,000

Source: Quebec Drug Pooling Insurance Corporation – Terms and Conditions for Pooling (annual)

(1) Pooling based on the list of medications covered by the public plan.

(2) From 2017 on, this stratum is expanded to include groups with up to 3,999 certificates.

(3) From 2017 on, this stratum starts at 4,000 certificates.

(4) From 2020 on, this stratum ends at 6,000 certificates. Groups above 6,000 certificates are not mutualized.

In the early years, groups subject to pooling were those with fewer than 125 certificates. At that time, self-insured groups with fewer than 125 certificates were not expected to exist. Even though the law creates an obligation for self-insured groups to participate in the pooling mechanism on the same terms as insured groups, it took some time for smaller self-insured groups, especially those not administered by insurers, to realize that they had to participate in the industry pooling system. These groups were eventually integrated in the system.

In 1999, pooling was expanded to groups with 125 certificates or more. However, the industry considered that pooling was a legal requirement only for groups with 124 or fewer certificates while it was simply desirable for larger groups. As a result, pooling for groups with 125 certificates or more was only offered to insured groups.

An extensive review of the pooling system took place in 2009 and it was decided that, from 2011, self-insured groups with 125 certificates or more would participate to the pooling system on the same basis as insured groups.

Until 2013, for groups with fewer than 250 certificates, the pooling was based on the prescription drugs covered by the private plans that can include medications not on the Quebec List. For groups with 250 certificates or more, only medications on the Quebec list were pooled. Since 2014, the pooling is based on the prescription drugs covered by the private plans for all groups.

The variation in the pooling thresholds for larger groups illustrates the difficulty of dealing with the risk of very large claims. If we consider the fact that an “exceptional patient” may cost close to $250,000 per year for a single medication, such a patient would create an annual charge of $1,000 per certificate on a group with 250 certificates, assuming that the patient takes no other exceptional or high cost medication, in the absence of a pooling mechanism. Even though employees tend to be in good health, private plans also cover dependents and cannot exclude anyone on the basis of health.

The Pooling Mechanism

Until 2002, pooling was done by group size. As a result, on a net basis, one insurer could collect money from the pool for its groups in the 50 to 124 band and pay money into the pool for its groups in the 10 - 24 band if its experience was bad for one band and good for the other. Beginning in 2003, a formula using cumulative strata is used. With this formula, claims below $18,000 (in 2023) are pooled only among groups with fewer than 50 certificates. On the other hand, claims between $18,000 and $32,500 are pooled among all groups with fewer than 125 certificates while claims above $300,000 are pooled among all strata in 2023 (groups with no more than 6,000 certificates).

The number of certificates is calculated considering participants in all provinces. As a result, a group with 100 certificates, 40 of which are Quebec residents, is assigned to the 50-124 stratum. Only claims incurred for Quebec residents are subject to pooling.

Special rules apply to multi-employer groups. The size of a multi-employer group where no subgroup pays a premium based on its own experience is considered to be the size of the whole group. However, for multi-employer groups that include subgroups whose premiums are based on their own experience, each of these subgroups is considered as a group of its own and is pooled in a band corresponding to its own size.

This pooling mechanism is mandatory; that is, the whole industry and the government have agreed to its terms, thus preventing the Minister of Health and Social Services from imposing a different pooling

mechanism that would not satisfy the industry. The whole mechanism is quite simple and easy to administer and has been working smoothly since its implementation.

In the early years, some insurers raised questions about the long-term neutrality of the pooling mechanism. When the mechanism was designed, it was expected to be neutral over time and that any particular insurer or self-insured group could lose money one year and be compensated by the pool and then make a profit another year and compensate the pool accordingly. Over the long run, bad years and good years would tend to offset each other and the pooling mechanism could be viewed not only as a mechanism allowing insurers to pool among each other but also to pool with themselves over time. After a few years, some insurers (mostly small companies) found out that, due to their market approach, they tended to get «better» groups than their competitors, even without any selection on health insurance, and, as a result, they end up reimbursing the pool year after year. This was probably due to stricter selection on life insurance and long term disability insurance that may have had a ripple effect on the overall quality of risks taken by an insurer, even though insurers have no control on the quality of risks of dependents.

The following table shows the pooling factors for year 2023. These factors correspond to an expected loss ratio of 90% and can give a good idea of what would be a reasonable large amount pooling charge for the various pooling thresholds.

Table 7

Group Size (nb. of certificates)	Pooling Threshold (/ certificate)	Annual Pool Factor (single coverage)	Annual Pool Factor (family coverage)
< 25	$ 10,000	$ 276.00	$ 771.00
25 - 49	$ 18,000	$ 188.00	$ 527.00
50 - 124	$ 32,500	$ 100.00	$ 339.00
125 - 249	$ 55,000	$ 66.00	$ 224.00
250 - 499	$ 80,000	$ 50.00	$ 169.00
500 - 999	$ 105,000	$ 36.00	$ 142.00
1,000 – 3,999	$ 130,000	$ 19.00	$ 52.00
4,000 – 5,999	$ 300,000	$ 15.00	$ 60.00
6,000 and up	No pooling – Free market		

Source: Quebec Drug Pooling Insurance Corporation – Terms and Conditions for Pooling (23)

As the lowest threshold ($ 10,000) is way above the claims amount that produces the maximum cost to be borne by an insured ($1,196/0.33 = $3,624), the compensation formula is 100% of claims above the threshold.

The increase in pooling thresholds has slowed considerably since 2015. As a counterpart, the pooling factors have increased sharply. For example, the pooling threshold for smallest groups increased for $7,500 to $10,000 since 2015 (an average annual increase of 4.6% as of 2023) while the pool factor for single coverage increased from $170 to $276 (an average annual increase of 6.2% as of 2023). Now if we look at the 1,000 – 3,999 stratum, the pooling threshold increased from $110,000 to $130,000 in 8 years (an average annual increase of 3.3% as of 2023) while the pool factor increased from $7.50 to $19.00 (an average annual increase of 12.3% as of 2023).

Experience on Pooled Claims

Full results of the pooling mechanism have been available for several years now, with a lag, though. Beyond showing that the system actually works, these results are also quite interesting from an actuarial point of view as they provide insight on the phenomenon of large prescription drug claims.

As the pooling mechanism can be seen as a form of stop-loss, albeit on an individual basis, the experience results can give an actuary valuable insight as to the evolution of stop-loss on benefits that are subject to material inflationary pressure. In particular, these results show that a high level of care must be applied when re-pricing this type of stop-loss from one year to the next. Interesting information provided by the Société is the occurrence of jumbo claims in groups with 124 certificates or less from 1997 through 2006. These data, shown in the following table, indicate a very significant increase in catastrophic claims and further demonstrate the need for inter-company pooling.

Table 8

Claim Size	Number of Claims									
($ '000)	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
20 - 29	12	39	59	88	98	186	275	375	406	474
30 - 39	4	4	10	13	14	27	48	61	109	131
40 - 49		2	3	5	6	13	13	22	35	46
50 - 59		1	0	1	2	3	11	9	10	21
60 - 69				1	1	4	4	7	4	11
70 - 79					1	0	0	2	2	7
80 - 89						1	1	0	2	3
90 - 99								0	0	0
100 - 149								1	3	1
150 +								1	0	0
Total	**16**	**46**	**72**	**108**	**122**	**234**	**352**	**478**	**571**	**694**

Source: Quebec Drug Pooling Insurance Corporation

More recent data on catastrophic claims were compiled in 2016:

Table 9

Claim Size	Number of Claims			
($ '000)	**2012**	**2013**	**2014**	**2015***
200 to 500	4	8	12	21
Over 500	4	6	8	13
Total Number	**8**	**14**	**20**	**34**
Total Amount	**$3,730,190**	**$6,200,521**	**$8,216,740**	**$15,805,833**

* Preliminary Data
Source: Quebec Drug Pooling Insurance Corporation

More recent data were published on very large claims, as shown in the following table:

Table 10

	The top 10 pooled drugs over $30,000 per certificate in 2021	
Drugs	**Number**	**Value of Pooled Claims**
Soliris	28	$17,143,652
Vimizim	10	$9,018,338
Crysvita	9	$7,964,350
Orkambi	16	$5,815,340
Symdeko	14	$4,866,625
Myozyme	5	$3,652,525
Revestive	4	$1,428,224
Aldurazyme	2	$857,703
Strensiq	1	$576,392
Nagalazyme	1	$511,164
Total Amount	**90**	**$51,834,313**

Source: Quebec Drug Pooling Insurance Corporation : Summary of Pooling in 2021

These tables show the existence of claims for prescription drugs over $20,000/certificate and that these claims are becoming more and more frequent. Claims above $300,000 are becoming a source of concern, showing clearly that private plans are facing the same type of jumbo claims as the public plan, hence the need for pooling even for larger groups.

The Evolution of Prescription Drug Insurance in Quebec

At the time of this writing, the Act respecting prescription drug insurance has been in force for 25 years. During this period, the system has been criticized by various persons and by various groups. Some of the alleged criticisms are:

- The deductible and coinsurance prevent some of the poor from obtaining drugs that they need (this concern has been mostly dealt with in 2007);
- Private plans are not required to pay for some drugs that are covered under the RAMQ plan for certain exceptional conditions;
- The cost of the public plan is increasing in an uncontrollable manner (this is no longer true; however, to contain cost increases, the deductible increased sharply over time while the coinsurance borne by the insured increases almost every year);
- Risks may not be appropriately shared between the RAMQ and private insurers, as there is no pooling between RAMQ and the insurers;
- The pooling process may harm smaller insurers;
- The current system does not allow insurers to perform drug utilization review;
- The currents system does not foster more efficient care, as it does not provide for personal information to be shared between insurers and RAMQ and can act as a barrier to a centralized patient file;

- If everyone was in the same universal plan run by RAMQ, the Quebec government would have a stronger bargaining power with the pharmaceutical companies and could better control costs;
- The premium rate in the RAMQ plan is increasing too fast from a political point of view; (this is no longer the case);
- The RAMQ plan is making deficits (this is related to the Québec government subsidizing coverage for seniors);
- The high cost of prescription drug insurance in private plans is forcing certain associations to cancel their whole group accident, sickness and medical-dental plans.

All the above criticisms are subject to discussion and interpretation by the various parties involved in the coverage of prescription drugs.

Back in 1996, when the law was passed, strong representations from the insurance industry convinced the Quebec government to allow private group insurance plans to cover prescription drugs, rather than putting everyone in the RAMQ plan. The Quebec government considered the possibility of putting everyone in the RAMQ plan and set up a committee in 2001, chaired by Professor Claude Montmarquette, whose mandate was to formulate recommendations on the relevance and feasibility of a public universal prescription drug insurance program along with funding approaches to adopt in order to foster equity, economic efficiency and global management of the health care system.

In response to the Montmarquette report, the Quebec government took the following actions (or non-actions):

- The joint, private-public character of the current program has been maintained (recommendation # 1);
- The mandatory character of participation to the general program of prescription drug insurance has been maintained (recommendation # 2);
- The financial participation of the insured, by the means of premiums and of a financial contribution in the form of coinsurance has been maintained (recommendation # 3);
- Data exchange between RAMQ and the Ministry of Revenue has been facilitated in order to improve fairness in the financing of the plan (recommendation # 5);
- The criteria used to determine whether a drug must be included on the list of prescription drugs (recommendation # 6) were reviewed over time. The lowest-price approach now applies to all drugs paid by the public plan and the 15-year rule has been abolished.

The debate on expanding the public plan to cover all Quebec residents resurfaces from time to time. Lobby groups such as the “Union des Consommateurs” and the AREQ (Association of Retirees from the Education Sector) have been campaigning actively for the integration of private prescription drug insurance plan in the public plan run by the RAMQ. Their arguments include the following:

- Premiums charged by private plans are not equitable since they do not vary with income;
- Children are covered for free in the public plan but not in private plans;
- Private plans are subject to the 9% tax (not to mention the 3% and the 0.30% taxes paid by insurers);
- Pharmacists’ fees are much higher (up to $30) in private plans compared with something around $10.00 in the public plan;
- The Quebec government would have a huge bargaining power with the pharmaceuticals and generic companies if it were a single purchaser for all prescription drugs in the province.

On the other hand, having everyone in the RAMQ plan would deprive the system from the employers’ contributions that would have to be replaced with a payroll tax to which employers would be strongly opposed. Moreover, employers pay a varying share of the cost of their prescription insurance coverage, depending either on collective bargaining agreement or simply the mere generosity or lack of generosity

of the employers. Replacing their varying cost with a uniform payroll tax would penalize certain employers and benefit others. Also, the fact that employers compare payroll tax from one province to another when making business decisions could cause issues for the Quebec government.

The fact that employers end up paying a significant share of the cost of new expensive drugs that can drive up the cost of the system is beneficial to RAMQ. Finally, if prescription drugs were moved from private to the RAMQ plan, the Quebec government would lose all its tax revenues on the premiums for prescription drugs (9%, 3% and 0.30%).

The Future of Prescription Drug Insurance in Quebec

The fact that prescription drug insurance has been controlled by the Quebec government since 1997 is now well accepted and this approach has gained some appeal in the rest of Canada.

As the Hoskins report showed, there is pressure for a very generous universal public prescription drug insurance scheme. The Canadian Institute of Actuaries, in its Public Statement in February 2021 entitled ***Pharmacare: Is There a Pill for That?*** pointed out the need for further analysis and consideration of all issues, before making any decision. In fact, the Quebec approach is a very interesting case for studying how a whole population can be covered against the risk of needing unaffordable medication.

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