The Conference Board of Canada

Understanding the Gap 2.0

A Pan-Canadian Analysis of Prescription Drug Insurance Coverage

Data Briefing | July 13, 2022

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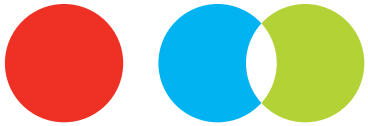


Key Findings

- We estimate that more than 36.8 million Canadians (or 97.2 per cent of the population) are eligible for some form of prescription drug coverage.
- This leaves a 2.8 per cent gap in prescription coverage, which is almost half the 5.2 per cent gap we estimated in 2016. This drop in the number of uninsured Canadians means 812,000 more Canadians were eligible for prescription drug coverage in 2020, compared with 2016.
- This boost in coverage is driven largely by the introduction of OHIP+, which provides prescription drug coverage to 1.3 million more children and youth under 25 years of age, compared with 2016.
- However, 1 million people living in Ontario and 56,960 living in Newfoundland and Labrador are not eligible for public drug coverage and therefore make up the uninsured population. In the case of high drug costs, these individuals may, however, become eligible for catastrophic drug coverage provided by their province.
- After accounting for private coverage, 3.8 million Canadians are not enrolled in a public or private plan for which they are eligible. This represents 10.1 per cent of the population, down slightly from 11.3 per cent in 2016.
- Despite widespread access to prescription drug coverage, some Canadians do not have sufficient access to medications. Key issues include public versus private differences in access to medications, delayed public access to new or innovative drugs, and out-of-pocket costs. These access issues can be addressed through targeted measures to fill the gaps.

The Gap in Prescription Drug Coverage Is Closing

In this updated analysis to The Conference Board of Canada's Understanding the Gap,[1] we estimate that 36.8 million Canadians (or 97.2 per cent of the population) are eligible for some form of prescription drug coverage across the country.

This coverage includes insurance offered through public prescription drug plans, private group plans, and private individual plans. The uninsured gap in coverage—defined as the number of people not eligible for a public plan and not enrolled in a private plan—is under 1.1 million people, or 2.8 per cent of the Canadian population. (See Table 1.)

Table 1
Most Canadians Are Eligible for Prescription Drug Coverage
(number of individuals; percentage of the population; 2020)

	Population	Eligible population – public	Enrolled population – private	Multiple eligibility	Eligible for insurance	Uninsured (ineligible for insurance)	Uninsured percentage of population
Canada	37,910,500	24,886,100	24,592,800	12,647,900	36,831,000	1,079,500	2.8
Newfoundland and Labrador	521,400	144,700	342,000	22,300	464,400	57,000	10.9
Nova Scotia	981,900	981,900	676,700	676,700	981,900		
Prince Edward Island	161,300	62,700	123,800	25,200	161,300		
New Brunswick	783,200	352,800	499,400	69,000	783,200		
Quebec	8,578,300	3,919,500	5,991,100	1,332,300	8,578,300		
Ontario	14,745,700	7,285,800	9,448,400	3,011,000	13,723,200	1,022,500	6.9
Manitoba	1,380,600	1,380,600	768,900	768,900	1,380,600		
Saskatchewan	1,179,300	1,179,300	715,900	715,900	1,179,300		
Alberta	4,420,000	4,420,000	2,767,900	2,767,900	4,420,000		
British Columbia	5,158,700	5,158,700	3,258,600	3,258,600	5,158,700		

Sources: Statistics Canada; Provincial Governments; Canadian Institute for Health Information; Canadian Life and Health Insurance Association of Canada; The Conference Board of Canada.

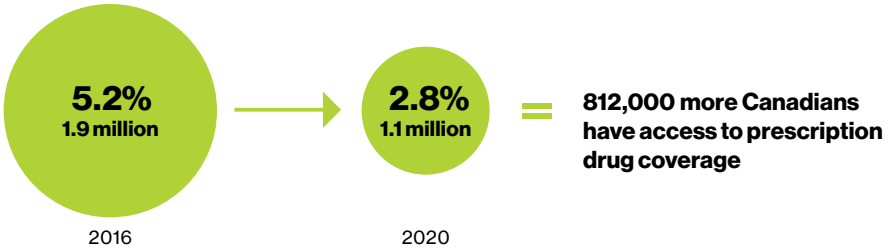
1 Dinh and Sutherland, *Understanding the Gap*.

The gap in prescription drug coverage was reduced by almost half between 2020 and 2016, when it stood at 1.9 million people, or 5.2 per cent of the population.[2] (See Exhibit 1.) This drop in the number of uninsured Canadians means 812,000 more people were eligible for prescription drug coverage in 2020, compared with 2016.

Exhibit 1

Large Drop in the Number of Uninsured Canadians

(percentage of the population; number of individuals)



Sources: Statistics Canada; Provincial Governments; Canadian Institute for Health Information; Canadian Life and Health Insurance Association of Canada; The Conference Board of Canada.

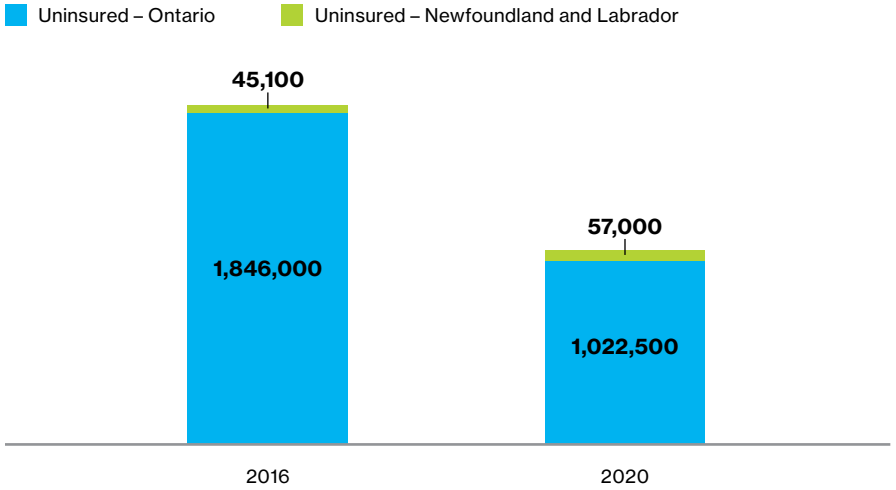
Two provinces—Ontario and Newfoundland and Labrador—contribute to the national gap in prescription drug coverage. (See Chart 1.) Of the 1.1 million uninsured Canadians, 94.7 per cent reside in Ontario, while the remaining 5.3 per cent reside in Newfoundland and Labrador. Although both provinces offer catastrophic drug coverage to help cover high drug costs incurred by some individuals (regardless of whether they are insured), a small proportion of the population in these provinces does not meet the plan's eligibility criteria and is considered uninsured. (See Appendix C.)

For the eight remaining provinces, public drug programs are designed to ensure widespread or universal eligibility as a complement or in addition to private drug coverage. (See Appendix D.)

Chart 1

Small Gap Remains in Ontario and Newfoundland and Labrador

(number of individuals)



Sources: Statistics Canada; Provincial Governments; Canadian Institute for Health Information; Canadian Life and Health Insurance Association of Canada; The Conference Board of Canada.

2 Ibid.

OHIP+ Drives Boost in Coverage

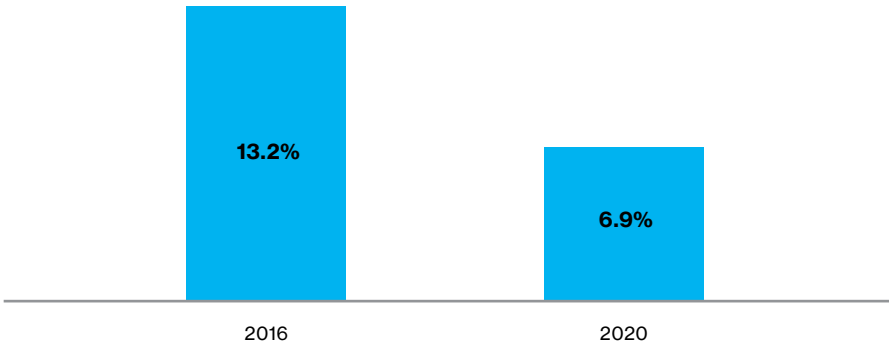
OHIP+ is a child and youth pharmacare program introduced in 2018. It provides prescription drug coverage to Ontarians under 25 years of age who are not covered under a private plan.[3] This new program significantly lowered the proportion of uninsured Ontarians from 13.2 per cent in 2016 to 6.9 per cent in 2020. (See Chart 2.) Compared with 2016, 1.7 million more Ontarians are now eligible for public drug coverage, including 1.3 million under the age of 25. The large boost in access driven by the introduction of OHIP+ helped close most of the gap in prescription drug coverage in Ontario and, by extension, nationally.

With many more young people now eligible for prescription drug coverage in Ontario, the age distribution of uninsured Canadians has shifted to the 25–64 age group. While those under 25 years of age made up the majority (67 per cent) of the uninsured population in 2016, this proportion has fallen to just 2 per cent in 2020. Almost all the remaining uninsured Canadians now are between the ages of 25 and 64. (See Chart 3.)

Chart 2

Number of Uninsured Ontarians Falls With the Introduction of OHIP+

(percentage of the Ontario population)

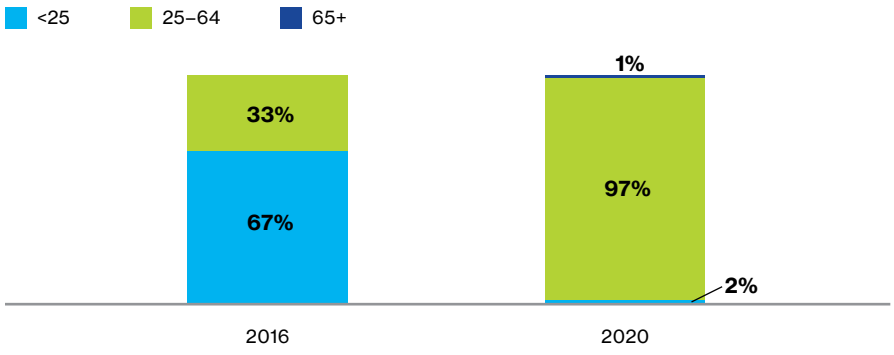


Sources: Statistics Canada; Government of Ontario; Canadian Life and Health Insurance Association of Canada; The Conference Board of Canada.

Chart 3

National Shift in Uninsurance to Older Age Groups

(age distribution as a percentage of the Canadian population)



Sources: Statistics Canada; Provincial Governments; Canadian Institute for Health Information; Canadian Life and Health Insurance Association of Canada; The Conference Board of Canada.

3 Government of Ontario, “Learn about OHIP+.”

One in 10 Canadians Remain Unenrolled

Automatic enrolment into OHIP+ for Ontarian youth helped boost national enrolment rates by one percentage point among those eligible for public drug coverage (from 59 per cent in 2016 to 60 per cent in 2020).[4] After accounting for private coverage, 3.8 million Canadians are eligible but not enrolled in a public or private plan. This number represents 10.1 per cent of the total population, down slightly from 11.3 per cent in 2016. (See Table 2.)

Non-enrolment rates vary greatly across the country, ranging from 3.2 per cent in Prince Edward Island to 28.2 per cent in Manitoba. Since 2016, non-enrolment has decreased in every province except British Columbia and New Brunswick. Several factors can drive non-enrolment in a public plan, including lack of awareness of public programs or eligibility criteria, lack of need (from a health status or financial perspective), unaffordable out-of-pocket costs, and existing coverage under a private drug plan.

Table 2
Non-enrolment Drops Slightly
(number of individuals; percentage of the population)

	2016		2020		
	Non-enrolled population – public or private	Non-enrolled as a percentage of the population	Non-enrolled population – public or private	Non-enrolled as a percentage of the population	Non-enrolled as a percentage of the population, 2020 vs. 2016
Canada	4,085,500	11.3	3,845,200	10.1	–1.2
Newfoundland and Labrador	42,200	8.0	40,900	7.9	–0.1
Nova Scotia	149,900	15.8	134,100	13.7	–2.1
Prince Edward Island	12,100	8.0	5,100	3.2	–4.9
New Brunswick	202,400	26.6	217,800	27.8	1.2
Quebec	–	–	–	–	–
Ontario	1,517,100	10.9	1,237,000	8.4	–2.5
Manitoba	387,700	29.0	389,000	28.2	–0.8
Saskatchewan	172,400	15.2	127,100	10.8	–4.5
Alberta	1,127,900	26.6	1,050,900	23.8	–2.8
British Columbia	474,400	10.0	643,100	12.5	2.5

Sources: Statistics Canada; Provincial Governments; Canadian Institute for Health Information; Canadian Life and Health Insurance Association of Canada; The Conference Board of Canada.

4 Enrolment for OHIP+ is automatic for anyone with a health card number and an eligible prescription.

The majority (62.0 per cent) of the 10.1 per cent of Canadians who are not enrolled in a program for which they are eligible are between the ages of 25 and 64, followed by individuals 25 years and under (27.3 per cent) and 65 and over (10.6 per cent). Between 2016 and 2020, the proportion of non-enrolled Canadians fell for individuals under 65 and rose slightly for those 65 and over. (See Table 3.)

The introduction of OHIP+ contributed to the 7.2 per cent reduction in the proportion of non-enrolled Canadians in the under-25 age group.

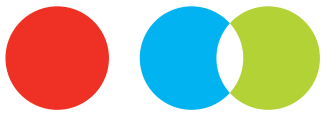
Table 3

Non-enrolment Down for Canadians Under 65 Years Old

(number of individuals; percentage of the population)

	2016		2020		
Age group	Non-enrolled population – public or private	Non-enrolled as a percentage of the population	Non-enrolled population – public or private	Non-enrolled as a percentage of the population	Non-enrolled as a percentage of the population, 2020 vs. 2016
<25	1,764,500	17.1	1,050,200	9.9	–7.2
25–64	1,990,900	10.0	2,385,600	11.6	1.6
65+	330,000	5.5	409,400	6.0	0.5
All ages	4,085,500	11.3	3,845,200	10.1	–1.2

Sources: Statistics Canada; Provincial Governments; Canadian Life and Health Insurance Association of Canada; The Conference Board of Canada.



Underinsurance and Access Issues

Despite widespread access to prescription drug coverage across the country, some Canadians may face barriers when trying to access the medications they need. Underinsurance issues can be related to which drugs are covered and how quickly they are covered (especially under public drug formularies), as well as how much is paid out of pocket by individuals. In general, these issues are more widespread in public plans compared with private plans.

Is Your Medication Covered?

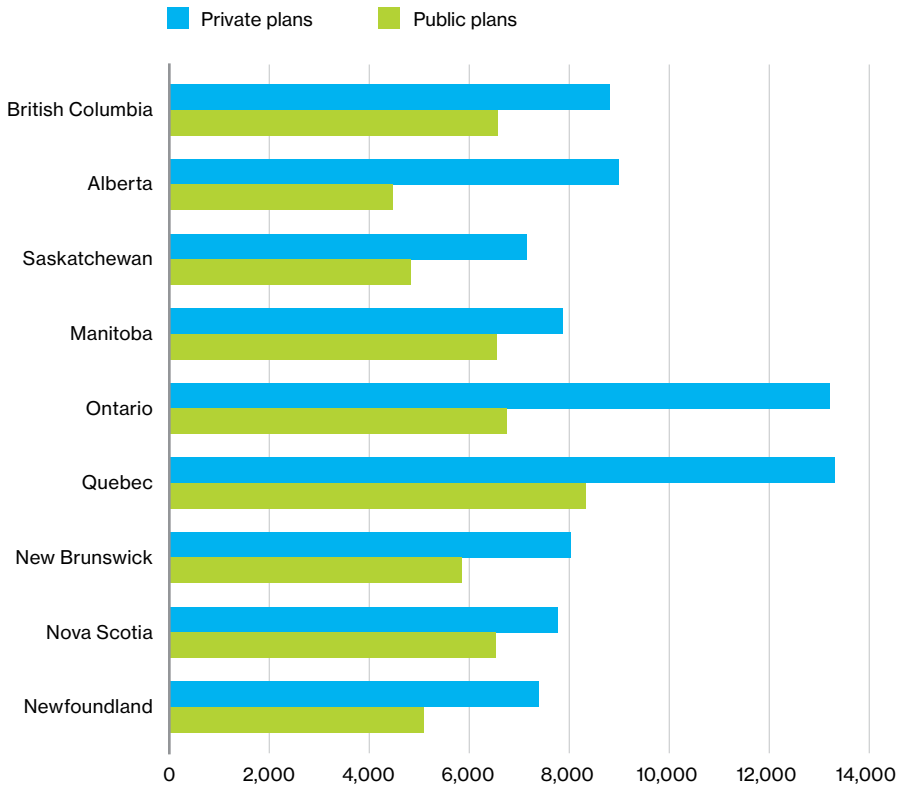
An analysis of drug claims data shows that the number of drug products (defined by unique drug identification numbers) reimbursed in full or in part varies among provinces as well as among primary payers (public or private).[5,6] Between 2018 and 2021, private plans reimbursed a greater number of drug products in every province, compared with public plans. (See Chart 4.) The difference ranges from 50 per cent in Alberta to 16 per cent in Nova Scotia.

In Ontario, a total of 6,313 drug products were reimbursed by both public and private drug plans between 2018 and 2021. In addition, the province's public drug programs (Ontario Drug Benefit program, OHIP+ and other smaller plans) reimbursed 435 other drugs, while private drug plans reimbursed an additional 6,907 drugs. (See Chart 5.) The net difference in drug products reimbursed by private plans as compared with public plans in Ontario stands at 6,472. The charts for the other provinces can be found in Appendix F.

Chart 4

Private Plans Cover More Drugs in Every Province, 2018–21

(number of unique drug products (DINs))



Notes: Analysis conducted by Innovative Medicines Canada (IMC) based on IQVIA's PharmaStat database. The number of unique drugs is defined as the number of unique drug identification numbers (DINs) reimbursed. P.E.I. public claims data not available.
Source: The Conference Board of Canada.

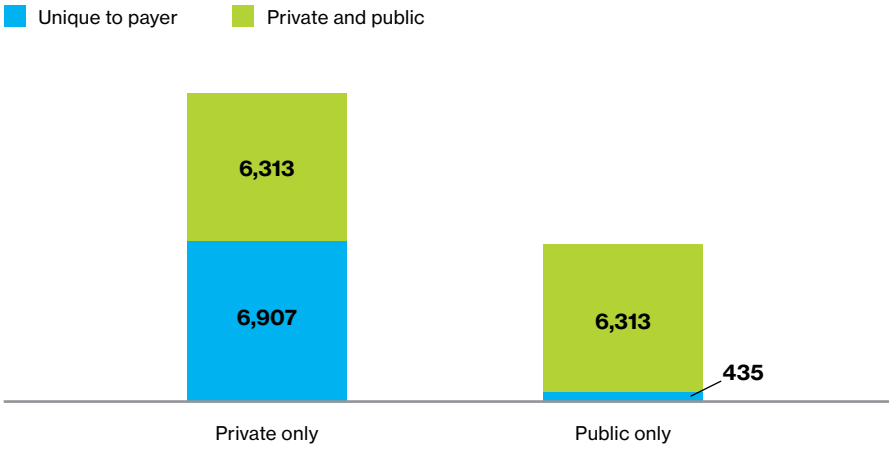
5 Innovative Medicines Canada, "Analysis of DINs by Province and Payer."

6 The primary payer is defined as the payer that reimbursed the majority (50 per cent or more) of the cost of a claim. Therefore, drug identification numbers (DINs) partially reimbursed by a second payer (and never assigned to that payer through other claims) would not be counted as covered by that second payer. Since private plans are usually first payer, the number of DINs reimbursed by public plans may be underestimated in this analysis.

Chart 5

Private Plans Reimbursed Twice as Many Drugs Compared With Public Plans in Ontario, 2018–21

(number of unique drug products (DINs))

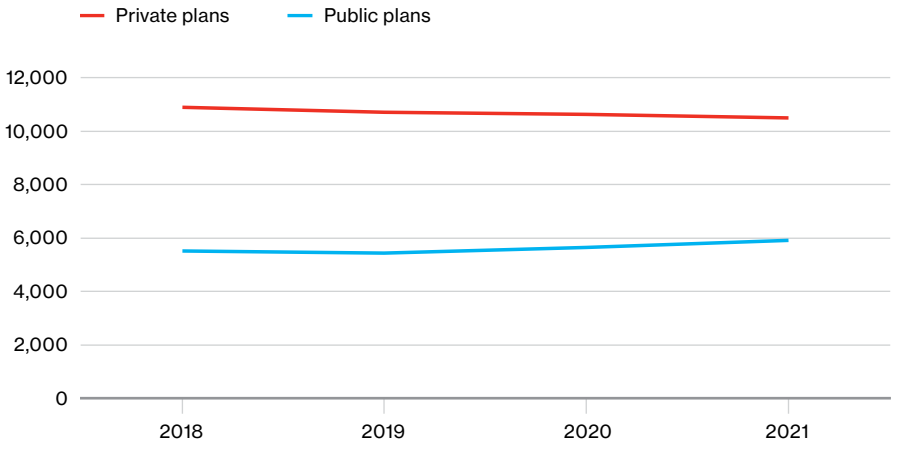


Notes: Analysis conducted by Innovative Medicines Canada based on IQVIA's PharmaStat database.
The count of unique drugs is defined as the number of unique drug identification numbers (DINs) reimbursed.
Source: The Conference Board of Canada.

Chart 6

Number of Drugs Reimbursed in Ontario Remained Stable Over Time

(number of unique drug products (DINs) by year)



Notes: Analysis conducted by Innovative Medicines Canada based on IQVIA's PharmaStat database.
The count of unique drugs is defined as the number of unique drug identification numbers (DINs) reimbursed.
Totals do not equal to previous charts since data is presented by year (instead of combined years).
Source: The Conference Board of Canada.

Between 2018 and 2021, the number of drug products reimbursed by public and private plans within each province remained fairly stable. For example, private plans in Ontario reimbursed 10,893 drugs in 2018, compared with 10,485 drugs in 2021 (a 4 per cent decrease). During the same period, the number of drug products reimbursed by public plans rose 6 per cent, from 5,524 to 5,904. (See Chart 6.)

The difference in access between public and private plans can have varying impacts on individuals and providers in terms of treatment options and realizing desired health outcomes. Factors include the specific medication and its cost, as well as availability and effectiveness of other drug options; the severity/particularities of the health issue and implications related to co-morbidities and allergies to specific active or other ingredients; the financial situation of the individual; and the provider's approach to shared decision-making in treatment options.

Access Delays

New prescription drugs take longer to be listed on provincial formularies for public coverage, as compared with reimbursement by private plans.[7] Canada ranks 18th out of 20 Organisation for Economic Co-operation and Development peer countries when it comes to the time between approval and public reimbursement.[8,9]

Delays can significantly affect individuals whose lives or well-being depend on timely access to innovative treatments. (See "Public Access to Medications Is Lagging.") A recent Conference Board of Canada study found that although Canada quickly approves breakthrough cancer treatments for use, complex price-payment negotiations have made the process to reimbursement slow and difficult to complete. As a result, doctors are seeing delayed access for patients who rely on provincial or territorial plans.[10] Given the delays, some patients must rely on manufacturer compassionate programs (also called patient support programs) to access drugs that would otherwise be unavailable to them.

Out-of-Pocket Costs

Out-of-pocket costs are another potential barrier to prescription drug access. For individuals insured by public programs, the costs can include premiums, annual fees, deductibles, and/or co-payments. Cost-sharing is also common in private plans through means such as co-insurance and annual or lifetime spending caps. (See "Cost-Sharing Mechanisms" and Appendix E.)

7 Van Mulligen, Moroz, and Leaver, *Tomorrow Can't Wait*.
8 Ibid.
9 Lussier Hoskyn, *Explaining Public Reimbursement Delays*.
10 Van Mulligen, Moroz, and Leaver, *Tomorrow Can't Wait*.

Public Access to Medications Is Lagging

The Example of Disease-Modifying Therapies for Multiple Sclerosis

Although not a cure for multiple sclerosis (MS), disease-modifying therapies (DMTs) are a type of medication that help reduce disease progression and debilitation. A Conference Board of Canada study found that a delay of 12 to 48 months can occur between when a DMT is approved by Health Canada and when it is listed on a provincial formulary for public coverage. Recently, these delays had an impact on reimbursement of two new DMTs: ocrelizumab and cladribine.

It took 19 months for ocrelizumab—the only drug approved by Health Canada for the treatment of both relapsing-remitting MS and primary progressive MS—to be included on provincial formularies after its introduction to market in September 2017. During this time, private drug plans in every province except Quebec initiated coverage. As a result, those covered under private drug plans had access to this medication much earlier than those covered publicly.

Source: Feng and others, *Accessing Disease-Modifying Therapies for Multiple Sclerosis: A Pan-Canadian Analysis*.

Cost-Sharing Mechanisms

Premium: A fixed amount paid (usually annually or monthly) by a plan member to be eligible for drug insurance coverage under a given plan. Premiums vary substantially by type of plan, province, and characteristics of enrollees.

Deductible: The amount that a beneficiary (i.e., an individual who makes a claim and is reimbursed) must pay out of pocket, either monthly or annually, toward prescriptions over a specific period before reimbursement coverage begins. After a deductible limit has been reached, the beneficiary becomes eligible to receive benefits (e.g., with no more or reduced payments, or with different kinds of payments) for prescription drugs. Deductibles vary substantially by type of plan, province, and characteristics of enrollees.

Fixed co-payment/co-insurance: A fixed cost that a beneficiary may be required to pay per prescription (e.g., $3 per prescription), or a system in which a beneficiary pays a percentage of the cost required to fill a prescription (e.g., 20 per cent per prescription). Both take place after deductible limits have been reached. The majority of plans require co-insurance, but the rates vary significantly across plans and characteristics of enrollees, from 5 per cent to 20 per cent or more.

Out-of-pocket spending limits: The total amount that a beneficiary is required to pay for a prescription (comprising deductibles, co-payments, co-insurance, and other out-of-pocket expenses), after which the insurer covers 100 per cent of prescription drug costs (occurs only in public plans). Not all plans have maximum out-of-pocket limits, and among those that do, the set limits vary.

Plan spending limits or caps: The total amount that a plan will cover for any given beneficiary over a year or a lifetime, after which the beneficiary must pay 100 per cent of prescription drug costs.

Source: The Conference Board of Canada.

Cost-sharing rules often vary by household income level and province, and sometimes within a province, depending on the specific drug plan. Therefore, usually not everyone covered under a public plan pays the same amount to access medications. Public plans offered by the Atlantic provinces generally have higher cost-sharing thresholds compared with the rest of the country. For example, a low-income person[11] insured through the New Brunswick Drug Plan who needs $5,000 worth of prescription drug coverage in a year would, in theory, need to pay $2,100 out of pocket for these drugs through premiums and co-payments. (See Table 4.)

This is a significant portion (almost half) of the actual drug costs. For someone with an average family income, the amount paid out of pocket would be $5,000, or equivalent to the full drug costs. In provinces such as Quebec and British Columbia, out-of-pocket costs are kept relatively low, even for higher-income families. In fact, British Columbia recently removed deductibles and other payments for low-income households (those earning less than $30,000 per year) and lowered deductibles for households earning between $30,000 and $45,000 per year. In 2019, this resulted in out-of-pocket costs being eliminated or reduced for 240,000 families living in British Columbia.[12]

Table 4

Estimated Out-of-Pocket Spending on Annual Prescription Drug Costs of $5,000, 2021

(C$)

	Low-income families ($30,000/year)	Average income families ($75,000/year)	High-income families ($150,000/year)
Newfoundland and Labrador	1,500	5,000	5,000
Nova Scotia	382	5,000	5,000
Prince Edward Island	1,500	5,000	5,000
New Brunswick	2,120	2,680	3,080
Quebec	0	1,792	1,792
Ontario	972	3,000	5,000
Manitoba	0	5,000	5,000
Saskatchewan	1,000	1,880	1,880
Alberta	1,433	1,662	1,662
British Columbia	300	1,050	1,950

Notes: Analysis conducted by Innovative Medicines Canada based on the Canadian Institute for Health Information's National Prescription Drug Utilization Information System: Plan Information Document, July 2021.
Source: The Conference Board of Canada.

11 Household income levels used in the analysis were low income ($30,000), average income ($75,000), and high income ($150,000).

12 Government of British Columbia, "$105-million investment to make prescription medications more affordable for families."

Likewise, the Conference Board of Canada study referenced in "Public Access to Medications Is Lagging" found that those living in some provinces paid more out of pocket than others to access drugs for multiple sclerosis.[13] It also illustrated that since public drug plans determine when and how medications can be used, these plans have a direct impact on which drugs are accessible and affordable for people living with MS. Generally, the older and more established disease-modifying therapies are approved as the initial (or first-line) treatment for MS. As such, patient access to more innovative and potentially more effective therapy is limited or comes at high out-of-pocket costs.[14]

Similar findings emerged from a 2016 survey of 28,091 Canadians on prescription drug affordability and associated impacts on healthcare utilization.[15] The study found that out-of-pocket costs are associated with forgoing prescription drugs. This phenomenon, known as cost-related nonadherence, came in the form of choosing not to fill or refill prescriptions, skipping doses, or reducing dosages. Furthermore, it led to additional use of healthcare services that would not have been needed otherwise for 24.1 per cent of patients who reported cost-related nonadherence.[16]

13 Feng and others, *Accessing Disease-Modifying Therapies for Multiple Sclerosis*.
14 Ibid.
15 Law and others, "The Consequences of Patient Charges."
16 Ibid.

Since out-of-pocket costs are a function of plan design and vary from one province to another, geographic location can be a barrier to equitable access to prescription medications and, by extension, the realization of optimal clinical and system-level outcomes.

This access issue and others can be addressed through targeted measures to fill the gaps, such as provincial-territorial (PT) programs or joint federal-PT agreements to improve affordable access to prescription drugs.[17]

17 Government of Canada, *Improving Affordable Access to Prescription Drugs*.

Appendix A

Methodology

The approach used to calculate the updated gap in prescription drug coverage in Canada is based on the methodology described in our 2017 report Understanding the Gap: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage. (See full methodology at pp. 85–90). The key concepts and data sources used in the analysis are described below.

For private coverage:

- Data on private coverage were provided by the Canadian Life and Health Insurance Association (CLHIA). We sourced the total number of people with extended health care coverage (EHC) by province in 2020 from the *Canadian Life & Health Insurance Facts, 2021 Edition*. We adjusted this total number to exclude those who do not have drug coverage through their extended health benefits, using the same "EHC with drug coverage/total EHC" ratio as the 2017 *Understanding the Gap* report.
- CLHIA also provided representative data (capturing approximately 70 per cent of their market) on the number of people with EHC by province, age group (<25, 25–64, 65+), and type of plan (group insured, group administrative services only [ASO], individual, drug only) as of March 1, 2020. To address the double-counting of individuals covered under separate benefits plans, we applied the duplication ratios by age and plan holder type (primary cardholder, spouse, dependent) used in the 2017 *Understanding the Gap* report to the 2020 data by age.
- After removing duplicates, we estimated the age distribution for each province and applied it to the total number of people with EHC drug coverage to get an estimate of private insurance enrolment by age, group, and province.

For eligibility of public programs:

- There may be overlap of eligibility across public programs. In these cases, it is essential to understand the program thoroughly and estimate the overlap accordingly, using the population distribution by age and claims data as constraints.
- For income support programs, eligibility is determined based on low-income estimates from Statistics Canada or social assistance data from the Canada Revenue Agency.
- For catastrophic programs, eligibility is measured by the proportion of households that spent more than an allotted percentage of income on prescription drugs, using the Survey of Household Spending data from Statistics Canada.

To determine multiple eligibility:

- For provinces where the entire population is eligible for public coverage (Nova Scotia, Manitoba, B.C.), or that have enough programs to cover everyone (Saskatchewan), or that have a program open to the entire population (Alberta), multiple eligibility is equal to the population with a private plan.
- For provinces where public programs target those without a private plan (P.E.I., Quebec, New Brunswick), there is little or no multiple eligibility.
- For the rest (Newfoundland and Labrador, Ontario), multiple eligibility is those eligible for a public plan and a private plan.

For enrolment in public programs:

- We scanned provincial report cards and annual reports published by provincial drug plans for data.
- For programs targeting specific medical conditions, enrolment is equal to the number of individuals who submit claims captured in CIHI's National Prescription Drug Utilization Information System (NPDUIS) dataset.
- For programs with automatic enrolment, enrolment is set to the population in that (age) group.
- For programs targeting residents without private coverage, enrolment is the corresponding population minus those with private insurance (as per CLHIA data).
- "Others" are defined as programs for which enrolment numbers cannot be estimated by the above methods and were therefore estimated based on plan usage (claims data) from CIHI's NPDUIS dataset.

Formulae for calculating the insurance gap in prescription drug coverage:

eligible for drug coverage = # eligible for public plan
+ # enrolled in a private plan
- multiple eligibility

uninsured = population - # eligible for drug coverage

non-enrolled = # eligible for public plan - # enrolled

private enrolment & non-enrolled public (see Understanding the Gap, pp. 89–90)

not enrolled in private or public plan = # uninsured + (# non-enrolled
- # private enrolment & non-enrolled public)

Limitations of the Analysis

While we made every effort to maximize the accuracy of the analysis and estimates produced, there were certain limitations in the data sources and assumptions. In the event of missing age-specific data on provincial drug plan eligibility or enrolment (especially for provinces with multiple or smaller drug programs), we sourced age and program ratios from the original 2017 report. The current analysis also leverages the same duplication ratios used in the original 2017 report. These ratios are used to estimate and remove double-counting of insured individuals in the following situations: between public drug programs/plans within a province, dual private coverage (as a primary cardholder and as a spouse or dependent), and between public and private coverage (multiple eligibility). While using the same duplication ratios helps ensure an "apples to apples" comparison with the 2017 results, these ratios may have changed over time. Further, the age distribution of private plan holders in the 2017 report was based on sample data from TELUS Health Solutions, while the current analysis uses sample data from CLHIA. Potential sampling differences between the two sources are therefore a limitation of this study.

Appendix B

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Download the following additional appendices and supplementary charts and tables of results:

Appendix C – Catastrophic Drug Coverage
Appendix D – Public Plans by Province
Appendix E – Out-of-Pocket Spending Rules
Appendix F – Supplementary Tables and Charts

Download appendix

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Isabelle Gagnon-Arpin, Wanlin Chen, and Chad Leaver

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