BIOTECanada

February 14, 2018

Karen Reynolds, Executive Director
Office of Pharmaceuticals Management Strategies
Strategic Policy Branch
Health Canada
Brooke Claxton Building, 10th Floor
70 Colombine Driveway, Tunney's Pasture
Ottawa, Ontario K1A 0K9

Re: BIOTECanada Response to Canada Gazette, Part I published December 2, 2017, Regulations Amending the Patented Medicines Regulations

Dear Ms. Reynolds,

I am writing regarding the **Regulations Amending the Patented Medicines Regulations** published in Canada Gazette, Part I on December 2, 2017 and the significant concerns the Canadian biotechnology innovation sector has regarding these proposed regulatory changes. Attached is a detailed comment table of the industry's feedback on the Regulatory Impact Analysis Statement (RIAS) and the proposed regulatory amendments.

The industry's principal areas of concern are:

- **Introduction of pharmacoeconomics as a primary price determination factor;**
- **Requirement to report confidential third party rebates; and**
- **Impact on Canadians' access to new medicines.**

BIOTECanada is the national trade association representing Canada's biotechnology industry. The 230 member companies of BIOTECanada are reflective of the broad and diverse Canadian biotech ecosystem which stretches across the country and includes: world-class universities and research institutes, Small and Medium Sized Enterprises (SME's), entrepreneurs and large multinational players, all of which are supported by a highly skilled and educated workforce. All told, the Canadian biotech ecosystem is an economic strength that positions Canada well to successfully compete in the emerging global bio-economy. Many Canadians are living longer, more productive and higher quality lives today because of biotechnology advances over the past 30 years. Regulatory policies that enable Canadians to access state of the art biotechnology treatments are necessary for stem cell, gene and cell therapies, immunooncology, CRISPR and new vaccines that hold the promise of cures for many more diseases.

The industry, as represented by BIOTECanada and the provincial life science associations[1], are very concerned that the government's analysis of the issue of pharmaceutical pricing and the solutions proposed in the draft regulations have not fully considered the real world impact on the industry, research and investment, and patient access to breakthrough therapies. Given the importance of fully understanding the impact of these proposed changes, the industry is requesting the government postpone their implementation until a complete assessment is undertaken and the impacts are fully understood. The industry understands

[1] Industry and Provincial Life Science Associations letter dated January 22,2018 appended

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the fiscal pressures facing the Canadian healthcare system and is prepared to bring solutions to the table to address the government's objectives on affordable healthcare. In this context, the industry appreciates and looks forward to contributing to the dialogue table that is expected to take place between senior levels of the Department of Innovation, Science and Economic Development (ISED), Health Canada and the biopharmaceutical industry

The Canadian market is increasingly becoming less competitive vis-a-vis other jurisdictions for biotechnology companies due to the uncertainty and absence of a holistic approach to modernization and transformational initiatives. Innovative manufacturers are simultaneously being faced with growing pressure on prices, a challenging reimbursement situation, increased costs of Health Canada reviews, uncertainty of improvements in performance standards and the regulatory drug review framework. Furthermore, transparency requirements (Bill C-17) are being proposed that go beyond those imposed by other major jurisdictions further negatively impacting the Canadian environment for innovation. Not only do the proposed PMPRB regulations intend to significantly lower price ceilings in Canada, they would also introduce a lengthy process for assessing price. Unlike today, where the regulations and guidelines provide certainty and usually allow patentees to predict the price ceiling prior to launch, under the new regulations, manufacturers may have to wait one to two years, or more, ***after*** bringing a drug to market to know the allowable price. This market uncertainty is likely to cause manufacturers to delay a launch in Canada pending greater clarity on the price. The cumulative effect of these regulatory changes is certain to force many companies to make difficult decisions regarding what new products they bring to Canada, and in what time frame.

Today, the major policy concerns raised by federal and provincial health ministers are about the "affordability, accessibility and appropriate use" of pharmaceuticals. These factors are interrelated. BIOTECanada has communicated that it is committed to working collaboratively with governments in support of these broad policy goals. The proposed amendments to the Patented Medicines Regulations attempt to address only one component of the broader policy issue; if addressed in isolation, there is the risk policy change in this area will produce unanticipated and negative impacts on patients and the other elements of the Canadian biotechnology ecosystem.

Health Canada asserts the proposed amendments will reduce costs and improve access to innovative medicines because governments will be able to use the savings realized to spend more on newer innovative therapies. This conclusion makes the unfounded assumption that companies will not alter commercial behaviour in the Canadian market after the changes are made and will continue to bring innovative medicines to Canada at the same pace as today. The cost benefit analysis provided in the RIAS is unable to provide any data to support this conclusion. Highlighted below are areas of particular concern:

First, it is imperative that Health Canada recognize and acknowledge the significant number of stakeholder submissions, many of which raised uncertainties and concerns with the regulatory amendments to the Patented Medicines Regulations. Virtually no changes to the proposed amendments were considered in the lead up to the Gazette proposal from previous responses to discussion papers and meetings where industry provided feedback. Meaningful consultation on the impacts these changes will have is necessary. Specifically, we are very concerned the risk assessment undertaken grossly underestimates the impact the changes will have on the ability of early stage Canadian biotech companies to attract the partners and investment they need to successfully commercialize innovation and become globally competitive Canadian-based companies. The small business impacts of these changes are dismissed in the cost benefit analysis but they are real and potentially impactful for small and start-up biotechnology companies. Our members are concerned that access to necessary venture capital and partnerships will become more difficult in the new pricing and market access environment in Canada if the regulations come into force.

Secondly, it is imperative Health Canada provide a complete, detailed and transparent disclosure of all of the calculations used in the cost benefit analysis. The industry's concerns arise in part from the RIAS which erroneously concluded: "It is not anticipated that these amendments would generate adverse impacts on industry employment or investment in the Canadian economy." Health Canada and PMPRB officials indicated that the RIAS impact assessment relating to industry investment refers to 'investment' as defined by the current PMPRB regulations; that is, only those investments eligible for SR&ED tax credits under the 1987 version of the Income Tax Act. The modern form of industry investment has changed materially over the past decade, and industry investment today is a complex model of partnership and/or direct investment. Rather than conducting all work in-house, multinational companies now invest in early stage companies to advance their innovation or partner with organizations such as Centre for Drug Research and Development (CDRD), NEOMED Institute, CQDM, MaRS Innovation to identify and develop the next wave of companies.

Third, a complete risk assessment of the proposed changes should be undertaken and the impacts fully understood, particularly about the following amendments:

Pharmacoeconomics

The proposed addition of pharmacoeconomics as a price determination factor is inconsistent with the PMPRB's mandate over excessive price. Pharmacoeconomics is an imprecise tool with ranges of results depending on the assumptions made and requirements of the drug plan; it is used by funders as only one factor to consider in negotiations on coverage. No jurisdiction in the world uses it as a precise measure of a regulated price and economists will say it is not appropriate to do so. Use of pharmacoeconomics by the PMPRB would also create a duplication of work done by CADTH, INESSS and the pCPA and will create greater uncertainty and potential conflict with existing mechanisms.

Confidential third party rebates

The industry is also concerned about the proposal to require patentees to file prices net of confidential third party rebates. Rebates are negotiated as part of a listing agreement that may incorporate a variety of factors of value to the drug plan; they are not reductions in the price at the time of sale, but rather are paid to insurers based on expenditures in a prior time period. Provincial laws require that they be confidential. The PMPRB proposes to calculate prices using the confidential rebates negotiated between manufacturers and larger public and private insurers. To our knowledge, this process is not used in any other jurisdiction and poses important business implications. It will significantly reduce the ability of a manufacturer to agree to a rebate and may threaten the very existence of rebate policies of FPT governments (according to the Council of the Federation, total rebates on brand name drugs totaled $1.28 billion in 2016-17). More impact analysis and consultation with all stakeholders is required on this proposal.

Access to medicines

The RIAS makes unsubstantiated assertions that the proposed regulatory changes will have no impact on access to medicines. If the Canadian market becomes significantly out of step with other jurisdictions, companies can be expected to alter their marketplace strategies. The proposed amendments by Health Canada are likely to have unintended consequences which should be thoroughly assessed before rushing to implement any new regulations.

Companies will be less likely to file submissions in Canada if their revenues are negatively impacted. This is particularly the case for innovative breakthrough therapies including first in class drugs and drugs for rare diseases. The PMPRB has already shared its plans to give highest priority for lower prices to these breakthroughs and impose a series of cumulative tests based on the new economic factors.

FPT health ministers have pledged to support improved access to drugs as well as improved affordability. The proposed PMPRB regulations will reduce patient access, especially to newer breakthrough therapies desperately needed by patients and the healthcare system.

It is requested that Health Canada re-assess the proposed regulatory amendments and conduct a more thorough analysis with industry of the intended and unintended consequences. A more detailed list of concerns and recommendations is attached.

In conclusion, the industry recognizes and supports the important role of Health Canada in regulating medicines for Canadians. Accordingly, the industry has indicated it is prepared to work collaboratively and constructively with the government on its health policy agendas. Ultimately, real and effective consultation and dialogue will be critical to the health, economic and social objectives that the government has identified.

Sincerely,

Andrew Casey
President & CEO

Enclosures

BIOTECanada

January 22, 2018

The Honourable Navdeep Bains, P.C., M.P.
Minister of Innovation, Science and Economic Development
Innovation, Science and Economic Development Canada
C.D. Howe Building
235 Queen Street
Ottawa ON K1A 0H5

Dear Minister,

On behalf of member companies and partners of the undersigned organizations, we are writing to express significant concerns the Canadian biotechnology innovation sector has regarding proposed changes to the Patented Medicine Prices Review Board's (PMPRB) regulations. Specifically, we are very concerned the risk assessment undertaken by the PMPRB grossly underestimates the impact the changes will have on the ability of early stage Canadian biotech companies to attract the partners and investment they need to successfully commercialize innovation and become globally competitive Canadian-based companies. Moreover, we are also of the view that the proposed changes will significantly undermine provincial innovation strategies. In this context, we are requesting the government postpone implementation of the proposed changes until a complete risk assessment of the proposed changes is undertaken and the impacts are fully understood.

Canada is home to a robust pan-Canadian ecosystem consisting of a network of strong biotechnology clusters in every province. Each cluster is a unique combination of early stage companies, entrepreneurs, research institutes, scientists, universities, hospitals and multinational pharmaceutical companies. Indeed, the membership of our respective organizations greatly reflect this strength and diversity. These clusters have supported the creation of hundreds of early stage biotechnology companies across the country all of which are striving to develop and deliver innovative solutions for the health challenges associated with global population growth and environmental change. Importantly, after a long and challenging period of early stage development, several early stage biotech companies are now poised to become commercial Canadian companies. But if Canada hopes to see these companies succeed and others follow suit, then it is imperative that public policy impacting the industry be developed with an understanding of the complex and interconnected relationships within the entire ecosystem. In this context, the proposed changes to the PMPRB mandate have been developed without proper consultation and are being rapidly implemented with an incomplete understanding of their impact.

The industry's concerns arise in part from the Regulatory Impact Analysis Statement (RIAS) issued with the draft regulatory changes which concluded: "It is not anticipated that these amendments would generate adverse impacts on industry employment or investment in the Canadian economy." During a December 13, 2017 briefing session for stakeholders, Health Canada and PMPRB officials indicated that the RIAS impact assessment relating to industry

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investment refers to 'investment' as defined by the current PMPRB regulations; that is, only those investments eligible for SR&ED tax credits under the 1987 version of the Income Tax Act. As you will be aware, the form of industry investment has changed materially over the past decade, and industry investment today is a complex model of partnership and/or direct investment. Rather than conducting all work in-house, multinational companies now invest in early stage companies to advance their innovation or partner with organizations such as Centre for Drug Research and Development (CDRD), NEOMED Institute, CQDM, MaRS Innovation to identify and develop the next wave of companies. Moreover, significant and important investments such as in JLABS in Toronto and clinical trials (Canada is presently one of the top global jurisdictions for clinical trials- an important source for new innovation) are also not captured in the PMPRB's 'SR&ED eligible expense' definition of investment. It is the new form of investment that must be assessed, not the model that existed when the PMPRB was created thirty years ago.

At the December 13 briefing session, officials stated that the changes to the PMPRB's mandate are necessary because government healthcare objectives, the industry, and the global marketplace have all changed significantly since the PMPRB was first established. Accordingly, the regulatory mandate for the PMPRB needed modernizing to enable it to effectively carry-out its mandate in this greatly altered environment. Given the scope of changes being proposed to modernize PMPRB, a corresponding modernization of the impact analysis should have also been undertaken. Although the RIAS and the proposed regulatory changes address the need to modernize many aspects of the PMPRB's mandate, they do not modernize the definition of eligible investments that PMPRB evaluates as R&D. At a minimum, given the stated objective of modernizing the PMPRB's mandate to equip it to operate in the twenty first century marketplace, the metrics it uses to measure the impact of its renewed mandate must also be modernized. In failing to do so, the RIAS analysis greatly underestimates the actual impact the changes will have on Canada's biotech ecosystem and its ability to support the commercialization of early-stage companies.

Canadian federal and provincial innovation strategies have all identified life sciences/health as a priority sector. Importantly, the various innovation strategies identify a key goal of developing Canadian innovation into globally competitive, Canadian-based commercial companies. A critical component to achieving this objective will be a healthy biotech ecosystem which depends heavily on the active support and engagement of the multinational pharma and biotech companies as partners, investors and adopters for early stage pre-commercial biotech companies and their innovations. It is important to note that most of the Canadian companies that have seen significant growth over recent years have one or more multinational pharma as an investor and/or partner. Similarly, industry discovery, incubator and accelerator organizations such as NEOMED Institute, CQDM, Accel-Rx, Centre for Drug Research and Development that are establishing the next wave of companies also depend heavily on the multinational companies as partners. In this context, we are very concerned that the PMPRB changes were developed with the sole objective of reducing costs with no effort made to understand how the significantly altered commercial environment resulting from the changes will necessitate a shift in the commercial and investment decisions of global companies. Ignoring this change in behaviour will greatly diminish Canada's ability to access innovative medicines and create new Canadian companies going forward.

The undersigned organizations and the hundreds of Canadian companies they represent are very concerned that the PMPRB changes as currently drafted will negatively impact the whole Canadian biotech ecosystem. We are of the very strong view that at a minimum, this impact needs to be fully assessed and understood before moving ahead with the proposed changes. Recognizing the important investment catalyst role multinational pharmaceutical and biotech companies must play in driving Canadian innovation forward, we strongly urge you, as the Minister responsible for innovation, to act immediately to postpone the implementation of the proposed PMPRB regulations until a proper and fulsome assessment of their impact can be conducted.

Sincerely,

Andrew Casey
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BIOTECanada

Mel Wong
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BioAlberta

Scott Moffitt
Managing Director
BioNova

Tracey Maconachie
President
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Regulations Amending the Patented Medicines Regulations Published in Canada Gazette Part I on December 2, 2017

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Date: 14-February-2018

Regulatory Impact Analysis Statement (RIAS)

Comment #	Section (RIAS)	Comment and Rationale	BIOTECanada Recommendation
1	General: Additive impact of Government of Canada policy and regulatory changes	Health Canada is proposing a number of regulatory changes that when taken together will have an additive impact on the industry, including changes to the Patented Medicines Regulations, cost recovery and transparency (Bill C-17) that will increase drug shortages and reliance on the Special Access Program (SAP). These initiatives may conflict with and undermine objectives/ initiatives of other key departments, including the Innovation Agenda and the recently announced Technology Science Education and Innovation partnership agreement with Switzerland.	Prior to proceeding further with the proposed regulations, Health Canada should take the time to consider the outcomes of the dialogue table that is expected to take place between the senior levels of the Department of Innovation, Science and Economic Development (ISED), Health Canada and the biopharmaceutical industry.

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2	Background: Patented medicines are an important part of Canada's health care system (p. 4499)	The pharmaceuticals market has changed significantly in the last 30 years. The industry has continued to bring forward innovative breakthrough therapies that are significantly improving health outcomes for Canadian patients. In many case, these innovations are reducing expenditures in other areas of the healthcare system.	The Regulatory Impact Analysis Statement (RIAS) should acknowledge the dramatic changes in drug discovery in the past three decades and the fact that new treatments often lower healthcare expenditures and improve health outcomes, allowing people to live longer and enjoy a higher quality of life.
		The statements contained in the RIAS do not account for the significant benefits new innovations bring to improved health outcomes. In past generations, innovative therapies to treat diseases such as HIV/AIDS, Hepatitis C, certain cancers and some rare diseases have remarkably changed the outcome of these fatal diseases to being treatable and in some cases to cures. Advances in vaccines have included the HPV vaccine, which has reduced the incidence of cervical cancer by 50% in the past decade.[1] Many Canadians are living longer, more productive and higher quality lives today because of drug therapy advances over the past 30 years.	The significant benefits new innovations bring to improved health outcomes are not captured by the traditional reporting mechanism used by the PMPRB. A modernized process of capturing these important investments is required to properly assess the impacts of the proposed amendments to the Patented Medicines Regulations.
		The RIAS refers to the increase in spending on drugs in the past 49 years, but fails to note the	The RIAS should acknowledge that according to the Canadian Institute for

[1] http://www.stuff.co.nz/world/australia/83779246/10-years-on-hpv-vaccine-halves-cervical-cancer-rates

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		increase to "about 16%" occurred prior to 2002. In fact, drug spending has remained relatively constant at "about 16%" of total health expenditures since then.	Health Information (CIHI) there has been no significant change in drug spending as a share of total health spending in the past 15 years.
3	Background: Canada's changing market and rising medicines costs (p. 4503)	The RIAS asserts that new medicine development is focussed more on "higher-cost medicines, such as biologics, genetic therapies targeted to smaller patient populations and medicines for rare diseases" and alleges a higher "risk" of excessive pricing as a result. It fails to acknowledge the substantial value such medicines bring in saving lives and improving quality of life. In this section and elsewhere, the RIAS treats spending on drugs as simply a cost without recognizing the value they bring to improve health outcomes. The RIAS also fails to acknowledge the substantial investments required to develop these breakthroughs. Investments by many smaller members of BIOTECanada and partnerships led by the multinational corporations are not captured by the traditional reporting mechanism used by the PMPRB as the industry's investments do not fit within the definitions of research and development (R&D) expenditures as set out in the Regulations developed in 1987. Those Regulations have failed to keep pace with the changing nature of drug discovery and research.	The RIAS should be amended to recognize medicines as an investment in the health of Canadians and not simply as a cost. Health Canada, in conjunction with ISED and other departments, should review the current definitions of R&D expenditures in the Regulations and consult with stakeholders on appropriate amendments.

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4	Background: Canada's changing market and rising medicines costs (p. 4503)	The government's proposals are supported in large part by claims about escalating drug costs in Canada. According to the CIHI, total drug expenditures in Canada have remained relatively flat as a share of total health spending for more than a decade. In 2014, prescribed drug spending represented 13.6% of health care spending, the same as in 2004 and 2005.[2] Of greater relevance, given that the PMPRB mandate is over manufacturer ***pricing*** of patented drugs and not total ***costs*** of all drugs (which includes utilization), the PMPRB has reported overall prices of patented drugs have been stable over the past two decades, with annual average changes ranging between minus 2.2% and plus 0.7%. Relative to the countries in the current foreign basket, Canadian prices declined to their lowest level, 25% **below** the international median on average, in 2016.[3]	The Regulatory proposals should acknowledge that in 2014, prescribed drug spending represented 13.6% of health care spending, the same as in 2004 and 2005. Canadian prices declined to their lowest level, 25% **below** the international median on average, in 2016.
5	Confidential price adjustments (p. 4503)	The RIAS fails to identify why the existence of confidential price adjustments is an issue. Under the Patent Act, the PMPRB reviews the manufacturer's ex-factory price to ensure it is not	For reasons discussed below, the Proposed Regulations should not require reporting of confidential third party rebates.

[2] CIHI, National Health Expenditures, Data Tables, G.14.3 Expenditure on Drugs by Type as a Share of Public, Private and Total Health Expenditures, by Source of Finance, Canada, 1985 to 2016, https://www.cihi.ca/en/national-health-expenditure-trends

[3] PMPRB, 2016 Annual Report. It is significant that while prices for patented drugs remain stable, prices for some non-patented drugs have not. According to the PMPRB, prices to public drug plans for new non-patented drugs, which do not fall under PMPRB jurisdiction, rose 18% over the period 2009-10 to 2015-16. Canadian prices for generic drugs remain high compared to other countries. See PMPRB, NPDUIS CompassRx, 3rd Edition, http://www.pmprb-cepmb.gc.ca/view.asp?ccid=1314&lang=en

		excessive. Why then would the availability of lower prices or benefits be a problem? The PMPRB should only be concerned about excessive prices, not whether prices fall below the excessive threshold. There are many potential discounts and other benefits, such as prompt payment discounts, volume discounts, patient support programs and more that may be calculated in the average price.	
6	Limitations of current price regulation (p. 4504)	The RIAS states that over the past 20 years, many countries are relying less on international price comparisons in favour of assessing the economic value of a new medicine. But it fails to acknowledge that Canada is one of these countries. Over the past two decades, Canadian public and private payers have developed sophisticated and robust systems for health technology assessment, including the Common Drug Review (CDR) and pan-Canadian Oncology Drug Review (pCODR) programs of CADTH and the pan-Canadian Pharmaceutical Alliance (pCPA) which negotiates listing and coverage decisions on behalf of all public drug plans. Health Canada participates in these programs and is the major funder of CADTH. These programs are designed to address issues related to value assessment, cost-effectiveness, budget impact, etc. The failure of the RIAS to acknowledge the important part FPT	Health Canada should consult further with FPT drug programs and agencies and assess the need for drug pricing reform in a holistic context rather than the siloed approach of looking only at the PMPRB. No changes to the Regulations should proceed without a thorough consideration and consultation on the impact of existing FPT programs on drug prices in Canada and the potential impact of PMPRB reform on those programs.

		programs play in managing drug prices and costs is a serious gap. The RIAS also fails to acknowledge the effectiveness of the current framework. Based on the statutory factor in ss. 85(1)(b), "the prices at which other medicines in the same therapeutic class have been sold in the relevant market,", the PMPRB has adopted guidelines that limit the price of almost all new drugs to the highest price in the class. Although this is a significant limitation, and patentees often disagree with the PMPRB's staff assessment, the industry has overwhelmingly followed the guidelines and complied. This factor along with the others has contributed to the decline of Canadian prices relative to other countries.	
7	Schedule of comparator counties (p. 4504)	BIOTECanada recognizes it may be appropriate to review the basket of countries as this has not been done in 30 years. The industry also agrees with the approach of starting by identifying the criteria to select the countries. Those criteria should be aligned with Canadian policy goals. The proposed amendment of eliminating the United States and Switzerland from the basket of comparator countries may undermine objectives/ initiatives of other key departments such as the	The PMPRB is created under the *Patent Act*, an important element of Canada's IP policy. The regulations governing the PMPRB should reflect it is part of Canada's policies to support innovation; they should also reflect major policy objectives such as Canada's Innovation Strategy, which has highlighted health and bio-sciences as one of six key components.

		Innovation Agenda, the renegotiation of NAFTA, and the recently announced Technology Science Education and Innovation partnership agreement with Switzerland.	As supported in our submission in June 2016, in reviewing the PMPRB basket of countries, BIOTECanada recommends the government modify the selection criteria to add the following: a) Policies to promote and improve health outcomes; b) Trading relationship with Canada through established agreements such as NAFTA and CETA; and c) Geographic proximity; d) Globally competitive innovation policies.
8	Issues: Limitations of current framework (pp. 4505-06) - Value - Market size - Wealth of country - Basket of comparators	The limitations outlined in the RIAS are addressed by other parts of the market access system in Canada. There are already mechanisms in place to determine value and negotiate with payers regarding price and volume. The proposed economic price determination factors will risk overlap and duplication of activities already performed by FPT governments, CADTH and INESSS. Furthermore, they are likely to disrupt provincial policies to extract maximum value in drug coverage decisions based on local circumstances and needs.	Health Canada should reassess the issues with the current PMPRB framework in the context of the Canadian FPT pricing and reimbursement system and not simply the PMPRB's role in it.

9	Issues Limitations of current framework - Value - Market size - Wealth of country Basket of comparators	The use of HTA and, in particular, a cost-per-QALY threshold is particularly inappropriate for drugs for rare and ultra-rare diseases. It is well established the prevailing methodologies used in pharmacoeconomic evaluations do not adequately address drugs for small patient populations. Because of the small number of patients involved, development of drugs for rare diseases is much more expensive on a cost-per-patient basis and the quality of evidence generated is not as complete. For this reason, most countries, except Canada, have adopted orphan drug policies to incentivize research and development in this area. Because traditional pharmacoeconomic models are based on assessing drugs intended for a large patient population, many countries, and some Canadian provinces, use separate review and funding mechanisms for drugs for rare diseases.	In addition to saving lives and improving quality of life, effective treatments for rare diseases can reduce indirect costs and societal burden. Standard pharmacoeconomic analysis does not take all these factors into consideration. The pharmacoeconomics factor should be removed from the proposed list of price determination factors as it is not appropriate to the PMPRB's excessive price mandate.
10	Objectives (p.4506)	The PMPRB program has been shown to be effective in fulfilling its statutory mandate, in particular when it has not sought to duplicate or interfere with the responsibilities and decisions of drug plans; and it has applied clear guidelines based on the statutory factors with a high rate of voluntary compliance by the pharmaceutical	The Proposed Regulations should be delayed until there has been further consultation and broader consideration of the PMPRB program as a whole and its impact on other government policies, including encouraging a viable biotechnology ecosystem.

		industry.	
		The proposed regulations are intended to "lead to lower prices for patented medicines in Canada" but the only rationale provided is the novel comparison with the median of patented drug prices in all OECD countries – Canadian policy has never sought to align with the OECD median in the past. This objective does not account for or address the impact of the proposals on other relevant elements such as health system benefits; patient access to new technologies and impact on the research-based industry in Canada.	The government should assess the appropriateness of the median of OECD countries as an aspirational target in health care.
		Although the RIAS and the proposed regulatory changes address the excessive price component of the PMPRB's mandate, they do not modernize the definition of eligible investments that PMPRB evaluates as R&D. At a minimum, given the stated objective of modernizing the PMPRB's mandate to equip it to operate in the twenty-first century marketplace, the metrics it uses to measure the impact of its renewed mandate must also be modernized. In failing to do so, the RIAS analysis greatly underestimates the actual impact the changes will have on Canada's biotech ecosystem and its ability to support the commercialization of early-stage companies.	The government has long been aware of the weaknesses in the current PMPRB definitions of R&D including the fact that they do not capture basic research spending by many Canadian and global members of BIOTECanada that do not yet market patented products. They do not capture major programs in today's R&D environment such as JLABs which foster and supports the emerging research-based companies. These investments are all at risk in a new environment that substantially lowers potential revenue streams and business certainty in Canada.

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			The investments and partnerships led by the multinational corporations are not captured by the traditional reporting mechanism used by the PMPRB as the industry's investments do not fit within the metrics developed in 1987. A modernized process of capturing these important investments is required to properly assess the impacts of these proposed amendments to patented medicine regulations
1.Introduce new economic-based price factors that would ensure prices reflect value and Canada's willingness and ability to pay for patented medicines:			
11	Pharmacoeconomic value of the medicine in Canada (p. 4508)	This provision has been proposed to require the PMPRB to consider cost-effectiveness in assessing excessive price. The PMPRB's Scoping Paper states how broadly the PMPRB proposes to interpret this factor: • PMPRB will assess the cost-per-QALY "against an explicit cost effectiveness threshold. The threshold would be based on the opportunity costs associated with displacing the least cost effective health technology in the Canadian health system..."	The "pharmacoeconomic" factor should be removed from the list of potential new price determination factors.

		The concept of "value" is not consistent with the statutory standard of "excessive." "Value" is a subjective assessment that varies according to the individual's needs, preferences and trade-offs among a variety of factors. To establish a maximum non-excessive price requires a precise calculation which is not possible in the case of pharmacoeconomics because it is not a precise science. Assessments are based on a multitude of assumptions and are dependent on the perspective employed. This proposed requirement would create a large additional regulatory burden for the PMPRB and manufacturers. In Canada, pharmacoeconomic assessments by CADTH and INESSS are conducted in the specific context of the participating public drug programs; assessments for private payers may differ, as they must be tailored to the perspective and needs of the plan sponsor. For example, a private payer may put more value on the impact of the drug in allowing a patient to return to work faster and less value on the savings that might be achieved in physician services and hospital stays. This is highly problematic for the reasons described above. It would also be unprecedented.	

		Information on cost-per-QALY is only used as input into subsequent negotiation on price and conditions for coverage. No country has attempted to use a fixed cost-per-QALY to establish a regulated maximum price. On the contrary, some countries (US, Germany and Spain) have banned the use of ICERs thresholds on the basis that this approach is too subjective and neither methodologically nor ethically robust. The use of HTA and, in particular, a cost-per-QALY threshold is particularly inappropriate for drugs for rare and ultra-rare diseases. It is well established the prevailing methodologies used in pharmacoeconomic evaluations do not adequately address drugs for small patient populations.	
12	Size of market for the sale of the medicine in Canada and in countries other than Canada (p. 4508)	This factor is proposed to allow the PMPRB to set different maximum non-excessive prices based on the anticipated volume of sales of the medicine. The RIAS has not provided any explanation or underpinning why market size relates to whether a price is "excessive." Payers currently take into account the expected expenditures in negotiating listing conditions for a new drug. They do so not because a price will be excessive based on total expenditures but	The "size of the market" factor should be removed from list of potential new price determination factors. All public drug programs and most private payers in Canada require information on the budget impact of new listings and take it into consideration in negotiating price and deciding on coverage. Consideration of budget impact by the PMPRB would unnecessarily overlap, produce delays and

		because they need to assess the listing of the product in terms of their budget capacity and to predict budgetary expenditures over time. Sometimes, payers negotiate risk-sharing agreements whereby manufacturers offer to subsidize expenditures if they exceed a predicted threshold. These assessments are developed for payers reflecting the requirements of the circumstances, e.g., for use in a limited population on specific criteria. A requirement to develop a model for PMPRB purposes to estimate the "uptake of the medicine, by indication, without restraint on utilization" for all relevant markets in Canada would be unnecessary to assess "excessive" price and unreasonable. It is also not consistent with market reality. Few new drugs are accessible in the market "without restraint on utilization;" most recommendations from CADTH and INESSS propose coverage be limited to circumstances narrower than those authorized by Health Canada's Notice of Compliance.	duplicate work. The potential size of the market and changes over time are not relevant in determining if a price is excessive for purposes of the Patent Act.
13	GDP in Canada and GDP per Capita	The RIAS proposes that the PMPRB would consider GDP per capita in assessing Canadians' willingness and ability-to-pay for a medicine.	The "GDP in Canada and GDP per capita" factor should be removed from list of potential new price determination factors.

		Willingness and ability-to-pay are highly variable and subjective factors as they are based on the payer's financial circumstances and needs. The pCPA record demonstrates it does a good job of assessing ability to pay and value for purposes of public drug plans. There are 57 drug products for which the pCPA has decided **not to negotiate** collectively or individually at the provincial and territorial level (private insurers do not typically publish information on their decisions not to cover treatments due to cost.).[4] There is no stronger evidence that ability and willingness to pay are adequately being addressed in the market. Duplication of that effort by the PMPRB will serve no added value but may create delays and market uncertainty. There is no apparent value in asking the PMPRB to make price assessments based on GDP. Payers take their own financial capacity and the anticipated value of a product in meeting their health needs into consideration in negotiating price and coverage for drugs.	Canada's GDP and relative economic strength are not appropriate in regulating a maximum non-excessive price of a unique product. They are currently applied in drug coverage decisions which is the appropriate place for such considerations. Canada's GDP and GDP per capita are relevant factors to consider in selecting appropriate countries for price comparisons.

[4] http://www.canadaspremiers.ca/pan-canadian-pharmaceutical-alliance/

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2. Update the schedule of countries used by the PMPRB for international price comparisons to be better aligned with the PMPRB's consumer protection mandate and median OECD prices.			
14	Update the basket of countries	The RIAS proposes a new Schedule of Countries for PMPRB comparison purposes based on the following criteria: • Pricing policies aligned with the PMPRB's consumer protection mandate; • Reasonably comparable economic wealth as Canada as measured by GDP per capita; and • Similar medicine market size characteristics. In BIOTECanada's submission to the Minister in June 2017, we had proposed different criteria; the RIAS has failed to acknowledge these proposals nor explain why they were rejected. Furthermore, we are advised that the PMPRB has completed a detailed report on the evaluation of the basket of countries using Health Canada's criteria, but that report has not been made public. The selection of appropriate criteria, and their application to select countries is a complex matter. The consultation paper does not provide any information on how the proposed criteria were applied to result in the proposed list. The industry also questions the added regulatory	The Proposed changes to the Schedule of Countries Regulations should be delayed until there has been further consultation. Health Canada should release its assessments and those of the PMPRB on how the proposed criteria were selected and how they were applied in developing the proposed Schedule. In reviewing the PMPRB basket of countries, BIOTECanada recommends the government modify the selection criteria to add the following: a) Policies to promote and improve health outcomes; b) Trading relationship with Canada through established agreements such as NAFTA and CETA; and c) Geographic proximity; d) Globally competitive innovation policies.

		burden an expanded basket will impose in light of Health Canada and government-wide objectives to reduce regulatory burden.	
3. Reduce reporting obligations for patented veterinary, over the counter and "generic" medicines			
15	Reduce Reporting obligations for patented veterinary, over the counter and generic medicines	BIOTECanada agrees with the objective of "an increased PMPRB focus on drugs that are at greatest risk of excessive pricing due to the degree of market power held by the patentee." The corollary is there should be less focus on drugs that do not have a high degree of market power. The proposal only goes part way. There are many multisource drugs, patented and non-patented, subject to marketplace competition and without benefit of market exclusivity or a high degree of market power. The circumstances for these drugs are the same as for patented generic drugs.	The industry recommends that the proposal to reduce the regulatory burden for patented generic drugs should be extended to all multisource drugs. In addition, the regulatory burden should be reduced for those products that are purchased through tendering and price negotiation such as vaccines and blood products.
4. Set out the patentee pricing information reporting requirements to enable the PMPRB to operationalise the new pricing factors			
16	Pharmacoeconomic value- requirement to provide "every cost-utility analysis prepared	This reporting requirement is intended to support the proposed new "pharmacoeconomic value" price determination factor.	The proposed filing requirement should be withdrawn as the information to be filed is already in the public domain and available to the PMPRB.

	by a publicly funded Canadian organization, if published, for which the outcomes are expressed as the cost per quality-adjusted life year for each indication that it the subject of the analysis."	As these analyses are by definition, already in the public domain, the reporting requirement introduces duplication and unnecessary regulatory burden particularly for small and medium sizes companies looking to enter the Canadian market.	
17	Market size	The proposed regulations would require patentees to file "the estimated maximum use of the medicine in Canada, by quantity of the medicine in final dosage form, for each dosage form and strength that are expected to be sold." – in support of the proposed "size of the market" price determination factor. The information is to be filed within 30 days of first sale and updated on an ongoing basis. The RIAS fails to acknowledge that the current regulations require patentees to report detailed sales and price information every six months; this information is relevant in assessing if they have charged an excessive price and potential excess revenues. Forecast sales are not.	The proposed filing requirement should be withdrawn as the information is not relevant in a determination of excessive price and would create an unnecessary regulatory burden; actual price and sales information is already reported to the PMPRB on a regular basis.

		This requirement will impose a huge regulatory burden on patentees and is inconsistent with government objectives to reduce regulatory burden. Especially in the early years after a new medicine is launched, forecasts will change frequently depending on the outcome of reviews and negotiations with payers, including the pCPA, and on changing market conditions, including the entry of new medicines in the class. The purpose of this reporting requirement is unclear at best; in the industry's view, the market size factor is not a relevant factor in assessing excessive price. Sales and expenditure estimates are sometimes developed for payers reflecting the requirements of the circumstances, e.g., for use in a limited population or specific criteria. These estimates are relevant to a payer in determining if it will fund a drug and may be even be subject of negotiation. A requirement to develop a separate model for PMPRB purposes to estimate the "uptake of the medicine, by indication, without restraint on utilization" for all relevant markets in Canada would be unnecessary to assess "excessive" price and unreasonable.	
5. Require patentees to report price and revenue, net of all price adjustments			

18	Reporting third party rebates	The proposed regulations would require patentees to include any price adjustments made to persons who purchase or reimburse drugs, directly or indirectly. The RIAS specifies that the proposal will require patentees to include any confidential rebates paid to public and private drug plans. On its face, this proposal is counterintuitive if the objective is to lower drug prices. However, the RIAS clarifies that the objective is to allow the PMPRB to calculate a lower price for existing drugs so it can then set an even lower price for new entrants to the market. In other words, the PMPRB would set a lower maximum price for a new drug using information that could not possibly be known to the new entrant. Among other things, such a practice will jeopardize the confidentiality of existing rebate agreements, which are often mandated by provincial law. This proposal carries several obvious risks. First, by reducing the confidentiality of rebates in the system, it will risk reducing the willingness of parties to enter new agreements, or at least to offer the same level of rebates currently available. Second, by using the information to establish lower benchmarks for new drugs, it will significantly reduce the negotiating room for	Before proceeding with the proposal to require patentees to report third-party rebates to PMPRB, Health Canada should conduct and make public a thorough analysis of the likely impact of the change on the existing Product Listing Agreement framework used by the pCPA and private payers. Because this proposal also raises legal questions in light of provincial legislation that requires the rebates be confidential and the previous Federal Court consideration of the issue, Health Canada should also make public the legal opinions it has received.

		rebates in future. The proposal appears to be intended to reduce or eliminate any net differences in final amounts paid by different customers and insurers in the market. By so doing, it threatens to undermine the objective of the Council of the Federation in establishing the pCPA – to take advantage of their combined "buying power" to extract lower prices. In 2016-17, the pCPA, which includes Health Canada, reported total rebates of $1.28 billion.	
19	Regulatory and non-regulatory options considered Status quo	The PMPRB has been successful in fulfilling its mandate to regulate the prices of patented medicines in Canada. The evidence as reported annually by the PMPRB shows the Canadian marketplace, including the PMPRB, CADTH, pCPA, private insurers and market competition have constrained price increases for patented drugs and overall spending on prescription drugs. Indeed, since 1992, prices for patented medicines have not increased by more than inflation. In fact, prices have essentially not increased at all over that time, a span of almost twenty-five years. Canadian prices for patented drugs on average have fallen to 25% below the median pries in the comparator countries. Total drug spending has been consistently in the range of 16% of total	The government and the PMPRB should provide evidence to support the claim that the current legislation and regulations are inadequate to fulfill the PMPRB's mandate to protect Canadians from excessive prices for patented medicines.

		health expenditures for the past 15 years. A need for reform has not been established. The PMPRB and Health Canada have not identified a single example where the existing powers of the PMPRB have been inadequate to address a case of excessive pricing. In September 2017, the PMPRB completed a hearing and ordered a price reduction of about 20% in the price of a drug; in the 16 months January 2016 to May 2017 it collected over $36 million in "excess revenues" from patentees.	
	Non-regulatory modernization	The RIAS has not identified if PMPRB has sought to make some of the changes it seeks under the existing Regulations. For example, its Scoping Paper proposes how it will now seek to "re-benchmark" prices of existing drugs; the PMPRB currently has the ability to re-benchmark and has frequently consulted stakeholders on this topic in the past – it does not need new regulations to do it. Similarly, it could change its rules and procedures regarding the use of international price comparisons; if it does not have confidence in the US price information it uses now, it could redefine it (it has done so in the past). The RIAS provides no evidence that the government or PMPRB have made any effort to	

		consider changes in its operations to achieve the goals it seeks other than the proposed regulations.	
	Benefit and Costs	The Cost Benefit Analysis (CBA) is seriously flawed. Other studies show the CBA underestimates the negative impacts of the proposed regulations and overestimates the positive impacts.[5] In addition, the CBA does not address the potential costs and benefits to the "consumers," i.e., FPT drug plans, private insurers, and cash-paying customers. As described elsewhere, FPT drug plans currently receive significant benefits ($1.28 billion in 2016-17) from joint negotiations; the PMPRB proposals place this benefit at serious risk. Private insurers also benefit from confidential agreements, but the extent is not known. However, the lower prices to insurers will lower the drug cost component of benefit plans they sell. There is no requirement that insurers pass on any savings to plan sponsors in the form of improved drug	Health Canada should revise the CBA taking into account expert studies and analysis.[5] Health Canada should release the data and detailed assumptions used to develop the cost benefit statement table.

[5] PDCI, "Proposed Amendments to the Patented medicines Regulations: A Critical Appraisal of the Cost Benefit Analysis" (January 2018) http://www.pdci.ca/wp-content/uploads/2018/01/20180129_PDCI-Critical-Assessment-PM-Regs-Amendments_Report-Final.pdf

		coverage or lower premiums. It is estimated that there are a small number of cash-paying customers in Canada. The Conference Board of Canada estimates that 1.8% of Canadians are uninsured as of January 2018.[6] PMPRB changes will do little to assist them; to the extent they experience affordability challenges in obtaining prescription drugs, the more appropriate response is to address the gaps in appropriate coverage.	
20	Cost – Industry Administrative burden Lost revenue to the medicine industry Lost revenues to the	The RIAS vastly underestimates the cost the proposals will have on industry. Health Canada did not consult with industry in developing its estimates of current administrative costs and projected increases due to the proposed regulations. Other analysis has concluded that a more accurate estimate is total costs of 100 times the Health Canada estimate.[5] The administrative burden reduction for the patented generic sector does not apply to members of BIOTECanada. The CBA has estimated lost revenues to industry of	The CBA should be revised to more accurately estimate administrative burden and lost revenues to the patented medicines industry.

[6] Conference Board of Canada, Understanding the Gap: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage, http://innovativemedicines.ca/wp-content/uploads/2017/12/20170712-understanding-the-gap.pdf

	medicine industry	$8.6 billion (PV) over 10 years, but the sensitivity analysis shows a potential range of $6.4 billion to $24.9 billion (PV) demonstrating the extreme variability of the assumptions made. Analysis by external experts finds that the total lost revenues to industry will be over $26 billion (PV) over the 10 year period.[5] In addition, it is anticipated there will additional revenue losses due to the volume of business uncertainty caused by the proposed changes.	
21	Cost -Government of Canada Increasing PMPRB 's capacity Increasing special purpose allotment funding	The RIAS anticipates additional budget requirements for PMPRB to administer the new regulations. Because of the uncertainty surrounding the impact of the proposals, it is likely that costs will exceed the projected $5.7 million per year after the fifth year. The PMPRB is anticipating patentees might be less willing to offer Voluntary Compliance Undertakings (VCU) and will instead press for formal and potentially long hearings. It may also be that the PMPRB staff will be encouraged to take more cases to hearings in order to establish jurisprudence under the new regulations and	Health Canada should reconsider the proposed regulations from the perspective of facilitating and encouraging voluntary compliance rather than increased litigation. Health Canada should provide detailed information on the historical costs of legal counsel and external experts from the Special Purpose Allotment and the actual cost of the recent hearing involving Alexion. The PMPRB should provide its estimates of the number of cases likely to proceed to a hearing.

		guidelines. The expectation of more hearings suggests a recognition that the regulations and guidelines will not provide the same level of certainty to facilitate voluntary compliance as they do today.	
22	Benefits – Lower patented medicine expenditure	It is anticipated the proposed amendments will lower patented medicine expenditure by an estimated $8.6 billion (PV) over 10 years (new price regulatory factors $3.8 billon, new schedule of countries $2.8 billon, and reporting of third party rebates $2 billon). It is not clear how Health Canada has arrived at these figures and if they change relatively across the wide range of the sensitivity analysis. External expert analysis more correctly estimates total reduction in patented medicine expenditure of over $26 billion (PV) over the 10 year period.[5]	The CBA should be revised to address the analysis in the external report.[5]
23	Health System benefits	The Healthcare System benefits line of $12.7 billion is not a directly quantifiable number and was calculated using a "fiscal multiplier" factor pulled from a study of healthcare spending in the EU during the recent recession. That study found that healthcare spending during the recession had a positive impact on the economy by a factor of around 4-fold. Whether it's legitimate to then turn around and use this fiscal multiplier to conclude	The CBA should be revised to reflect more appropriate multiplier effects; other expert reports offer more reasonable approaches relying on evidence in a Canadian context.[5]

		that reducing drug spending (which is of course, health spending) will generate positive fiscal impacts to the rest of the health system, is arguable. The proposal also states that in the absence of these regulatory changes, there will be an increase of $3.9 billion in drug expenditures and this will have a ripple effect on the economy as a whole equal to $12.7 billion – again this is not clear and this may also be double counting. Health Canada argues there are positive multiplier benefits to drug savings, but there is no acknowledgement that there could be negative multiplier effects to the economy resulting from those same lost revenues. More importantly, the RIAS does not consider the impact on patient health and healthcare costs due to delayed access or the non-availability of treatment in Canada.	
24	Sensitivity Analysis Summary	The range of impact on patented medicine expenditures over 10 years presented in the sensitivity analysis is large, from $6.4 billion on the lower end and up to $24.9 billion on the high end. This wide range reflects the range of assumptions and lack of certainty about	The CBA should be revised to consider and address the alternate assumptions and approaches in other studies. [5]

		significant variables. There is a lack of clarity in how Health Canada calculated the estimated impact; it is not clear why $8.6 billon was selected. An external expert report has set out clearly the assumptions and analysis it employed to estimate total impact on industry revenues of $26.1 billion.[5]	
25	Small Business Lens	The RIAS takes the position that the small business lens does not apply as only medicine manufacturers that have a patented medicine for sale would be affected. BIOTECanada believes that many other business entities will be affected negatively by the proposals and this impact should be recognized. Researchers and start-up biotechnology companies in Canada rely on investments and partnerships from established firms. Consider for example JLABs in Toronto which offers support to many researchers and start-ups. The Canadian pharmaceutical patentees of today and the future will be impacted if the proposed regulations lead to reduced investment and incentives to bring new innovations to Canada.	Health Canada should consult with the industry to learn more about the potential impact of the regulations on new enterprises in Canada.
26	Consultation	These proposals represent the largest change to federal pharmaceutical pricing policy in 30 years. But since the Minister of Health's speech on May 16, 2017, the entire process has been condensed	Health Canada should follow the Treasury Board guidelines for regulatory consultation which require departments to be accountable for why they have not

		into a short time frame to accommodate the planned 2019 implementation date. As a result, the consultations have been limited and regulations were developed quickly with little meaningful consideration of the input from the regulated industry and other stakeholders. - The industry is concerned that there is almost no change in the regulatory proposal compared to the May 2017 Consultation paper – despite Health Canada receiving over 100 submissions in June 2017. - The RIAS does not adequately address the issues raised by the industry including, to highlight only some, the inappropriateness of adding a pharmacoeconomics factor – both as a being incompatible with the excessive price mandate of the PMPRB and the duplication and overlap with existing FPT programs and agencies; it did not address concerns regarding the schedule of countries including the criteria for selecting countries and their specific application, e.g., exclusion of the U.S.; it did not address concerns about the reporting of third party information and the potential to negatively impact FPT programs to use their buying power to achieve rebates and other	taken into consideration the feedback of stakeholders. "Accountability: Departments should demonstrate accountability by documenting how the views of stakeholders were considered during the development of the regulations and informing stakeholders of how those views were used. Where stakeholder input could not be reflected in the proposed regulations, officials should be able to outline the reason(s) why. Accountability also involves ensuring that the consultations take place over a reasonable period of time, so that participants have sufficient time to submit their views." - Guidelines for Effective Regulatory Consultations Pg. 4. The industry recommends that the government conduct broader multi-stakeholder consultations, including the provincial/territorial governments, ISED, patient and research organizations and other stakeholders impacted by the proposed policy changes.

		benefits.	
27	Regulatory Cooperation	The proposals would place Canada out of step with international jurisdictions in a number of ways, including by requiring disclosure of confidential rebates and by using fixed pharmacoeconomic cost per QALY thresholds to establish a single maximum price for all buyers regardless of drug plan size and other characteristics.	Health Canada should conduct further study of practices in other countries and share the results of that analysis in developing alternatives to the proposed regulations.
28	Rationale	The RIAS acknowledges that Canada's health system does not have a single payer for medicines unlike most other international health systems.	The RIAS should acknowledge that it seeks to apply tools and approaches used in those systems even though such tools and approaches are currently being used by the FPT and private drug programs.
29	Implementation, Enforcement and service standards	These proposals are the largest changes to pharmaceutical policy in 30 years. The entire process has been condensed into a short process to accommodate the 2019 implementation date. In the past, minor guideline changes have taken up to 4 years to finalize.	A more comprehensive, meaningful and thorough consultation with industry should be conducted before implementing the proposed amendments with the necessary consideration of appropriate transition measures.

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Proposed Text -Regulations Amending the Patented Medicines Regulations Published in Canada Gazette

Comment #	Section	Comment and Rationale	Proposed Amendment
30	1 Section 3 (3.1)	BIOTECanada agrees with the objective of "an increased PMPRB focus on drugs that are at greatest risk of excessive pricing due to the degree of market power held by the patentee." The corollary is there should be less focus on drugs that do not have a high degree of market power. The proposal only goes part way. There are many multisource drugs, patented and non-patented, subject to marketplace competition and without benefit of market exclusivity or a high degree of market power. The circumstances for these drugs are the same as for patented generic drugs	The industry recommends the proposal to reduce the regulatory burden for patented generic drugs should be extended to all multisource drugs. In addition, the regulatory burden should be reduced for those products that are purchased through tendering and price negotiation such as vaccines and blood products.
31	4.3 (1)	see comments above 1 Section 3 (3.1)	see comments above 1 Section 3 (3.1)
32	4.1 (1)	The requirement to provide every cost-utility analysis for which the outcomes are expressed as a cost per quality-adjusted life year for each indication, introduces a highly problematic fixed cost-per-QALY threshold that would be unprecedented. In Canada and other countries, information on cost-per-QALY is only used as input into subsequent negotiations on price and conditions	The proposed filing requirement should be withdrawn as the information to be filed is already in the public domain and available to the PMPRB.

		for coverage. No country has attempted to use a fixed cost-per-QALY to establish a regulated maximum price for different groups of purchasers. The use of HTA and, in particular, a cost-per-QALY threshold is particularly inappropriate for drugs for rare and ultra-rare diseases. It is well established the prevailing methodologies used in pharmacoeconomic evaluations do not adequately address drugs for small patient populations. As these analyses are already in the public domain, the reporting requirement introduces duplication and unnecessary regulatory burden particularly for small and medium sizes companies looking to enter the Canadian market.	
33	4.2	This requirement will impose a huge regulatory burden on patentees and is inconsistent with government objectives to reduce regulatory burden. Especially in the early years after a new medicine is launched, forecasts will change frequently depending on the outcome of reviews and negotiations with payers, including the pCPA, and on changing market conditions, including the entry of new medicines in the class. The purpose of this reporting requirement is unclear at best; in	The proposed regulatory text regarding this filing requirement should be withdrawn as the information is not relevant in a determination of excessive price; actual price and sales information is already reported regularly to the PMPRB.

		the industry's view, the market size factor is not a relevant factor in assessing excessive price.	
34	4.4(a) (b) (c)	The use of a pharmacoeconomic factor is out of step with other international jurisdictions. The industry is not aware of any jurisdiction in the world that regulates a nation-wide maximum non-excessive price for a medicine based on pharmacoeconomics, so there are no precedents allowing industry to contemplate how it might be applied by the PMPRB. The concept of "value" is not consistent with the statutory standard of "excessive." "Value" is a subjective assessment that varies according to the individual's needs, preferences and trade-offs among a variety of factors. To establish a maximum non-excessive price requires a precise calculation which is not possible in the case of pharmacoeconomics because it is not a precise science. Assessments are based on a multitude of assumptions and are dependent on the perspective employed. This proposed requirement would create a large additional regulatory burden for the PMPRB and manufacturers.	The regulatory text should not be amended to include the new factors.

		Size of Market: This factor is proposed to allow the PMPRB to set different maximum non-excessive prices based on the anticipated volume of sales of the medicine. The RIAS has not provided any explanation or underpinning why market size relates to whether a price is "excessive." GDP and GDP per Capita: The RIAS proposes that the PMPRB would consider GDP per capita in assessing Canadians' willingness and ability-to-pay for a medicine. These factors are highly variable and subjective based on the payer's financial circumstances and need. The pCPA record demonstrates it does a good job of assessing ability to pay and value for purposes of public drug plans. The pCPA reports there are 57 drug products as of January 31, 2018 for which it has decided not to negotiate collectively or individually at the provincial-territorial level; they represent 21% of all the new drugs for which pCPA has completed its assessment and consideration. (Private insurers do not typically publish information on their decisions not to cover treatments due to cost.).[7]	

[7] http://www.pmprovincesterritoires.ca/en/initiatives/358-pan-canadian-pharmaceutical-alliance

		There is no stronger evidence that ability and willingness to pay are adequately being addressed in the market. Duplication of that effort by the PMPRB will serve no added value but may create delays and market uncertainty. There is no apparent value in asking the PMPRB to make price assessments based on GDP. Payers take their own financial capacity and the anticipated value of a product in meeting their health needs into consideration in negotiating price and coverage for drugs.	
35	Schedule – Comparator countries	In BIOTECanada's submission to the Minister in June 2017, we had proposed different criteria; the RIAS has failed to acknowledge these proposals nor explain why they were rejected. Furthermore, we are advised that the PMPRB has completed a detailed report on the evaluation of the basket of countries using Health Canada's criteria, but that report has not been made public. The selection of appropriate criteria, and their application to select countries is a complex matter. The consultation paper does not provide any information on how the proposed criteria were applied to result in the proposed list.	The Proposed changes to the Schedule of Countries Regulations should be delayed until there has been further consultation. Health Canada should release its assessments and those of the PMPRB on how the proposed criteria were selected and how they were applied in developing the proposed Schedule. BIOTECanada recommends the government modify the selection criteria to add the following:

		The industry also questions the added regulatory burden an expanded basket will impose in light of Health Canada and government-wide objectives to reduce regulatory burden.	a) Policies to promote and improve health outcomes; b) Trading relationship with Canada through established agreements such as NAFTA and CETA; and c) Geographic proximity; d) Innovation policies.