

Introduction & Background

This response to the consultation document has been prepared by Neil Palmer, Founder and Principal Consultant of PDCI Market Access Inc. (PDCI) The views expressed are solely those of Neil Palmer & PDCI.

PDCI is Canada's leading pricing and reimbursement consultancy, co-founded in 1996 by Neil Palmer who previously was on the staff of the PMPRB for several years. Mr Palmer is widely acknowledged as an expert on pricing and the PMPRB and has been recognized by the Federal Court of Canada in several cases as an expert in market access, reimbursement policies, and pricing regimes of the Canadian pharmaceutical marketplace. Mr Palmer is also Adjunct Assistant Professor of Pharmaceutical and Health Economics Practice at the University of Southern California¹ where he lectures on pricing, reimbursement and market access.

Potential Conflicts of Interest

Neil Palmer and PDCI have received no financial assistance or any input from the pharmaceutical industry or anyone else in the preparation of this document.

PDCI's clientele is predominantly the innovative pharmaceutical industry. PDCI assists pharmaceutical manufacturers (patentees) navigate the PMPRBs regulations and guidelines and assists patentees with advice when their products are subject to PMPRB compliance and enforcement measures.

Furthermore, PDCI assists patentees with their filing of international prices by sourcing the prices from the PMPRB recognized prices sources, backing out the upcharges and VAT, and compiling the price data on the PMPRB Form-2 Block5- in accordance with the Regulations. Accordingly, PDCI will likely benefit financially (increased revenues from consulting fees) should the basket of reference countries be expanded and/or the new proposed price factors and reporting requirements be implemented in Regulation.

General Observations

Regulatory Framework. The federal government has established a framework for making and amending regulations. The framework consists of 6 key elements²:

1. Canadians are consulted
2. Risk exists, government intervention is required, regulation is best alternative
3. Benefits of regulation outweigh costs

¹ <https://hcda.usc.edu/faculty/>

² *Guide to Making Federal Acts and Regulations: Part 3 - Making Regulations, Privy Council Office*
<http://www.pco-bcp.gc.ca/index.asp?lang=eng&page=information&sub=publications&doc=legislation/part3-eng.htm>

4. Adverse economic effects are minimized, no unnecessary regulatory burden
5. International and intergovernmental agreements are respected
6. Systems in place to manage regulatory resources effectively

It is not apparent from the consultation document that a risk exists given that the PMPRB's own analysis suggests that on average Canadian prices are consistently at or below the international median and that prices have remained flat³ despite guidelines that allow for price increases. And to the extent that any risk exists, it is not evidence that government intervention is required, nor that regulation is best alternative to address the risk. Furthermore, the added costs to PMPRB and the regulatory reporting burden for patentees has not been considered at all.

PMPRB can already consider additional excessive price factors. The *Patent Act* (para 85 (2) (b)) already allows the Board to consider any factor it considers to be relevant in the circumstance whether or not that factor is in the *Act* or in the *Regulations*:

(2) Where, after taking into consideration the factors referred to in subsection (1), the Board is unable to determine whether the medicine is being or has been sold in any market in Canada at an excessive price, the Board may take into consideration the following factors:

(a) the costs of making and marketing the medicine; and

(b) **such other factors** as may be specified in any regulations made for the purposes of this subsection **or as are, in the opinion of the Board, relevant in the circumstances.**

There is nothing in the consultation document to support how the proposed factors could be applied as primary factors. The Act already allows these and any other factor to be considered by the PMPRB as secondary factors. In addition, the PMPRB has the power to issue orders to require patentees to provide any information necessary to assess the price in the context of any additional factors. In summary, it is not evident that new factors need to be added through regulation or that significant additional regulatory reporting burden be imposed on all patentees when PMPRB can seek the information in the few cases where it is relevant.

Lack of detail. The consultation document is long on concepts and generalities and short on specifics that would allow for informed comment. Future consultations must offer specific, detailed examples of how the new factors or information would be used in practice by the PMPRB.

Patients. The consultation document gives only lip service to patients (the most important stakeholder) and indirectly equates \$/QALY as "value to patients" when in fact it is really value to payers. This oversight is disrespectful of patients who have their own priorities and metrics for assessing value – Health Canada is encouraged to engage in meaningful consultation with patients and not assume that payers or others somehow represent their interests.

³ PMPRB Annual Report 2015

PMPRB Annual Report. There is a troubling trend of the Minister delaying the tabling of the PMPRB's Annual Report. Historically the Annual Report was tabled by the Minister concurrently with the summer adjournment of the House of Commons. In recent years both the current Minister and her Conservative predecessor have delayed tabling the Annual Report for several months after receiving it from the PMPRB. Although the delays may be allowed under the Act, absent an explanation these delays are often perceived as politically motivated and frustrate the PMPRB's ability to exercise its reporting mandate.

As of June 28, 2016, the PMPRB's 2016 Annual Report has yet to be tabled and its important contents unavailable to stakeholders who would benefit from the most recent available information on pharmaceutical price trends. The Minister should table the 2016 Annual Report at the earliest opportunity.

The PMPRB Annual Report is an expansive repository of data and information valued by all stakeholders. The PMPRB should be required (in regulation or legislation) to publish on its website the information ordinarily contained in its Annual Report within 120 days of the end of the calendar year to which the information pertains. The actual report itself could be tabled in accordance with current requirements outlined in the Act.

Research and Development (R&D). The Regulations require patentees to report Canadian R&D expenditures using a 1987 definition of R&D. The R&D reporting requirement was included in regulation to assess manufacturer R&D commitments at the time of C-22 and C-91. The timeframes of these commitments have long since passed and the figures reported are no longer reflective of pharmaceutical R&D conducted in Canada. The requirement to report R&D should be removed from the *Regulations*.

Consultation Questions

1. Introducing New Factors to Help Determine if a Price is Excessive

1.1. Do you agree that a pharmacoeconomic evaluation is an important factor for the PMPRB to consider when determining whether a drug is priced excessively? If so, how should the evaluation be considered?

Extensive pharmacoeconomic (PE) evaluation is already conducted by CADTH and INESSS (in Quebec) the Canadian HTA agencies with expertise in the evaluation and interpretation of health economic analyses. The purpose of the PE evaluations is to inform the potential value to payers - not to determine whether a price per se is "excessive".

There is no information offered in the consultation document to show how PE information would be used in the price review process (ie, as part of the PMPRB Guidelines) or why repeating / duplicating analyses already conducted by CADTH and INESSS (and possibly with different results) contributes to the price review process.

The PMPRB Guidelines anticipate price tests that calculate non-excessive prices with precision (to 4 decimal places or 1/100th of a cent) for each unit of a medicine (e.g. \$1.2345/tablet). PE analysis does not offer such precision. The common measure of cost-effectiveness is an incremental cost effectiveness ratio (ICER) expressed as the cost per Quality Adjusted Life Year (or cost per QALY). However, the cost per QALY is not calculated as a single figure but rather as a range given various underlying assumptions, scenarios and the uncertainty of the clinical evidence upon which the PE analysis is based.

Moreover, there are many limitations to QALY based analyses as they are often not appropriate for acute conditions (eg, pain) or for rare diseases. In addition, the informal ICER thresholds that have evolved in practice (eg, \$50,000/QALY) are arbitrary and not founded in evidence or academic study other than post-hoc analyses that offer “after-the-fact” rationale.

While PE analysis may not be helpful in setting non-excessive prices, it may serve an exculpatory role. That is, a price that is considered to be cost effective (say by CADTH or INESSS) would by definition be considered to be non-excessive.

In summary, PE analysis should not be a primary factor in determining non-excessive prices but rather could be reserved as an additional factor that would confirm that cost-effective prices by definition are not excessive.

To ensure minimal regulatory burden and the efficiency of regulatory resources, PMPRB should rely on the PE evaluations conducted by CADTH or INESSS and not conduct de novo evaluations of the same PE models submitted by manufacturers.

- 1.2. *Do you agree that the size of the market for the drug in Canada and other countries is an important factor for the PMPRB to consider when determining whether a drug is priced excessively? If so, how should the size of the market be considered?*

There is insufficient information to provide meaningful comment. The consultation document does not define market size. Is it the dollar value of a therapeutic class of drugs (eg, statins) or is it the potential market for the single drug entity? Alternatively, market size could be expressed as the number of potential patients (incidence and prevalence).

The discussion overview of the proposed new factor alludes to prevalence and suggests that even cost effective drugs could be priced excessively if the volume of potential patients strains drug budgets. This concern was likely raised by new treatments for hepatitis C – treatments that are highly cost effective (according to CADTH) but the sheer volume of potential patients created affordability concerns for public and private drug plans.

The affordability issue is best addressed by the pan Canadian Pharmaceutical Alliance (pCPA) that negotiates price volume agreements on behalf of all public drug plans in Canada. Indeed, in February 2017, the pCPA managed to negotiate agreements with the manufacturers of six

breakthrough hepatitis C drugs to ensure their affordability and sustainability with the drug plans.

Moreover, the assumption (in the consultation document) that patented medicines are monopolies protected from new entrants is flawed. Increasingly, new patent protected medicines quickly face competition from similar (often better) medicines, particularly where there is a significant patient population that could benefit from treatment. This was the case for hepatitis C where the number of new entrants has been dramatic and the competition intense – competition leveraged by the pCPA to negotiate price volume agreement for the entire therapeutic class. The PMPRB mandate is tied to individual drugs and the PMPRB's protracted quasi-judicial legal framework does not lend itself to group price negotiations. The pCPA and not PMPRB is best positioned to address the affordability issue.

- 1.3. *Do you agree that Canada's GDP and GDP growth are important for the PMPRB to consider when determining whether a drug is priced excessively? If so, how should GDP be considered?*

There is insufficient information to provide meaningful comment. Moreover, the consultation document has not established how or in what circumstances GDP and GDP growth would be helpful to the PMPRB in carrying out its mandate.

- 1.4. *Are there any other factors that should be considered by the PMPRB when determining whether a drug is priced excessively? How should the factor(s) be considered and what information should be required from patentees?*

No. As outlined in observations section above, the PMPRB is already empowered in paragraph 85 (2) (b) of the *Act* to consider any factor relevant in the circumstances when the primary factors are not sufficient.

2. Amending the list of countries used for international price comparisons

- 2.1. *Are there other countries that should be considered in revising the Schedule?*
- 2.2. *Are there other criteria that should be considered in revising the Schedule?*
- 2.3. *Please provide any other comments you may have on the Schedule of comparator countries.*

The consultation document cites three criteria that were ostensibly the basis of selecting the new basket of reference countries. However, it would appear to be no coincidence that the the proposed basket of countries would result in a median price corresponding to the median of OECD countries (as publicly proposed by the Minister on May 16 and in PMPRB tweets). Accordingly, the three "selection"

criteria really appear to be post hoc rationale for justifying a desired outcome (OECD median) and not the objective, reasoned approach portrayed in the consultation document.

As with all the other proposals in the consultation document, stakeholders have little information upon which to make informed comment beyond the PMPRB's current framework and Guidelines. Under its current Guidelines, Canadian prices can never exceed the highest price in the reference countries and the median international price, in certain circumstances, sets the maximum introductory price. Stakeholders need to understand how and under what circumstances PMPRB will apply international price comparisons with the expanded basket of countries if different from the current Guidelines.

It is widely acknowledged that international reference pricing (IRP) is becoming less relevant. Canada was the first country to employ IRP in regulating or negotiating drug prices. IRP in Canada began with the C-22 amendments to the Patent Act that created the PMPRB and the subsequent Regulations (1988) that identified the reference countries and the Guidelines (1990) that laid out the price tests including the international price comparison test. Although the Act, Regulations and Guidelines have all been amended and updated since, the PMPRB has maintained its approach to IRP until recently when its 2016 consultation document suggested that less reliance should be placed on IRP.

“Given that it is standard industry practice worldwide to insist that public prices not reflect discounts and rebates, should the PMPRB generally place less weight on international public list prices when determining the non-excessive price ceiling for a drug?”⁴

It is important to note that prices are most often available in only a subset of the current seven reference countries, particularly at introduction. In some cases, prices are only ever available in only one of the reference countries (most often it is the US when there is only one reference country). Removing the US would create a situation such that international price comparisons would not be possible for many patented drugs (likely more than 100 products by our estimates).

Given the prevalence of significant confidential rebates and discount, the US list price (as measured by the Wholesale Acquisition Cost or WAC) is now clearly an outlier when compared to other international prices. However, there are other price sources in the US market that may be more representative of actual transaction prices. These include the FSS price already reported by patentees as well as Medicare and Medicaid prices (or average prices) that are widely available on federal and state websites.

There is no analysis offered as to why Switzerland was removed or South Korea added – the intended purpose appears to be to drive the PMPRB median to the OECD median (although that rationale was not offered).

⁴ PMPRB Guidelines Modernization – Discussion Paper – June 2016

If it is determined that the basket of reference countries must be expanded the government should consider existing grouping such as the G10⁵ (really 11) or G12⁶ (really 13) that group together industrially advanced nations with similar economic characteristics.

Adding reference countries adds to the regulatory burden of patentees and the resources required by PMPRB to carry out its mandate. There is no analysis in the consultation documents assessing and justifying the added burden and cost.

3. Reducing regulatory burden for generic drugs with a patent

3.1. Do you agree that patentees of generic drugs, i.e. drugs that have been authorized for sale by Health Canada through an ANDS should only report information about the identity of the drug and its price in the event of a complaint or at the request of PMPRB?

Any reduction in regulatory burden is welcome however it should be noted that patented generic products account for a very small proportion of the patented medicines regulated by the PMPRB and this proposal is of no benefit to the vast majority of patentees who have no patented generics.

Moreover, any patented generic drug that is lower priced than its branded alternative should by definition be considered non-excessive.

4. Modernizing reporting requirements for patentees

4.1. Is the information sought in relation to the new factors relevant and sufficient?

4.2. Is this information generally available to patentees?

It is difficult to understand how significantly increasing the regulatory reporting burden to patentees is somehow “modernizing”. There is nothing “modern” about PMPRB duplicating the role of CADTH, INESSS, and the provinces. Streamlining and harmonizing the PMPRB’s role with those of the HTA and payer bodies would be a welcome, “modern”, step forward.

As outlined earlier the consultation document has offered little if any information on how the new factors will be used by the PMPRB, much less how the information sought in relation to the factors could inform the price review process. Until such time that there is compelling evidence that the proposed factors are relevant to the price review process, the information sought cannot be considered relevant.

If PE information is ultimately considered relevant the information should be limited to the health economic models submitted to CADTH and INESSS as these are the models relevant to the Canadian health care system. Foreign models will be in different currencies, often in different languages and

⁵ The Group of Ten is made up of eleven industrial countries (Belgium, Canada, France, Germany, Italy, Japan, the Netherlands, Sweden, Switzerland, the United Kingdom and the United States) which consult and co-operate on economic, monetary and financial matters

⁶ The Group of Twelve or G12 is a group of industrially advanced countries whose central banks co-operate to regulate international finance. (G10 + Spain and Australia)

always reflecting a different healthcare system. Will patentees be expected to convert the models to Canadian dollars and translate to English or French?

Should cost effectiveness be relevant in a particular price review, the PMPRB can request the models that have been submitted to CADTH or INESSS. If no models have been submitted to Canadian HTA agencies, the PMPRB can seek out international models that are in the public domain. For example, NICE publishes the health economic models of the medicines it reviews on its website including the models it commissions independent of the manufacturer.

Information on market size (assuming incidence and prevalence are the relevant metrics) are largely based on national health care statistics, literature review and expert opinion – information that is not proprietary to the patentee. And even if available to patentees, there is no certainty that market size information for other countries has been estimated in a similar manner to Canadian estimates.

5. Providing information related to third party rebates

5.1. Are there any reasons why patentees should not be required to disclose to the PMPRB information?

It is surprising that the consultation document does not acknowledge the potential legal hurdles associated with seeking this information. The Federal Court concluded that PMPRB cannot require patentees to report 3rd party rebates.⁷ The consultation document offers no analysis as to how placing in regulation a requirement for patentees to report 3rd party rebates would be consistent with the court's order.

Moreover, the rebates to provinces are subject to confidential agreements with provincial ministries of health – there is nothing in the consultation document to suggest that the respective ministries have been consulted or that they would give permission for patentees to submit their confidential agreements to the PMPRB. In addition, the confidentiality provisions of s.87 of the Patent Act are insufficient as there are circumstance where confidential information can be disclosed over the objections of the patentee and it is not apparent how the provinces' rights are protected under s.87 when patentees submit information that is confidential to the provinces.

Apart from the legal uncertainty, there is the obvious question of how PMPRB would use such information. Again, there are no details in the consultation document.

⁷ Pfizer Canada Inc. v. Canada (AG), 2009 FC 719.