

IMC Response to PMPRB 2020 Draft Guidelines – August 4, 2020

Innovative Medicines Canada (IMC) is an association of 41 biopharmaceutical and vaccine companies that represents the majority of patentees subject to the regulatory authority of the Patented Medicine Prices Review Board (PMPRB). IMC and its members have participated in each stage of a multi-year process regarding proposals that would significantly change the role of the PMPRB.¹

Throughout this process, and now in addressing the COVID-19 pandemic, the pharmaceutical and vaccine industry's primary goal is to support the health and well-being of Canadians. Unfortunately, the proposed PMPRB Guidelines will do nothing to help achieve this objective and, unless fundamentally altered, will limit access to new medicines and vaccines in Canada.

Executive Summary

- The June 2020 Federal Court decision that confidential third-party payments are *ultra vires* the *Patent Act* calls the PMPRB's fundamental regulatory approach into question. The central concept of a maximum rebated price (MRP) is unviable.
- The 2020 Draft Guidelines do not meaningfully address the key concerns of industry and stakeholders regarding the new economic factors, confidentiality, legal issues, operational barriers, and the resulting risks to future product launches and timely patient access.
- For these and other reasons, a fundamental reset of the Guidelines process is required.
- This reset should focus on core regulatory principles of feasibility, fairness, clarity, and predictability, and ensure that Canadians can access new medicines in a timeframe reflective of health care systems within the top tier of the OECD nations.¹
- A simple path forward is required. For future products, PMPRB should anchor to the bright-line, predictable principle that Canada should not exceed the international median price.
- Proposed policy to force innovative products to be priced according to low-priced generics is unreasonable. The median therapeutic class comparison must be removed. Exemptions for all tendered products, including vaccines, are also needed.

¹ Innovative Medicines Canada (IMC) understands that the PMPRB intends to update its Guidelines within the framework of the amendments to the *Patented Medicines Regulations*, which are not yet in force. While IMC is committed to constructive engagement with the PMPRB on the draft Guidelines, IMC's response to this consultation is not intended and should not be interpreted as supporting the amendments to the Regulations or current Guidelines proposals. On June 29, 2020, the Federal Court of Canada declared that subsection 3(4) of the amended Regulations on the net price calculation is invalid, void, and of no force and effect for being *ultra vires* the *Patent Act*. IMC continues to have grave concerns about the practicality and legality of the remaining amended Regulations. IMC reserves the right to oppose any aspect of the amended Regulations or Guidelines that exceed the jurisdiction of the Board.



Despite the ongoing concerns and objections of patentees, the latest draft Guidelines released on June 19th, 2020 (“2020 Draft Guidelines”) continue to advance the concept of a “maximum rebated price” (MRP) which reflects the inclusion of third-party payments that are beyond the PMPRB’s jurisdiction. On June 29th, 2020 Justice Manson of the Federal Court of Canada ruled that sections of the August 21, 2019 amendments to the *Patented Medicines Regulations* in relation to confidential third-party payments are *ultra vires* the *Patent Act*.² This decision is consistent with previous jurisprudence and IMC’s position throughout the PMPRB amendment process. The PMPRB 2020 Guidelines proposals are based on having access to this *ultra vires* information. Not only must patentees “ensure that the patented medicine’s net price in Canada, (i.e., its average transaction price or “ATP”) is no higher than the MRP [maximum rebated price],” but “[c]umulative potential excess revenues will also begin to be calculated by Staff based on net prices filed by the patentee”.³

Given that this maximum rebated price concept is so central to the proposed Guidelines approach, the industry disagrees with the PMPRB’s July 8, 2020 provisional statement that it does “not believe any substantive changes to the June 2020 Draft Guidelines are required” in response to the decision on third-party payments.

To the contrary, the Federal Court decision marks a fundamental departure from the PMPRB’s proposed regulatory approach. Without access to third-party payments, or “rebates”, the PMPRB cannot implement its maximum “rebated” price (MRP) concept. As noted by Health Canada in May 2017, “without this information, the PMPRB is left to set its domestic price ceilings on the basis of information that only includes list prices.” As such, we note that the PMPRB must propose and consult on alternative Guidelines. These should focus on predictable list price ceilings and international price referencing anchored to the principle that future Canadian prices should generally be at the median level of international prices.

The 2019 regulatory amendments are clear that PMPRB access to third-party payments is central to patentee compliance with the very low price ceilings that the new economic factors will be used to set.⁴ In the absence of this information, the MRP cannot be used to determine instances of excessive pricing in a manner consistent with the legal mandate of the Board. Given that the new economic factors (pharmaco-economic value, market size, and GDP/GDP-per-capita) are also centrally linked in the draft Guidelines to the MRP concept, a fundamental reconsideration of those Guidelines proposals must be undertaken. It is foreseeable that failing to do so could result in significant disruptions within the Canadian reimbursement system.

Given recent developments, the PMPRB must suspend the current consultation, draw on the expertise of patentees through technical working groups, and re-release a Guidelines package that is consistent with regulatory tools that are within its mandate. It is inappropriate to be consulting on the use of information that is deemed by the Federal Court to be beyond the PMPRB’s jurisdiction. The obligation of meaningful stakeholder consultation on the Guidelines required by the *Patent Act* cannot be met by the present or past consultations, all of which have featured the mandatory disclosure of third-party payments as an essential component of the new regime.

If implemented without major changes, the 2020 Guidelines will have a significant and negative impact on patient access to new medicines in Canada. The formulaic approach that PMPRB has proposed to regulate rebated prices rather than ex-factory list price ceilings would provide international markets with clear



visibility to confidential pricing information and would therefore undermine the viability or delay the launch of many new medicines in Canada.⁵

Deficiencies with respect to regulatory predictability must also be addressed. The Guidelines provide PMPRB staff with new and excessive discretion to unilaterally assess therapeutic improvement and clinical comparators without necessarily having the scientific expertise to do so and to arbitrarily change price tests at an investigation stage.

In addition, transitional compliance measures for existing products have yet to be fully articulated and PMPRB staff acknowledged on July 21st, 2020 that these remain under development. Having such central compliance guidance still under development only a few months before the new regime is scheduled to come into effect creates harmful and unnecessary uncertainty in the Canadian life sciences sector. PMPRB's representations that staff will "work things out" with patentees with respect to the transition for existing products is untenable for companies attempting to navigate an already complex business environment.

Notwithstanding our industry's continued opposition to the proposed changes, IMC remains open to further discussions with the PMPRB and the federal government on a reasonable path forward. IMC's key positions with respect to the 2020 Draft Guidelines are substantively consistent with its input provided in past submissions, and we would also refer readers to those documents rather than reiterate each point at length.⁶ The case studies set out in Appendix below have been compiled to provide PMPRB and other interested parties with insights to help inform the development of a new Guidelines package for further comment by patentees and stakeholders.

Updated IMC Positions on the 2020 Draft Guidelines

In the 2020 Draft Guidelines, the PMPRB provided some clarity on the pricing tests for existing products. However, the picture is far less clear for future products, and is especially concerning with respect to the most innovative high-value medicines and vaccines. With respect to future products, the 2020 draft Guidelines do not address industry's concerns regarding the previous 2019 draft Guidelines.

The cornerstone of the Guidelines' approach for most high-value products continues to be a controversial maximum rebated price (MRP) concept, the inappropriate use of pharmacoeconomics for price ceiling regulation, and revenue control-tiering through the market size factor. In other words, the legality, confidentiality, operational feasibility, and predictability concerns of industry have not been meaningfully addressed. Moreover, as demonstrated in the case studies in Appendix, the proposed Guidelines result in outcomes that lack regulatory clarity and consistency.

The 2020 draft Guidelines set out a new regime that cannot be operationalized unless a fundamentally different approach is developed through technical working groups with patentees. For example, there are numerous product launch risks and fundamental operational barriers connected to the new economic factors and the MRP concept, which do not detect instances of excessive pricing or adequately protect confidential and internationally sensitive business information. They will also act as a significant disincentive to future product launches in Canada. Operational complexity is also a key factor in potential delays to access, particularly for smaller, rare disease companies.



The 2020 Guidelines also remove measures specific to rare diseases and the threshold adjustments are simply not meaningful for such products. Additionally, the magnitude of the required price reductions for rare and other “high risk” drugs remains deeply concerning.

IMC has ongoing concerns that the PMPRB Guidelines specifically target the most innovative high-value products for significant price reductions. IMC has obtained third party analysis suggesting that Category 1 products would capture and reflect almost 80% of the industry’s revenues (versus the two-thirds acknowledged by the PMPRB). A system that captures almost all of an industry’s future revenue stream within the high regulatory burden classification cannot reasonably be characterized as a ‘risk-based’ approach to regulation.

Substantive Issues

IMC’s key positions on substantive issues can be summarized as follows:

- **Proposals such as the MRP concept fail to detect instances of excessive pricing consistent with the mandate of the Board, compromise confidential business information, are inconsistent with the recent Federal Court decision, and should be discontinued.** This will help to mitigate some product launch risks caused by competitors and international jurisdictions formally or informally referencing Canadian prices.
- **For new products, PMPRB should only regulate list price ceilings and anchor to the principle of Canada at the international median. The median international price (MIP) should set the standard.** The MIP provides a “bright line” rule and is more reflective of Canada’s elevated socioeconomic status amongst the OECD nations. Provided an ex-factory customer average transaction price is at or below the MIP, that price should not be considered excessive.⁷
- **The proposed median therapeutic class comparison test should be abandoned.** Unlike the median international price (MIP) test which makes an “apples-to-apples” comparison for the same medicine, the median therapeutic class comparison is a new concept which makes unreasonable and inappropriate comparisons between innovative and generic medicines. The use of a median therapeutic class comparison is inconsistent with an excessive price standard and is therefore inappropriate (please see IMC’s previous submissions).⁸ The proposed use of a median dTCC to set MRP ceiling when actual sales are greater than \$50 million (Category 1 High Market Size products) and for Category 1 products with an HTA cost-minimization analysis also remains problematic. IMC strongly opposes this effective penalization for cost-minimization products. If a TCC is employed, only the highest therapeutic comparator price can reasonably be used, as has been the accepted standard throughout the PMPRB’s existence. This approach has already been proposed in the 2020 Draft Guidelines for use in some cases to set the maximum list price. Similarly, the median International Therapeutic Class Comparison (iTCC) should be removed. IMC also opposes the use of the lowest price when multiple manufacturers produce the same molecule. Fairness cannot be achieved when establishing the ceiling for an innovative product using generic comparator prices (see Case Study 5).
- **Reasonable transition measures for in-market medicines and vaccines are essential.** IMC reiterates that the current proposals do not truly “grandfather” existing products and full



grandfathering would be most preferable. Existing products (receiving a DIN prior to August 21, 2019) and “Gap” products (receiving a DIN after August 21st, 2019 but before January 1st, 2021) should not be subject to the accumulation of excessive revenues for the 2021 calendar year.⁹ In absence of full grandfathering, PMPRB should simply apply its international price ceiling threshold (highest for existing products; median for Gap products) and use the current highest compliant list price rather than the current non-excessive average price (NEAP) as part of its “lower-of” tests for both existing and Gap products. The NEAP is based on protected information, would add significant uncertainty, and should be eliminated from PMPRB’s regulatory approach.¹⁰ List prices are more appropriate and efficient for transitional purposes. This approach will still ensure that transition measures do not result in undue price increases during the transition period. Allowing continuity for list prices would also avoid an additional administrative burden for payers.

- **Pharmacoeconomic value proposals remain highly problematic and will lead to frequent disputes.** The regulatory approach for Category 1 products imposes a punitive degree of pricing control for the most innovative products through arbitrary economic factor thresholds. Formulating one “pharmacoeconomic price” (PEP) to reflect all scenarios (e.g. comparators, combinations, indications, etc.) for all ICER ranges, and various point estimates which result from different practice and utilization patterns in Canada is a subjective and questionable basis on which to set a unitary national regulated price ceiling. There are also significant adverse incentives created by this proposal that will interfere with the effective functioning of the current reimbursement system, with no gains or positive impacts for patients. For example, in the absence of a pharmacoeconomic review (or a pharmacoeconomic analysis that cannot be used to determine the MRP), Category I products would be subject to an automatic 50% reduction from the median price if annual sales exceed \$12 million. The absence of a pharmacoeconomic (PE) review report or lack of ability to use PE information should not result in automatic penalization (please see Case Study 1). There are many legitimate reasons why PE information may not be available or useful, for example, where there are data limitations due to small patient populations or where it is unethical to run a Phase III trial. This is an unreasonable and arbitrary approach that will serve as a significant disincentive to future innovative product launches in Canada. Similarly, and as noted above, the penalization of products with cost-minimization analysis is inappropriate and the median dTCC must be removed entirely. As discussed, any price at or below the median international list price should not be considered excessive. Finally, IMC reiterates its ongoing opposition to the use of new economic factors for price setting and notes that further discussion is required through technical working groups with patentee pricing experts.
- **Implementation of therapeutic value is questionable and requires further consultation.** The current proposals regarding therapeutic category level definitions suggest that most new drugs would trigger the 50% price reduction standard. The definitions do not meet international standards of best practice in that they do not provide for clinician or patient input. Moreover, the downgrading of the role of clinical experts on the Human Drug Advisory Panel (HDAP) in favour of PMPRB staff discretion is concerning. Non-disclosure of therapeutic value assessments does not meaningfully address industry’s domestic and international confidentiality concerns regarding the MRP concept.
- **Implementation of the market size factor for revenue control remains fundamentally problematic.** The draft Guidelines introduce a *de facto* revenue control mechanism through the



market size factor, and the approach of compounding price reductions [MRP, MRP(A) or adjusted]. This represents a major change to PMPRB's role with respect to the regulation of price ceilings. Despite the incorporation of the new economic factors into regulation, the PMPRB still has an obligation to ensure those factors are implemented in a manner consistent with its role and mandate. A case comparison of the 2019 draft Guidelines and 2020 draft Guidelines demonstrates that despite increased market size thresholds there can be even greater negative impacts due to the MRP (please see Case Study 4). The proposed market size factor implementation measures would move the PMPRB away from determining excessive price to actively controlling expenditures, which is the jurisdiction of Canadian provincial and territorial governments (please see case Study 7). If the intent is to adjust the MRP (i.e., revert to MLP) in cases where gross sales fall below specified market size thresholds (\$12M for cost-based Category 1 or \$50M for market size Category 1), this has not been made clear in the Draft Guidelines.

- **Excessive discretion has been provided to PMPRB staff.** The recognition of therapeutic value remains an important element that must be properly reflected in the Guidelines. However, we respectfully submit that PMPRB staff do not have the scientific expertise to determine levels of therapeutic improvement, appropriate comparators, or the relevant indication. As such HDAP expert committee must continue to have a primary and regular role in such assessments. Similarly, staff are provided with Board-like powers and excessive discretion to choose price tests at the investigation stage, which represents a major departure from accepted practice and basic regulatory predictability (see below).
- **The rules must be consistent for Guidelines triggers and investigations.** The Guidelines state that the tests and ceilings used during investigations may differ from the initial thresholds that led to the triggering of the investigation. In such cases, "the investigation ceilings (as opposed to the triggering ceilings) will be used to calculate potential excess revenues." For example, the PMPRB indicated during its June 29th outreach session that HTA reports may be considered under an investigation for drugs below the Guidelines MRP thresholds. This provides PMPRB staff with inappropriately broad discretion to alter price tests and ceilings to arrive at a desired outcome. Furthermore, no rationale is provided for this extensive and unprecedented staff discretion.
- **An alternative approach to pricing and access for drugs for rare disease and other high-value products is essential.** The new economic factors and MRP concept will prevent or delay the launch of many drugs for rare diseases in Canada, given that the proposed threshold adjustments do not significantly ameliorate launch and price reduction concerns for these products. Discounts of more than 50% below the already discounted maximum list price (MLP) set at the median of the PMPRB¹¹ are possible when MRP rules are taken into account. The automatic penalization of rare disease products is likely in many cases due to the limited nature of clinical data packages for small patient populations.
- **The policy for tendered products, such as vaccines and blood products, should be reconsidered.** Given the central importance of vaccines and blood products to the health of Canadians, IMC remains disappointed that no exemptions or alternative policy proposals have been included for such products. The pricing for these products cannot be left to ad hoc negotiations with PMPRB staff and therefore the pricing rules should be made explicit for further consultation.¹¹ At a minimum, vaccines should be classified as a Category 2 products. The carve-out of COVID-19 related products



is a telling acknowledgment of the risk posed by the PMPRB's proposed Guidelines, which do not reflect a reasonable or predictable regulatory mechanism for vaccines and other tendered products (please see Case Study 6).

- **The Guidelines approach will create many adverse incentives that can be addressed by focusing on list prices.** In different situations there are arbitrary “early entrant” or “second entrant” disadvantages associated with the proposed use of therapeutic class tests, even when these products may offer improved benefits or cost-effectiveness. This is harmful to the interests of provincial health care systems, which benefit when more cost-effective medicines displace less cost-effective ones. There are also clear inequities and market distortions created by proposals that would apply widely different pricing policy tools to direct market competitors (please see Case Studies 2, 3 and 7).
- **The reassessment criteria remain excessively broad.** This will exacerbate pricing predictability issues for patentees. IMC recommends that reassessments should be conducted primarily on the basis of exceptional circumstances (e.g., on a complaints-only basis).
- **Significant information gaps remain.** The Guidelines continue to leave many important information gaps unaddressed including but not limited to, international price verification sources, details on proposed application of the new market size reporting requirement, pharmacoeconomic price (PEP) calculations, and the proposed treatment of combination products. The proposed treatment of line extensions and the reasonable relationship test in the 2020 Guidelines is similar to current practice and is favorable in comparison to 2019 Guidelines proposals; however, implementation issues require further clarity.¹²

Process and Conclusion

In addition to the substantive concerns set out above, IMC would also like to highlight several process issues. The draft Guidelines remain excessively complex and not ready for implementation on January 1st, 2021, the effective date of the regulations. Despite their significant expertise, IMC's members are still struggling to understand key aspects of the 2020 Guidelines. Given the challenges confronting our members, it seems unlikely that stakeholders with more limited resources and expertise will be able to fully understand the implications of the proposed regime.

As such, the present Guidelines consultation period is insufficient, particularly given the ongoing global pandemic. While IMC appreciates that the PMPRB provided details on its case studies analyses on July 30th, neither IMC or other stakeholders are in a position to review or comment on them, given that they were provided one business day prior to the end of the consultation period.

More fundamentally, basic information is required for patentees to understand how the system will be operationalize under the Guidelines to ensure compliance. The information gaps were most glaring on July 21st, 2020 when PMPRB refused to engage in any discussion on its proposed Guidelines approach regarding the MRP, given the Federal Court ruling noted above.

IMC also notes that patentees and other stakeholders were discouraged from providing feedback with respect to the 2020 draft Guidelines. PMPRB staff presented this iteration of the Guidelines as being in near-



final form during the consultation period, advising that the present consultation would only lead to “tweaks on the margins” of the proposed regime. Stakeholders who believe that significant and serious issues remain unresolved have been dispirited by PMPRB’s presentation of the Guidelines as a *fait accompli*.

Patentees should also have access to and be consulted on the information contained in the yet to be released Online Help Tool, which will replace the current Patentee Guide to Reporting. This portal contains critical compliance information for patentees. PMPRB has advised that the Online Help Tool will not be available until late summer or early fall, long after the present Guidelines consultation process is concluded, but without access to the final version of the Guidelines.

We also continue to request an opportunity for a virtual meeting of IMC’s Board of Directors and the full PMPRB Board as was signaled and agreed to by PMPRB, prior to the COVID-19 pandemic.

In addition and as noted in previous submissions, IMC believes that technical working groups with PMPRB staff and patentee pricing experts should be struck for virtual meetings in the coming months.¹³ These groups should be given adequate time to generate an alternative Guidelines package consistent with core regulatory principles of feasibility, fairness, clarity, and predictability, and ensure that Canadians can access new medicines in a timeframe reflective of a high-quality health care systems within the top tier of the OECD nations. Our position remains that the implementation of Guidelines on the new economic factors is not strictly required in advance of the regulation coming into force January 1, 2021. The Federal Court decision invalidating third-party payment reporting requires a reset with respect to the Guidelines process.



APPENDIX: Case Study Examples

The following case studies are provided for illustrative purposes only and do not encompass all of the issues arising from the 2020 draft Guidelines. The case studies illustrate some of the market distorting effects and adverse incentives that are likely to impact access to new medicines in Canada unless substantial changes are made prior to the final publication of the Guidelines.

It should also be noted that the cases below should be considered working drafts developed by IMC on an accelerated basis given the accelerated consultation timeframe. In addition, due to ongoing information gaps, the cases may not represent IMC's complete or final interpretation of the 2020 Guidelines. However, they illustrate some of the fundamental issues that cannot be remedied through "tweaks at the margins" of the June 2020 draft Guidelines, or ad hoc discussions with PMPRB staff.

The examples are as follows:

- 1) A rare disease medicine that is arbitrarily penalized because its CADTH report could not determine a pharmacoeconomic price (PEP). This case also illustrates how a one-time influx of units due to the onset of reimbursement would require an artificially low price in perpetuity. In this scenario, the medicine would not be launched in Canada.
- 2) An example of the adverse incentives created by the market size factor where there is an arbitrary first-launch disadvantage despite a medicine's clinical superiority. This is a delayed launch scenario and a disruptive intervention into competitive markets
- 3) An example of the adverse incentives created by the market size factor where there is an arbitrary and sizable second-entrant disadvantage despite offering similar efficacy. This is another no-launch scenario where the operation of the Guidelines would deny patients and clinicians alternative therapeutic options - which are essential due to clinical non-response or diminishing response - and limit competition.
- 4) A case comparison of the 2019 draft Guidelines and 2020 draft Guidelines which demonstrates that despite increased market size thresholds there can be even greater negative impacts due to the MRP. This case demonstrates that some elements of the 2020 Guidelines will have a more negative impact than the previous 2019 Guidelines.
- 5) An example demonstrating a lack of predictability and arbitrary price reductions required by the median domestic therapeutic class comparison (dTCC). This test would unreasonably force innovative medicines to be priced like generic drugs. Pricing would be unreasonably based upon the number of generic comparators in the market rather than excessive pricing.
- 6) A tendered product, such as a vaccine or blood product, where the Guidelines would obstruct competitive multi-year tendering.
- 7) A low-priced drug that would offer significant cost savings to the system is required to take additional discounts to already discounted list prices. This case demonstrates how the Guidelines automatically penalize medicines that bring savings to the health care system.



Case 1: A rare disease medicine that is arbitrarily penalized because its CADTH report could not determine a pharmacoeconomic price (PEP). This case also illustrates how a one-time influx of units due to reimbursement would require an artificially low price in perpetuity. In this scenario, the medicine would not be launched in Canada.

This scenario depicts a drug that is Category 1 Due to Cost – a one-time influx of patients at reimbursement permanently impacts MRP for years thereafter.

At time of reimbursement, most of the diagnosed patients are treated with a one-time injection. In subsequent years, only the newly diagnosed patients require the treatment. Perhaps most concerning is the automatic penalization due to the PMPRB deeming that the pharmacoeconomic analysis (i.e. cost/QALY) submitted to CADTH does not allow for the determination of the MRP: automatic penalization of 50% reduction to the MLP is assigned. This is unwarranted given that this drug is a highly innovative TCL 1 product that would otherwise expect a 20% floor reduction.

	2021	2022	2023	2024	2025
Gross Revenues	\$24,500,000	\$95,550,000	\$10,780,000	\$10,780,000	\$10,780,000
MRP/MRP[a] %	74%	55%	55%	55%	55%
Revenues @ MRP/MRP[a]	\$18,250,000	\$52,831,250	\$5,960,449	\$5,960,449	\$5,960,449

List Price \$98,000 (MLP<MIP)

PMPRB TCL 1 (no comparator)

MRP Adjustment based on Actuals from the prior year

CADTH HTA submitted but deemed not useful

Despite the gross revenues being below the \$12M threshold in subsequent years, the medicine would need to be compliant to the MRP

After the initial market size adjustment, a patented medicine's MRP will only be readjusted following an increase in annual units sold. A patented medicine's MRP will not be readjusted following a decrease in annual units sold, or if its actual realized revenues fall into a lower tier.

64. For patented medicines that have a 12-month treatment cost greater than 150% of GDP per capita and estimated maximum revenue greater than \$12 million per year; but do not have an available cost-utility analysis or if the analysis submitted does not allow for the determination of the MRP as described above, the MRP is set at 50% of the MLP. A MRP[A] based on this MRP may be calculated if applicable (see Appendix C).



Case 2: Adverse incentives created by the market size factor where there is an arbitrary first-launch disadvantage despite a medicine’s clinical superiority. This is a delayed launch scenario and a disruptive intervention into competitive markets.

In this case, the MRP is subject to the median of the comparators. Drug A, the first clinically superior entrant, is penalized for being first to market after Drug X (multi-source; List Price \$60). In this example, Drug C’s MRP is equal to its List Price while Drug A’s MRP is 40% lower than its list price. The first entrant is penalized for being the first to provide early access to patients.

	Drug A	Drug B	Drug C
1st sale	Jan-2021	Jul-2022	Jan-2024
List Price	\$100	\$100	\$100
PMPRB TCL Level / Floor	3/ 40%	4 / 50%	4 / 50%
MRP = median dTCC*	\$60	\$80	\$100

* also includes Drug X (\$60) - NOC 2002

Drug A:

	2021	2022	2023	2024	2025
Gross Revenues	\$20,000,000	\$75,000,000	\$90,000,000	\$75,000,000	\$70,000,000
MRP/MRP[a] %	100%	82%	76%	76%	76%
Revenues @ MRP/MRP[a]	\$20,000,000	\$61,250,000	\$68,000,000	\$56,666,667	\$52,888,889

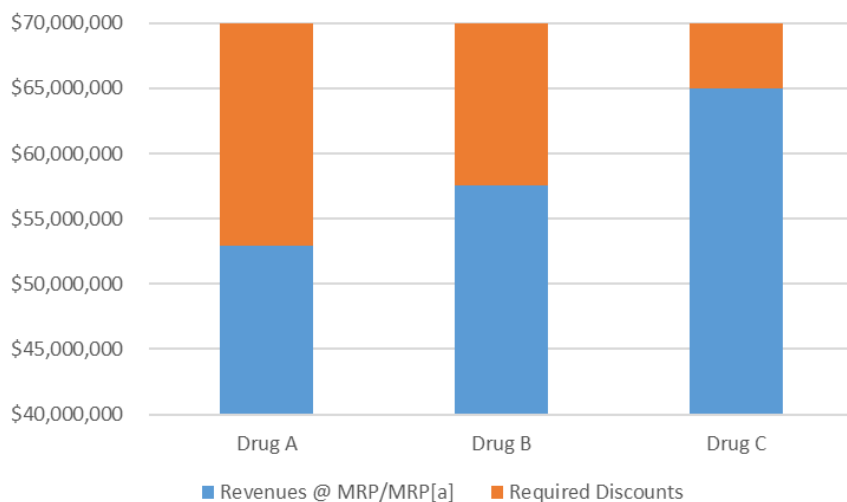
Drug B:

	2021	2022	2023	2024	2025
Gross Revenues		\$25,000,000	\$75,000,000	\$90,000,000	\$70,000,000
MRP/MRP[a] %		100%	87%	82%	82%
Revenues @ MRP/MRP[a]		\$25,000,000	\$65,000,000	\$74,000,000	\$57,555,556

Drug C:

	2021	2022	2023	2024	2025
Gross Revenues				\$25,000,000	\$70,000,000
MRP/MRP[a] %				100%	93%
Revenues @ MRP/MRP[a]				\$25,000,000	\$65,000,000

Products have the same list price, same gross revenues; yet, different MRP(a) resulting in different net revenues. Why?
Because of different median dTCC.





Case 3: Adverse incentives created by the market size factor where there is an arbitrary and sizable second-entrant disadvantage despite offering similar efficacy. This is another no-launch scenario where the operation of the Guidelines would deny patients and clinicians alternative therapeutic options - which are essential due to clinical non-response or diminishing response - and limit competition

This case is a companion to Case 2 above. It illustrates that first-launch and second-launch disincentives are arbitrary under the PMPRB’s proposed regime.

Drug A	
1st sale	Mar-21
MLP:	\$100,000
List Price:	\$100,000
TCL:	Level I

Drug A is Category 1 based on price and it is the first medicine to treat a new indication. It is classified as innovative and receives a TCL Level I.

When Drug A reaches \$12M in revenue, the following mandated rebates are applicable:

Revenues	Mandatory Discounts
Between \$12M and \$50M	up to -20% (MRP)
Between \$50M and \$100M	additional -25% (MRP[A])
Above \$100M	additional -35% (MRP[A])

Drug B is launched 6 months later. It has same list price, same indication and similar efficacy as Drug A.

Drug B	
1st sale	Sept-21
MLP:	\$100,000
List Price:	\$100,000
TCL:	Level IV

However, Drug B is classified as Level IV (no improvement over Drug A).

When Drug B reaches \$12M revenue:

Revenues	Mandatory Discounts
Between \$12M and \$50M	up to -50% (MRP)
Between \$50M and \$100M	additional -25% (MRP[A])
Above \$100M	additional -35% (MRP[A])

Drug B is very similar and clinically comparable to Drug A. The regime results in much higher mandatory discounts for Drug B, solely due to a 6-month delay in first sale.

This case demonstrates that the proposed MRP calculation has structurally inequitable results and would place a much higher burden of compliance on the subsequent entrants in a market. This is a disincentive to competition that will not benefit patients. It is also inconsistent with an excessive price standard, because it suggests that a patentee has abused its patent and that the medicine’s price is excessive if it does not offer significant discounts to an existing comparable drug launched only one reporting period earlier.



Case 4: A case comparison of the 2019 draft Guidelines and 2020 draft Guidelines which demonstrates that despite increased market size thresholds there can be even greater negative impacts due to the MRP. This case demonstrates that some elements of the 2020 Guidelines will have a more negative impact than the previous 2019 Guidelines.

	Drug A	Drug B
1st sale	Jan-2021	Jan-2021
Therapeutic Area	Diabetes	Mental Health
List Price	\$100	\$100
PMPRB TCL / Floor	1 / 20%	4 / 50%
median dTCC	N/A	\$25
MRP	\$80	\$50

Market Size Adjustment as per Nov 2019 Draft – for Drug A

	2021	2022	2023	2024	2025
Gross Revenues	\$25,000,000	\$50,000,000	\$75,000,000	\$100,000,000	\$125,000,000
MRP/MRP[a] %	100%	95%	90%	85%	80%
Revenues @ MRP/MRP[a]	\$25,000,000	\$47,500,000	\$67,500,000	\$85,000,000	\$100,000,000

Market Size Adjustment as per June 2020 Draft - Drug A (TCL 1)

	2021	2022	2023	2024	2025
Gross Revenues	\$25,000,000	\$50,000,000	\$75,000,000	\$100,000,000	\$125,000,000
MRP/MRP[a] %	100%	100%	87%	80%	77%
Revenues @ MRP/MRP[a]	\$25,000,000	\$50,000,000	\$65,000,000	\$80,000,000	\$95,700,000

Market Size Adjustment as per Nov 2019 Draft – for Drug B

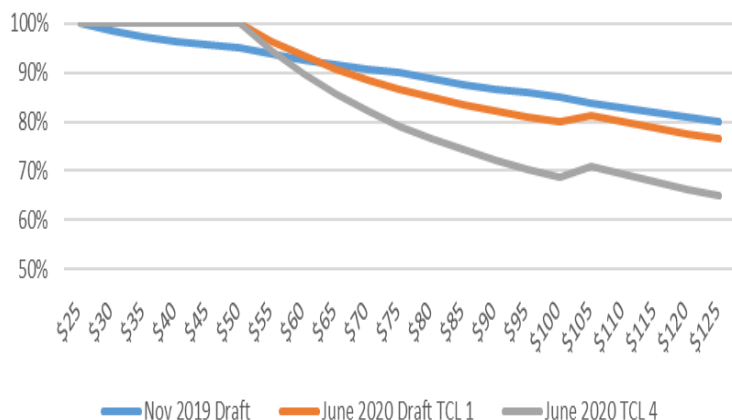
	2021	2022	2023	2024	2025
Gross Revenues	\$25,000,000	\$50,000,000	\$75,000,000	\$100,000,000	\$125,000,000
MRP/MRP[a] %	100%	95%	90%	85%	80%
Revenues @ MRP/MRP[a]	\$25,000,000	\$47,500,000	\$67,500,000	\$85,000,000	\$100,000,000

Market Size Adjustment as per June 2020 Draft - Drug B (TCL 4)

	2021	2022	2023	2024	2025
Gross Revenues	\$25,000,000	\$50,000,000	\$75,000,000	\$100,000,000	\$125,000,000
MRP/MRP[a] %	100%	100%	79%	69%	65%
Revenues @ MRP/MRP[a]	\$25,000,000	\$50,000,000	\$59,375,000	\$68,750,000	\$81,075,000

Despite the introduction of 1) higher market size thresholds (\$50M vs \$25M), 2) concept of Therapeutic Criteria Level with 3) corresponding Reduction floors, the revised Market Size adjustment formula provides much lower MRP ceilings than previously proposed.

MRP Adjustment (MRP(a)) – 2019 Draft vs 2020 Draft Guidelines





Case 5: A lack of predictability and arbitrary price reductions required by the median domestic therapeutic class comparison (dTCC). This test would unreasonably force innovative medicines to be priced like generic drugs. Pricing would unreasonably be based upon the number of generic comparators in the market rather than excessive pricing.

Assumptions:

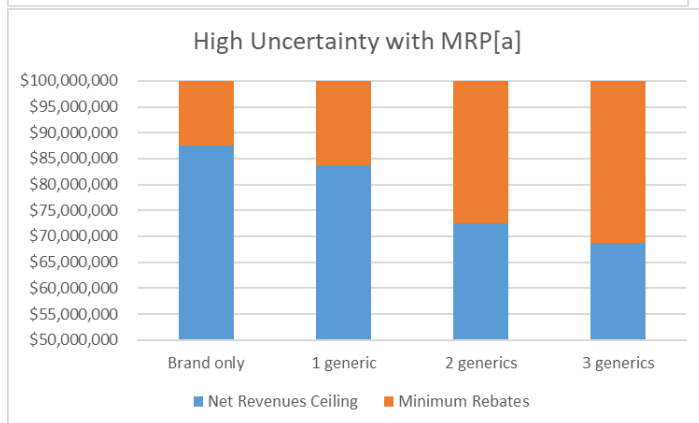
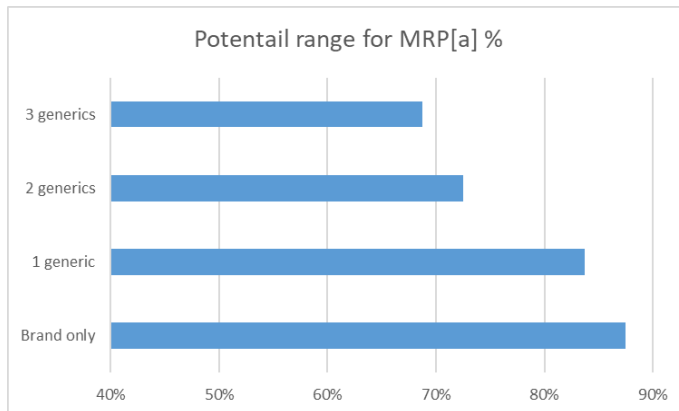
List Price \$125 (MLP<MIP)
 PMPRB TCL = Level 4 (Floor = 50%)
 Expected to launch in Fall 2021
 Expected revenues > \$50M by 2025

	2022	2023	2024	2025
Gross Revenues	\$15,625,000	\$31,250,000	\$48,750,000	\$100,000,000
MRP/MRP[a] %	100%	100%	100%	?
Revenues @ MRP/MRP[a]	\$15,625,000	\$31,250,000	\$48,750,000	?

Example 1: Pricing based on the lowest comparator brings high impacts and uncertainty.

Potential scenarios for prices used in dTCC (i.e. lowest available price) – Comparator could potentially experience generics as early as 2024.

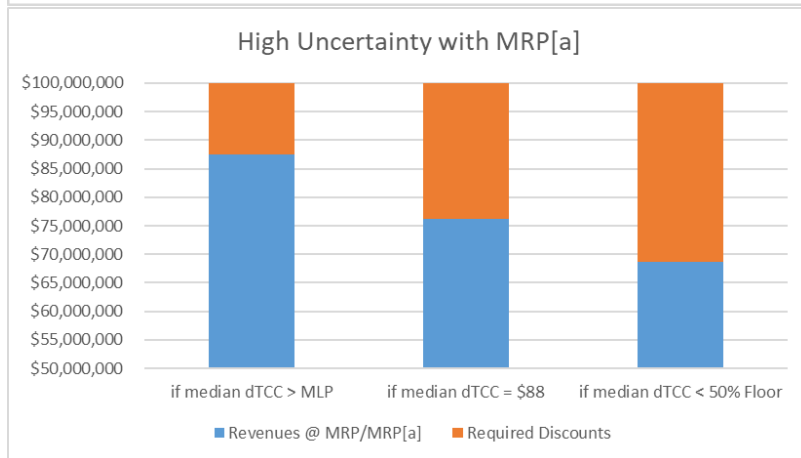
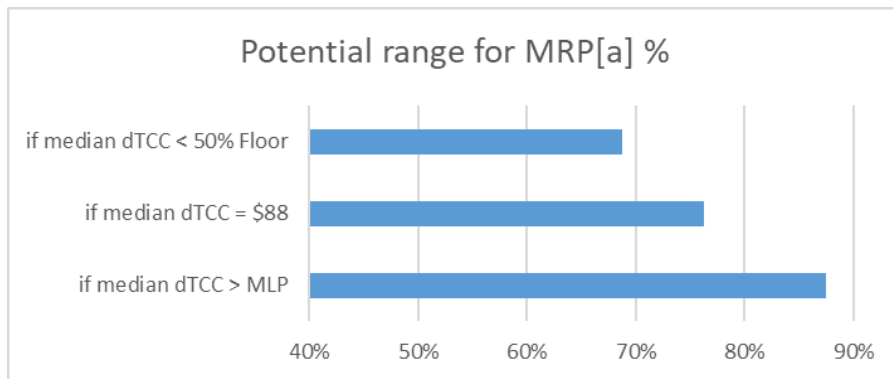
	Brand only	1 generic	2 generics	3 generics
Comparator	\$150	\$113	\$75	\$38





Example 2: Pricing based on the median dTCC is arbitrary and punitive. A medicine's price is forced well below the price of appropriate standard-of-care comparators.

	List Price	National Market Share	Cumul Market share	Few examples of potential median dTCC				
Comparator 1	\$250	20%	20%					
Comparator 2	\$200	35%	55%					
Comparator 3	\$125	35%	90%					
Comparator 4	\$50	5%	95%					
Comparator 5	\$50	1%	96%					
Comparator 6	\$25	2%	98%					
Comparator 7	\$25	2%	100%					





Case 6: A tendered product, such as a vaccine or blood product, where the Guidelines would essentially obstruct competitive multi-year tendering.

In this case, two new products with same list price per unit and same annual treatment costs (below 150% GDP/capita) competing in a \$50M/year tender (at list price):

- Product A has several long-term contracts that will sustain same price for several more years.
- Product B is newly launched and does not have current sales.
- Clinically superior to Product A but the main determinant in winning the bid will be on price.

Drug	Annual Treatment Cost (C\$)	Current Annual Sales (C\$)	MLP / Unit (C\$)	MIP PMPRB11	MRP @ \$200M	MRP if tender won (\$50M)
Product A	< 150% GDP/capita	\$200M	\$10	\$10	\$7.71	\$7.47
Product B	< 150% GDP/capita	\$0 M	\$10	\$10	n/a	none

Assuming Product A wins the \$50M incremental tender, market size proposals suggest manufacturer has no choice but to bid at a lower price than previous contracts to be compliant with new MRP. If one or several previous contracts expires or are not renewed, the manufacturer may be unable to comply with the MRP given contracts fluctuations. Market size concepts incorrectly assume the same rebates are offered in a consistent and uninterrupted fashion. Compliance will be extremely challenging or lead to unnecessary investigations and disputes over benefits variations.

In order to win the \$50M tender, Product B will derive the estimated Product A MRP from the existing annual sales and calculate a potential \$200M revenue corresponding to a weighted average MRP of \$7.47 per unit. As a result, Product B will need to offer at a minimum a 25% discount/unit, at launch, despite anticipated revenues of less than \$50M.

- The draft PMPRB Guidelines may serve as a deterrent for Product B to enter the Canadian market given the 25% discount that they would have to provide from the median international price.
- New entrants can be indirectly subject to more punitive MRP ceilings at launch than existing entrants, further discouraging submissions for regulatory approval in Canada and diminishing market competition.

This example demonstrates that the draft Guidelines, especially the market size concept, are unworkable with respect to products subject to tenders, group purchasing agreements or any other multi-year price/volume contractual agreements (which can apply to therapeutic class products, hospital products, cancer medicines, blood products, vaccines, etc.). IMC is disappointed that no exemptions or alternative policy proposals have been included in the Guidelines to address and acknowledge the existing competitive price negotiation processes.



Case 7: A low-priced drug that would offer significant cost savings to the system is required to take additional discounts to already discounted list prices. This case demonstrates how the Guidelines automatically penalize medicines that bring savings to the health care system.

Drugs A and B are not high cost. They are in the same therapeutic class and treating the same indication.

Drug C is slightly more efficacious, and it is launched at a lower list price level than these other 2 drugs in this class. It is classified by PMPRB as a therapeutic criteria level (TCL) IV.

As payers recognize the cost-savings, and Drug C grows and takes market share from the other products, as illustrated in the annual revenues of these drugs:

Revenues (in million CAD)				
	2021	2022	2023	2024
Drug A	48	40	30	17
Drug B	45	38	30	18
Drug C	-	10	27	50

When Drug C reaches the \$50M threshold, it must comply with significant mandatory rebates.

Annual revenues	MRP	Incremental MLP adjustment factor
<50M	MLP	0%
\$50M-\$100M	Lowest of the MLP and the median of the dTCC	-25%
>\$100M		-35%

¹ Lower of the MLP and List Price

This case demonstrates that the proposed market size approach can be punitive when applied to the best products, even when they provide cost savings for Canadian payers. In fact, Drug C is being penalized for bringing savings to Canadians.

The “one-size-fits-all” approach to market size creates a distortion in the market and disincentives to competition, and potential savings to the health care system would not be realized.



¹ See <http://www.oecdbetterlifeindex.org/countries/canada/>

² Innovative Medicines Canada v. Canada (Attorney General) 2020 FC 725 <https://decisions.fct-cf.gc.ca/fc-cf/decisions/en/item/481803/index.do>

[at 208] “While the New Price Calculation is ostensibly intended to protect consumers from excessive pricing of patented medicines, the Governor in Council cannot exceed the scope of her regulation-making authority within the scheme of the *Patent Act* in attempting to advance this objective. The New Price Calculation does just that, and is therefore *ultra vires* the *Patent Act*. An interpretation that may accord with an objective of the Patented Medicines Regime, but is inconsistent with the Board’s mandate within the scheme of the *Patent Act* and flies in the face of the ordinary meaning of the “price” at which a medicine is “sold” is not reasonable.”

[at 215] “the requirement for patentees to report price information net of transactions involving third parties unrelated to the factory-gate sale of the a patented medicines is inconsistent with subparagraph 4(1)(f)(i) of the *Regulations* and paragraph 80(1)(b) of the *Patent Act*. By amending subsection 4(4) of the *Regulations* in this way, the Governor in Council exceeded the scope of her regulation-making mandate found in paragraph 101(1)(a) of the *Patent Act*.”

³ 2020 Guidelines at para 57, 95.

⁴ New economic factors and rebates are centrally linked in the August 21, 2019 Regulatory Impact Analysis Statement (RIAS): “Requiring patentees to provide this information will facilitate compliance with the new, lower price ceilings that are expected to result from the PMPRB’s application of the new subsection 85(1) factors. More generally, it will also allow the PMPRB to factor third party rebates into its calculation of average transaction prices to inform existing factors.”

⁵ Proposal to withhold certain PMPRB assessments from publication do not correct for this fundamental challenge.

⁶ See: 1) IMC submission to the PMPRB October 2016 ([link](#)); 2) our February 2018 response to Canada Gazette Part II ([link](#)); 3) our on the record comments as part of the PMPRB’s steering committee ([link](#)) and technical working group ([link](#)); our February 2020 Guidelines submission ([link](#)); and other verbal representations.

⁷ Further discussion through technical working groups is required to address alternatives to PMPRB’s proposed price tests in situations where no international prices are available.

⁸ See our detailed commentary and logical argument on the lack of consistency of a median therapeutic class comparison with an excessive price standard in our February 2020 Guidelines submission ([link](#)). PMPRB has not responded to this central criticism, nor provided a reasonable rationale for its use which appears arbitrary.

⁹ Further discussion through technical working groups is required to address alternatives to PMPRB’s proposed price tests in situations where no international prices are available.

¹⁰ Furthermore, asking patentees to systematically file a request for PMPRB staff to re-calculate a non-excessive benchmark ceiling would be an inefficient use of both patentee and PMPRB staff resources.

¹¹ It is not sufficient to simply state that manufactures can “talk to PMPRB staff” in special cases, or in the event of an investigation, as was suggested by PMPRB staff at the June 29, 2020 Patentee webinar. PMPRB is not a negotiation body. The rules for vaccines could have significant future access implications and therefore must be made explicit.

¹² In addition, PMPRB should revise the statement regarding its mandate with respect to the “pre-grant period (from the patent application date)” (see para 20). This statement lacks specificity since it can be read as the patent filing date, which is not an accurate description of Board jurisdiction. This should be amended to “from the laid open date or the date of first sale, whichever is later.”

¹³ We also suggest a virtual opportunity for a public policy forum with the full PMPRB Board is achievable.