



2026 COST DRIVERS REPORT

Analysis of Private Drug Plan Claims Trends in Canada





TABLE OF CONTENTS

Key Findings	1
About	2
Executive Summary	3
Overall Private Drug Plan Claims Cost Growth	4
Impact of Chronic Disease	8
Impact of Treatment Costs	9
Returning Value Through the Innovation Cycle	11
Impact of Therapeutic Class	12
Impact of Aging	14
Value of Canada's Dual Drug Market System	15
Impact of Days' Supply	16
Key Takeaways	18
Data Sources and Methodology	21
Appendix 1 – Growth by Region	22
Appendix 2 – 2023 Volatility Analysis	23
Appendix 3 – Supplemental Charts	31



KEY FINDINGS

- Overall, private drug plan cost growth in 2025 was 6.7%. This is down from 7.5% in 2024 and in line with the 2019-2025 compound annual growth rate (CAGR) of 6.7%. Growth was driven by a combination of higher costs per claim (4.2%), increased claims per claimant (1.9%), and modest claimant growth (0.5%).
- Utilization remains a key driver of private drug plan cost growth, specifically among higher-cost drugs (greater than \$10,000 annually), where the increase in claimants accounts for most of the growth. The larger category for drugs costing less than \$10,000 grew primarily due to higher cost per claim and claims per claimant. Because this category accounts for twice the share of total costs as the more than \$10,000 category (66.8% vs. 33.2%), it has a greater influence on overall market results, making its cost-per-claim growth appear more prominent at the aggregate level.
- The \$25,000-\$100,000 category experienced a considerable decrease in claimants of 8.5%, which resulted in an increase in the lower cost \$10,000-\$25,000 category of 17.1% as claimants shifted. This transition from higher to lower cost therapies can be mainly attributed to the innovation cycle's introduction of biosimilars in the biologic disease modifiers for RA/PsO/IBD/AMD¹ category.
- Chronic, lower-cost drug utilization continues to have the greatest impact on cost growth. Chronic therapies accounted for 73.9% of total private drug plan costs and contributed 78.7% of annual cost growth. Lower cost drugs under \$10,000 annually were responsible for two-thirds (66.8%) of total spending.
- Antidiabetic and obesity therapies were the largest contributor to cost growth, followed by biologic disease modifiers and other immunomodulating and immunosuppressive agents.
- Adults aged 45 to 64 represented half of all private drug plan spending and accounted for more than half of total cost growth.
- The 65+ age group experienced the fastest claimant growth (3.3%) and the highest total cost growth (8.9%) between 2024 and 2025. This trend points to more Canadians remaining in the workforce longer.
- Increasing days' supply can drive additional savings without compromising access, as just under half (47.2%) of claims for three common categories of oral solid drugs are currently dispensed at 90 days or more. Increasing days' supply can reduce the average daily treatment cost by up to 40%, with savings driven by reducing the proportion of non-drug costs like dispensing fees and markups.
- Private drug plans provide faster² and broader³ access to new medicines than public plans. By doing so, the market for private drug benefits plays a critical role in improving health outcomes while strengthening Canada's attractiveness as a destination for innovative medicines, research, and clinical trials.

¹ Rheumatoid arthritis, psoriasis, inflammatory bowel disease and age-related macular degeneration category

² IQVIA Canada. Private Payer Time to Access Analysis. 2026.

³ Gagnon-Arpin, Isabelle, Wanlin Chen, and Chad Leaver. Understanding the Gap 2.0: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage. Ottawa: The Conference Board of Canada, 2022.



ABOUT

Since 2018, Innovative Medicines Canada (IMC) has published its annual national private market Cost Drivers Report. The report provides a comprehensive analysis of the drivers contributing to the cost growth of private drug plan claims and insights into overall trends reflective of prevailing market conditions. These findings can help plan sponsors, advisors, insurers, and policymakers better understand how private drug plans are evolving and how they can continue to balance access, innovation, and affordability.

The research is based on IQVIA claims data, representing 80% of the Canadian private market. References to changes from previous years are based on this updated database. This analysis does not account for potential savings resulting from the growing use of negotiated product listing agreements (PLAs) and may, therefore, overstate growth and cost estimates. In addition, this analysis measures growth based only on submitted private market claims and claimant activity. Readers are encouraged to compare their own experience with these broader market trends.

EXECUTIVE SUMMARY

Canada's private drug insurance system plays a foundational role in supporting the health and productivity of Canadians and their families by offering faster and more generous access to medicines compared to public plans. This level of access is invaluable to plan members managing chronic or acute health needs, and for employers seeking to support a healthy, productive, and engaged workforce. By enabling timely access to optimal treatment options, private drug benefits contribute to better health outcomes, reduced treatment delays, and lower long-term costs for individuals, employers, and the broader healthcare system.

Total private drug plan cost growth in 2025 remained in line with historical trends at 6.7%, consistent with the 6.7% compound annual growth rate observed since 2019. Despite ongoing introductions of innovative specialty and high-volume medicines, this rate steadiness shows that the market remains sustainable. Importantly, this measure does not reflect confidential discounts negotiated through Product Listing Agreements (PLAs), meaning that the reported cost growth does not fully capture the net cost to private plans and likely understates the market's underlying stability. Through the combined effects of drug plan management, the evolution of the treatment mix, and the broader innovation cycle, the private market demonstrates the compatibility of value, broad and timely access to innovation, and sustainability.

Total cost growth comprised 4.2% growth in cost per claim and 2.4% growth in utilization, which was influenced heavily by distinctive differences in growth patterns depending on drug cost category. For drugs costing less than \$10,000, cost per claim was the primary driver of growth. For drugs costing more than \$10,000, utilization had the greater influence. Given that the less than \$10,000 category represents a substantially larger share of the market costs (66.8% vs 33.2%), its cost-driving dynamics had a more pronounced impact on overall results.



Although high-cost claims feature prominently in discussions about affordability, annual claims exceeding \$100,000 represent just 0.03% of all claims. Approximately 99.3% of claims filed by plan members were for drugs costing less than \$10,000 annually, with only 0.7% of claims attributable to drugs costing more than \$10,000 annually. This suggests that the sustainability challenge posed by high-cost claims stems less from their prevalence than from the financial volatility they create, particularly in the absence of appropriate pooling mechanisms.

Chronic therapies remained the dominant component of private drug plan spending, accounting for 73.9% of total costs and 78.7% of overall cost growth. Therapies used to treat diabetes, obesity, autoimmune diseases, inflammatory conditions, cardiovascular disease, and mental health disorders continue to play an increasingly important role in supporting the long-term health of working Canadians. The largest contributors to annual growth were antidiabetic and obesity therapies, biologic disease modifiers, and other immunomodulating and immunosuppressive agents, reflecting ongoing advances in the treatment of chronic and complex conditions.

The data showed claimants shifting significantly from the \$25,000-\$100,000 category (-8.5%) to the \$10,000-\$25,000 (17.1%) category, largely attributed to the growing uptake of biosimilars in the biologic disease modifiers for RA/PsO/IBD/AMD category. This shift demonstrates the pharmaceutical innovation cycle in action: therapies that initially enter the market at higher costs often become more affordable over time as competition increases. By providing access to these innovative therapies earlier, during their patent-protected stage, private drug plans enable plan members to benefit from advanced treatment years sooner than they otherwise might. For those living with chronic diseases, earlier access can help improve disease management, reduce the risk of progression, and potentially prevent longer-term disability, delivering value beyond drug costs alone.

Working-age Canadians remain the primary users of private drug benefits. Individuals aged 25 to 64 accounted for the majority (76.9%) of private drug plan spending, with those aged 45 to 64 representing 50.1% of total costs and 53.6% of annual cost growth. The fastest claimant growth was among Canadians aged 65 and older at 3.3%. This trend reflects both broader demographic changes and the growing number of Canadians who are remaining in the workforce longer and continuing to rely on employer-sponsored benefits.

By providing faster and broader access to new medicines than public plans, the private drug benefits market plays a critical role in improving health outcomes while strengthening Canada's attractiveness as a destination for innovative medicines, research, and clinical trials. Preserving this value proposition requires sustainability strategies that protect broad and timely access to innovation rather than restricting or delaying it. For example, near-term savings can be achieved by encouraging longer days' supply where clinically appropriate for lower-cost medicines to reduce non-drug costs like pharmacy fees and markups. At the same time, strengthening pooling and other risk-sharing mechanisms can better distribute the financial impact of the relatively small number of high-cost claims across a broader population. Together, these complementary approaches improve affordability and predictability for insurers and plan sponsors while preserving timely, comprehensive access to innovative medicines that distinguishes Canada's private drug benefits market.



OVERALL PRIVATE DRUG PLAN CLAIMS COST GROWTH

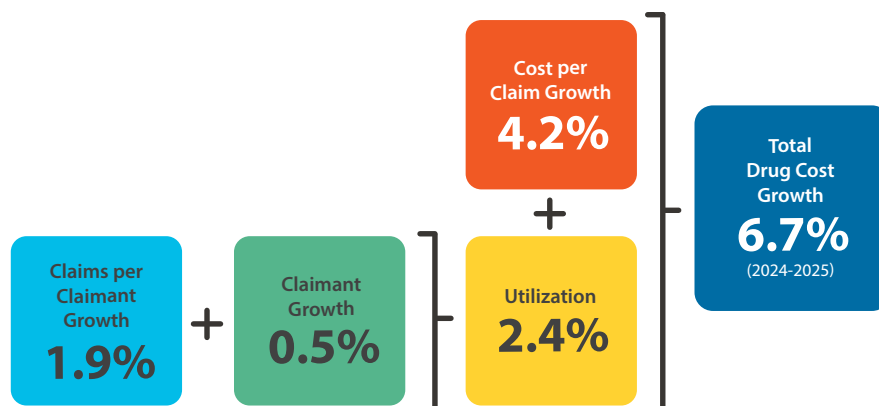
Private drug plan cost growth is driven by three factors:

1. Utilization
 - a. The number of people making claims,
 - b. How many claims each person makes,
2. The cost of each claim.

The first two factors are grouped as utilization, which represents how often a drug plan is used. The cost per claim reflects the reimbursement amount for each claim, which is influenced by changes in the drug used (drug mix), manufacturer pricing, dispensing fees, and pharmacy markups. Distinguishing these factors helps show whether costs are rising because more people are using more medications, or because each claim is becoming more expensive.

Total private drug plan costs increased by 6.7% in 2025, with increased utilization (2.4%) accounting for 35.8 % of the total cost growth. (See Figures 1 and 2) These numbers show a high-level view of growth in the market, but a closer examination of individual cost categories reveals important differences in the drivers of this growth. (See Impact of Treatment Costs)

FIGURE 1: **Private Market Cost Drivers, 2024-2025**

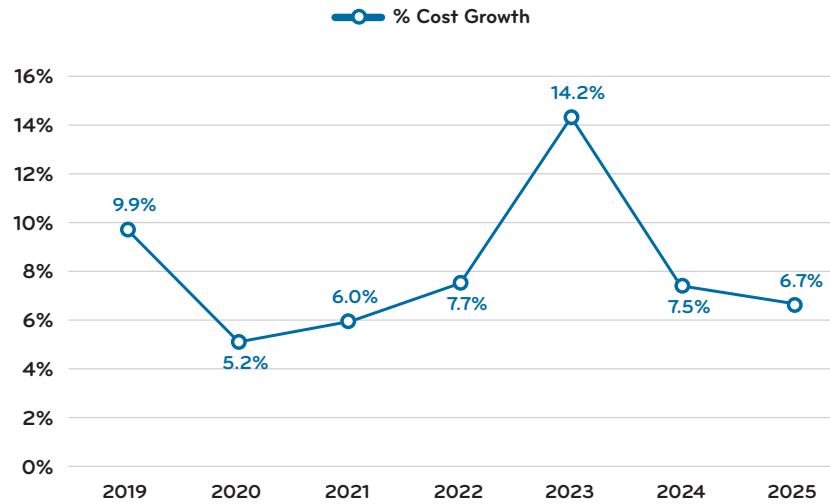


Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Note: A Cross Effect of 0.1% was also calculated, which is a minimal effect that none of the effects above account for in isolation; in other words, the Cross Effect is a residual component of the Net Change that contributes to the Total Drug Cost.



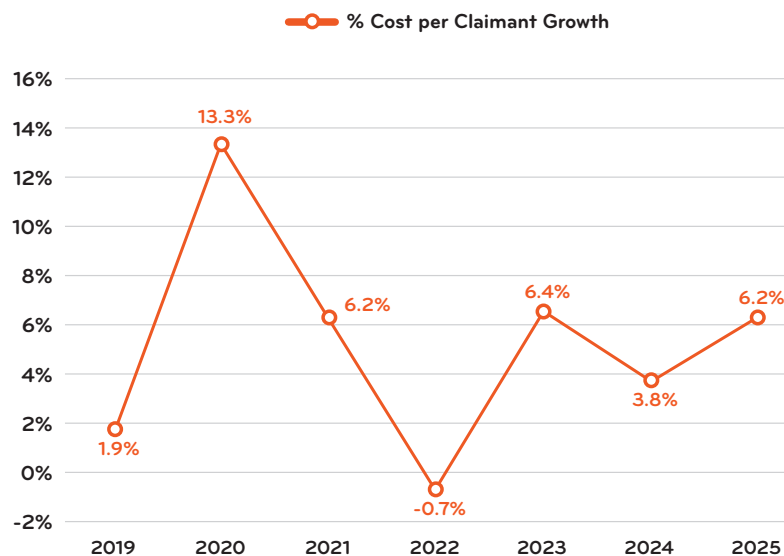
FIGURE 2: **Private Drug Plan Cost Growth, 2019-2025**
CAGR 2019-2025: 6.7%



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

The average cost per claimant grew by 6.2% in 2025. (See Figure 3)

FIGURE 3: **Private Drug Plan Average Cost per Claimant, 2019-2025**

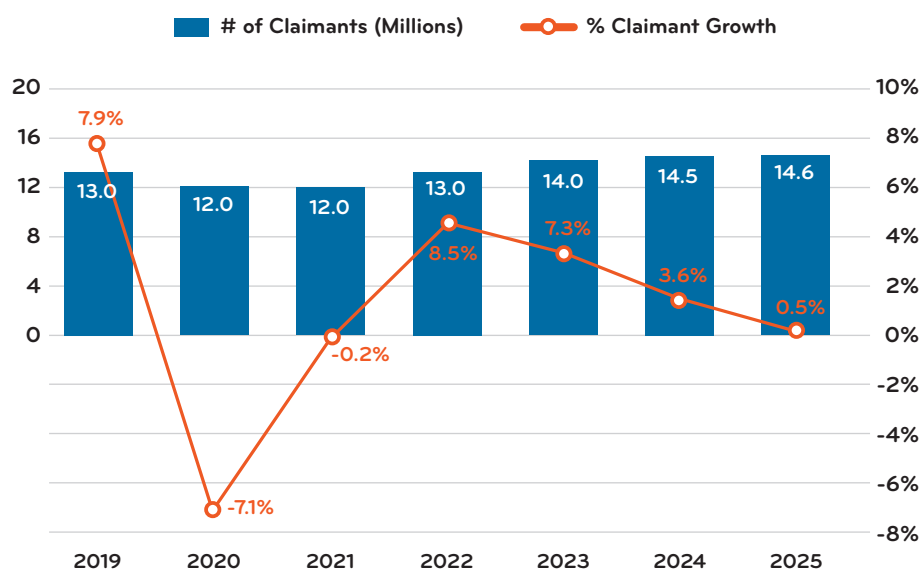


Source: IQVIA Private Drug Plan (PDP) Claims database, 2025.



The number of claimants increased by just 0.5% in 2025. This marks a significant decrease in the growth rate compared to the past three years of elevated growth driven mainly by unprecedented population increases and market recovery from pandemic-related disruptions. (See Figure 4)

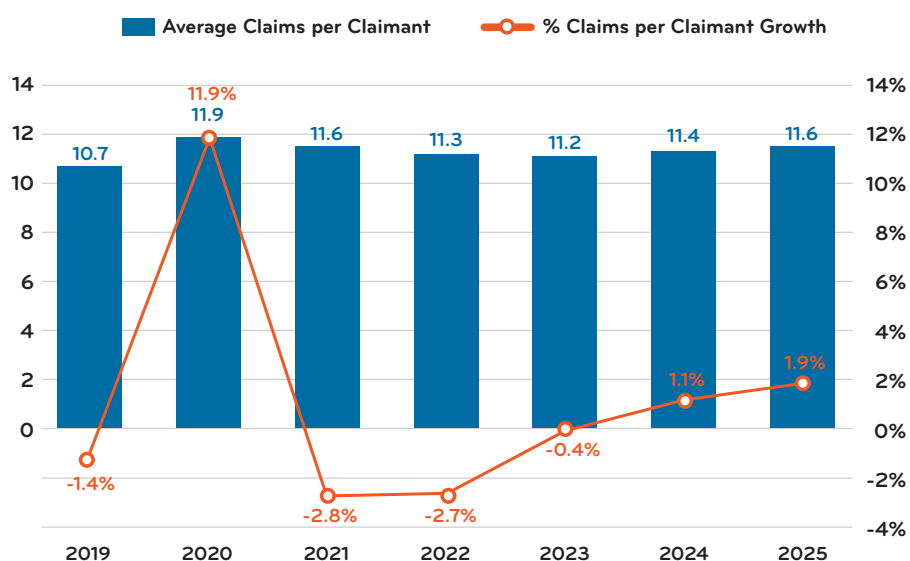
FIGURE 4: **Private Drug Plan Claimants, 2019-2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Following the sharp increase in 2020 due to days' supply restrictions implemented during the pandemic to mitigate the risk of drug shortages, the number of claims per claimant has remained relatively steady between 11 and 12 claims annually. The 1.9% increase in 2025 was the largest since 2020. (See Figure 5)

FIGURE 5: **Private Drug Plan Average Claims per Claimant, 2019-2025**

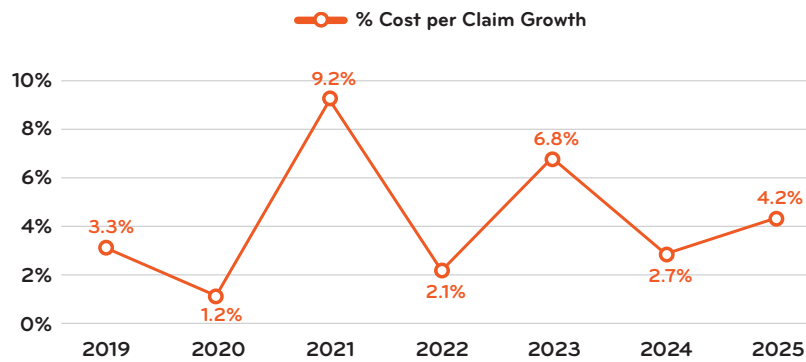


Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.



The average cost per claim increased by 4.2% in 2025. (See Figure 6)

FIGURE 6: **Private Drug Plan Average Cost per Claim, 2019-2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.





IMPACT OF CHRONIC DISEASE

To better understand growth trends within treatment categories, this analysis divides them into chronic, non-chronic, and cancer. Chronic medications are those used on an ongoing basis to treat long-term conditions such as diabetes, hypertension, or depression, and typically involve predictable, stable usage across a large claimant base. In contrast, non-chronic medicines treat short-term or acute conditions and have significantly lower claimant persistence. Cancer therapies are treated as a distinct group, as their duration and intensity can vary significantly by cancer type and diagnosis. Understanding these distinctions provides a clearer picture of treatment patterns, what types of conditions are most prevalent in the working population, and where private drug benefits are most heavily used.

Weight Loss Treatments

For the first time in this report's methodology, weight loss medications were categorized as chronic and combined with the antidiabetic therapeutic class. Newly approved medications prescribed for obesity management for durations of one year or more⁴ resulted in the re-categorization of weight loss medications from non-chronic to chronic.

Chronic medications continued to dominate private drug plan spending in 2025, accounting for 73.9% of total costs and 78.7% of annual cost growth. Non-chronic therapies accounted for 21.0% of total costs and 15.7% of annual cost growth. Cancer therapies accounted for the remaining 5.1% of total costs and 5.5% of annual cost growth. (See Figures 7 and 8)

FIGURE 7:
Share of 2025 Private Drug Plan Costs by Chronic, Non-Chronic, and Cancer Therapy

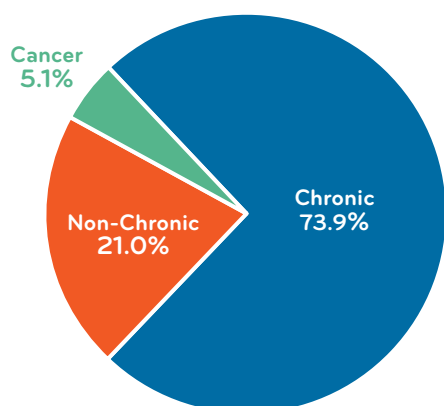
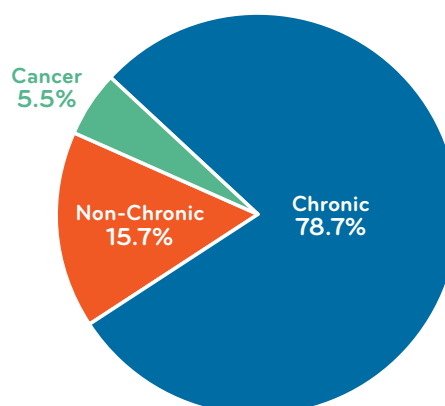


FIGURE 8:
Contribution to 2024-2025 Cost Growth by Chronic, Non-Chronic, and Cancer Therapy



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Note: Totals may not add up to 100% due to rounding.

⁴ Pedersen SD, Manjoo P, Wharton S. Canadian Adult Obesity Clinical Practice Guidelines: Pharmacotherapy for Obesity Management. Available from: <https://obesitycanada.ca/guidelines/pharmacotherapy>. Accessed June 25, 2025.



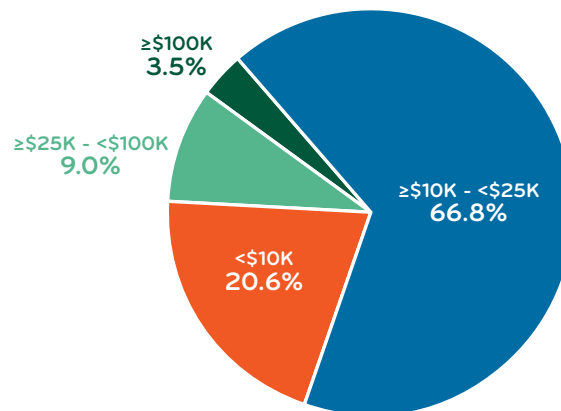
IMPACT OF TREATMENT COSTS

Drugs costing under \$10,000 annually made up 99.3% of all private drug plan claims in 2025. (See Appendix 3 – Figure 23) They accounted for 66.8% of total private claims costs and 51.0% of cost growth, driven largely by antidiabetic and obesity medicines. Drugs in the \$10,000-\$25,000 annual treatment cost range made up 20.6% of private drug plan costs and 53.1% of cost growth, with the most common treatments in this category being for autoimmune diseases.

The data showed a decline in the share of drugs costing between \$25,000-\$100,000 from 10.3% in 2024 to 9.0% in 2025, following a 10.5% decline in cost growth. This was driven largely by the introduction and uptake of biosimilars. Drugs exceeding \$100,000 annually made up 3.5% of total costs and 6.4% of the cost growth, while accounting for 0.03% of claims. (See Figures 9 and 10)

While high-cost drug claims are uncommon and account for a small share of total costs, they continue to be a sustainability concern for smaller plans. As highlighted in the 2023 IMC Cost Drivers Report, Volatility Analysis (see Appendix 2), the median cost per claimant for small plan sponsors who experienced a claim over \$50,000 was up to 20 times higher compared to those without. Modernizing pooling mechanisms outside of Quebec is critical to mitigating these impacts and preserving access while managing risk.

FIGURE 9: **Share of 2025 Private Drug Plan Costs by Treatment Cost Category**

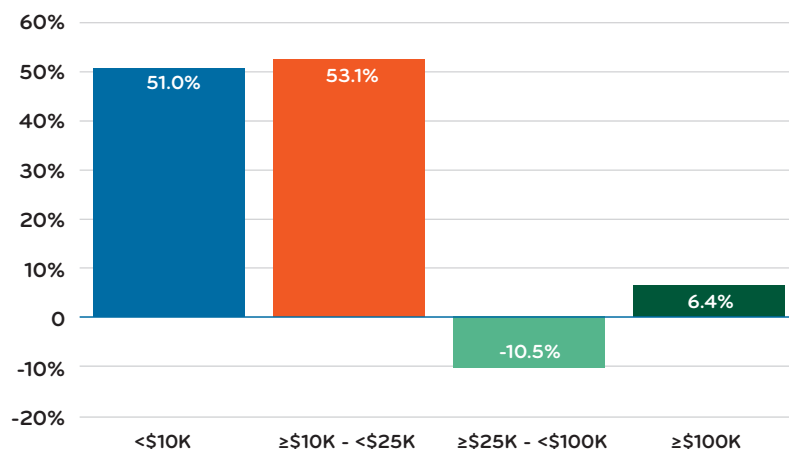


Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Note: Totals may not add up to 100% due to rounding.



FIGURE 10: **Contribution to 2024-2025 Cost Growth by Treatment Cost Category**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Note: Totals may not add up to 100% due to rounding.

The growth drivers by annual treatment cost category in 2025 reveal distinct dynamics across the private drug market. Drugs under \$10,000 accounted for the majority of total market spend and more than half of overall growth, with increases driven primarily by higher cost per claim. This reflects the increased uptake of newer diabetes therapies displacing older treatments, highlighting the role of evolving clinical practice within high-volume categories. In contrast, drugs above \$10,000 were driven primarily by increased utilization, almost entirely attributable to growth in new claimants.

Within this category, notable shifts in claimant distribution were observed, particularly from the \$25,000-\$100,000 to the \$10,000-\$25,000 range. This largely reflects increased adoption of biosimilars for biologic disease modifiers used to treat rheumatoid arthritis, psoriasis, inflammatory bowel disease, and age-related macular degeneration.

While higher-cost drugs represent a smaller share of total claims, these utilization shifts are important in understanding underlying growth patterns.

The less than \$10,000 category remains the dominant contributor to overall market growth given its scale. As a result, trends within this category continue to disproportionately influence total market outcomes and help explain why utilization had a more moderate impact on overall growth compared to prior years.

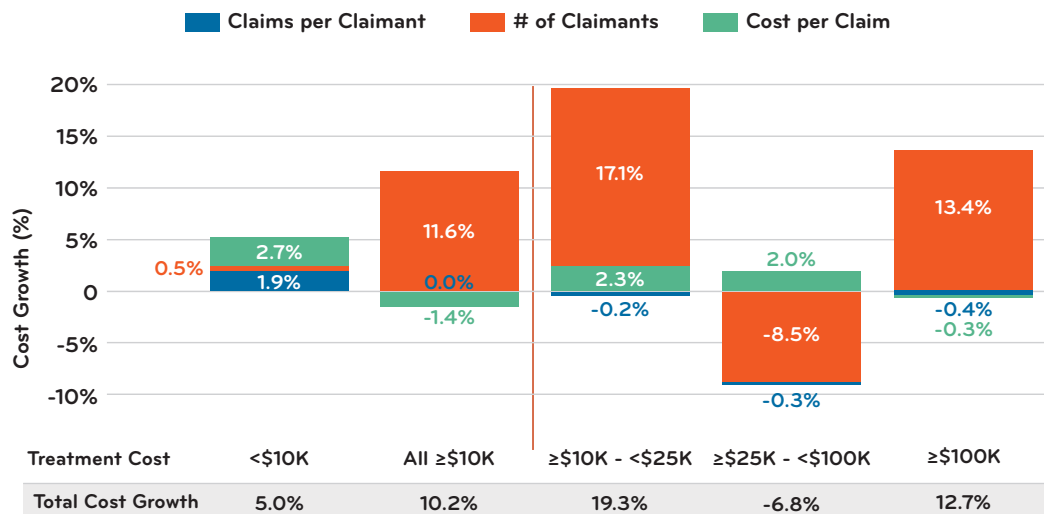
Growth in the \$100,000+ treatment cost category was driven entirely by new claimants initiating therapy (+13.4%), while cost per claim (-0.3%) and claims per claimant (-0.4%) both declined modestly.

The \$25,000-\$100,000 treatment cost category saw an 8.5% decline in claimants, primarily driven by movement into lower-cost biosimilar therapies in the \$10,000-\$25,000 category. This is consistent with the 17.1% increase in claimants in the \$10,000-\$25,000 range, reflecting continued biosimilar uptake within biologic disease modifiers. (See Figure 11)

Despite these shifts across categories, the absolute number of affected claimants remains small in the context of the overall market.



FIGURE 11: **Cost Growth Drivers by Treatment Cost Category, 2024-2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Note: Totals may not add up to 100% due to rounding.

Returning Value Through the Innovation Cycle

The private market provides more generous⁵ and faster⁶ access than the public system, making it a critical pathway for ensuring Canadians benefit from the latest therapeutic innovations. For plan members, earlier access to more effective therapies can help them manage their conditions sooner, maintain their quality of life, remain active in the workforce, and potentially avoid disease progression or more costly interventions down the road.

While innovative medicines are typically introduced at a higher price point, this reflects the significant investment required to research, develop, and bring new treatments to patients. Over time, as patents expire, generic and biosimilar competitors enter the market, creating competition that substantially reduces costs while preserving access to proven therapies. The market impacts become evident as products lose their exclusivity and face significant competition.

This is the innovation cycle in action: investment in new therapies enables patients to benefit from the latest advances in medicine today; those therapies eventually become lower-cost treatment options through generic and biosimilar competition; and the resulting savings help create capacity to cover the next generation of innovations. The latest cost driver data demonstrates that this cycle is functioning effectively within Canada's private market; new therapies are being adopted, patients are gaining access to innovation sooner, and overall growth remains manageable without destabilizing the system.

⁵ Gagnon-Arpin, Isabelle, Wanlin Chen, and Chad Leaver. Understanding the Gap 2.0: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage. Ottawa: The Conference Board of Canada, 2022.

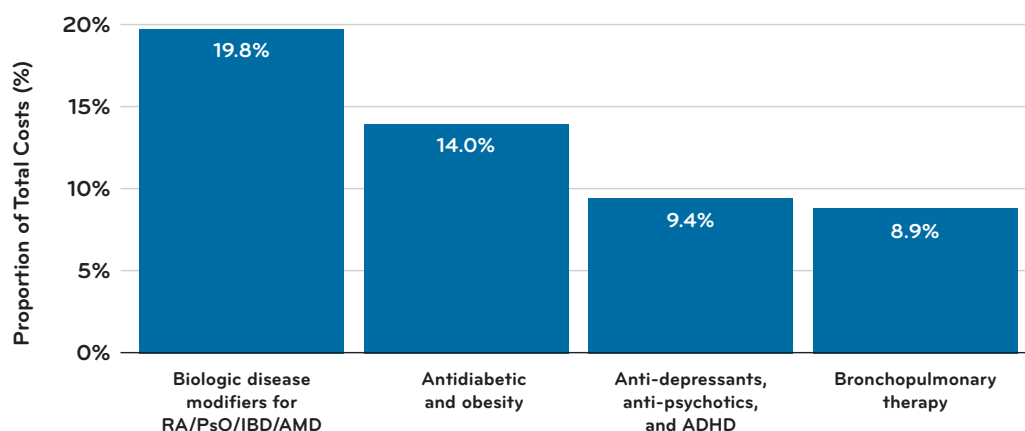
⁶ IQVIA Canada. Private Payer Time to Access Analysis. 2026.



IMPACT OF THERAPEUTIC CLASS

Biologics for autoimmune diseases were the top therapeutic class in private drug plan claims costs in 2025 at 19.8%, consistent with previous years. Obesity products were combined with antidiabetics in the 2025 dataset, leading to the category accounting for 14.0% of claims costs. These categories were followed by anti-depressants, anti-psychotics, and ADHD drugs at 9.4%, and bronchopulmonary therapies at 8.9%. (See Figure 12)

FIGURE 12: **Top 4 Therapeutic Classes in Private Drug Costs, 2025**



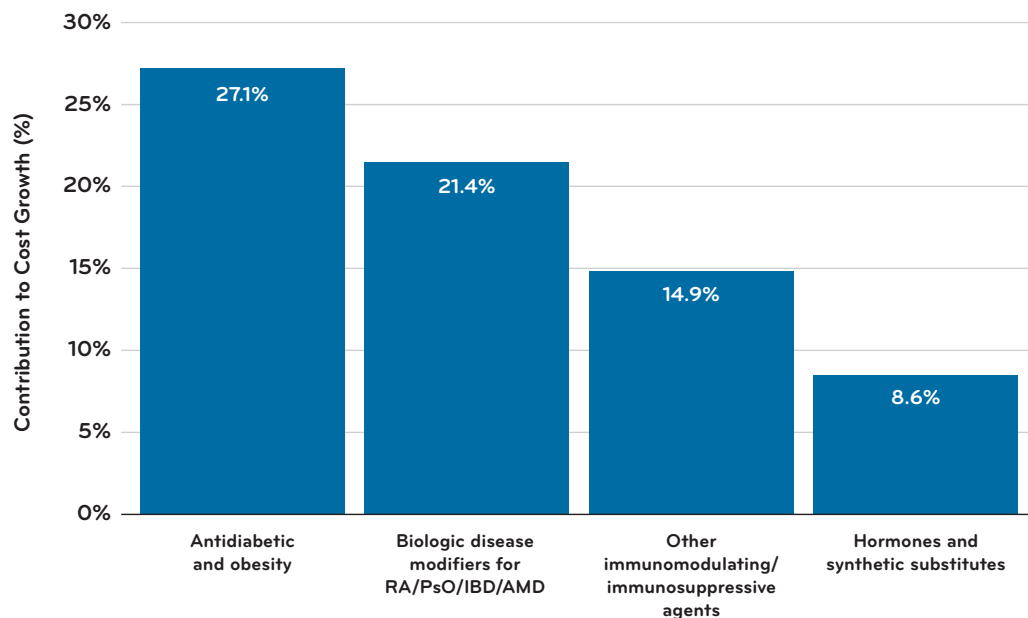
Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Antidiabetic and obesity drugs were the top contributor to cost growth at 27.1%, reflecting the reclassification of obesity drugs into the antidiabetic category. Biologics for autoimmune diseases also contributed a significant portion to cost growth at 21.4%, although this was lower than in previous years. Other immunomodulating and immunosuppressive agents, which include JAK inhibitors, contributed another 14.9% to 2024-25 cost growth. Hormones and synthetic substitutes rounded out the top 4 classes, contributing 8.6% to cost growth. (See Figure 13)





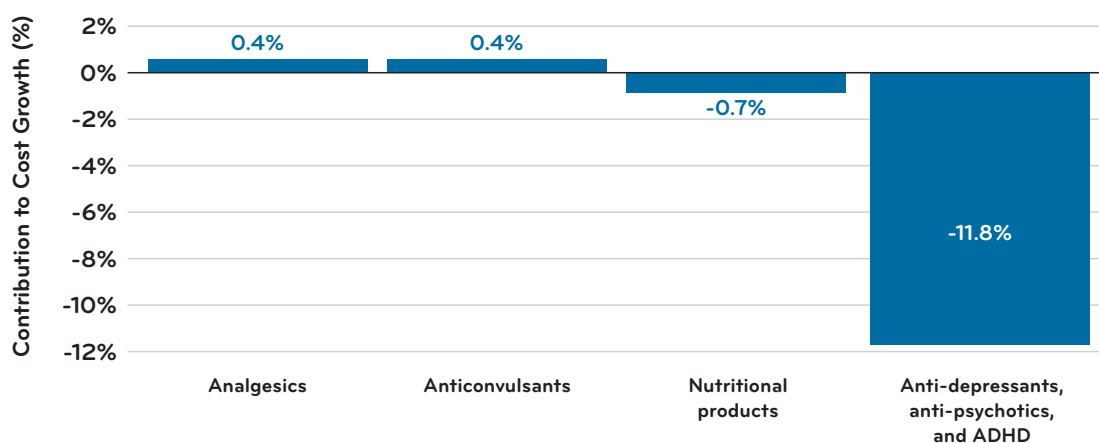
FIGURE 13: **Top 4 Therapeutic Classes by Contribution to Cost Growth, 2024-2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Antidepressants, antipsychotics, and ADHD drugs accounted for an 11.8% decrease in cost growth, following several years of steady growth. This decrease was attributed to the launch of generics. Other therapeutic classes with relatively small contributions to cost growth included nutritional products (-0.7%), anticonvulsants (0.4%), and analgesics (0.4%). (See Figure 14)

FIGURE 14: **Bottom 4 Therapeutic Classes by Contribution to Cost Growth, 2024-2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.



IMPACT OF AGING

Age has a significant impact on utilization, as both the likelihood of making a claim and the volume of claims typically increase with age. The findings of this year's report related to the impact of aging are consistent with previous Cost Drivers Reports.

The 25 to 44 and 45 to 64 age groups, which make up the majority of Canada's workforce, remained the largest contributors to claims cost growth, accounting for 76.9% of total costs and 79.5% of total cost growth. (See Figures 15 and 16)

FIGURE 15:
Share of 2025 Private Drug Plan Costs by Age Group

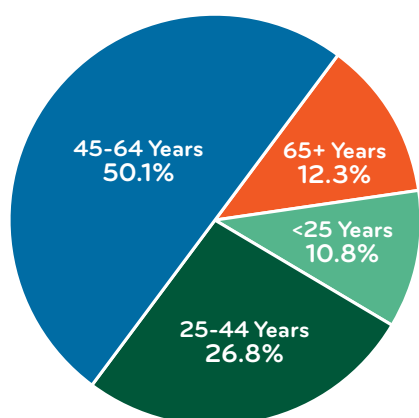
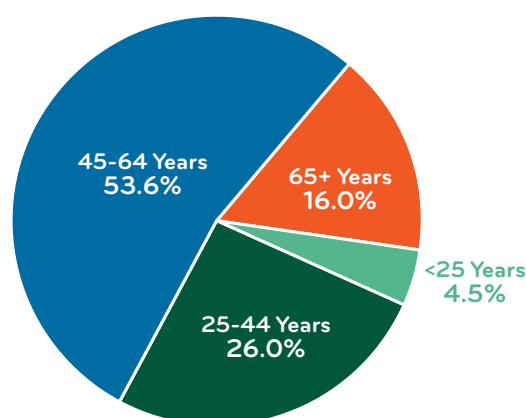


FIGURE 16:
Contribution to 2024-2025 Cost Growth by Age Group



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

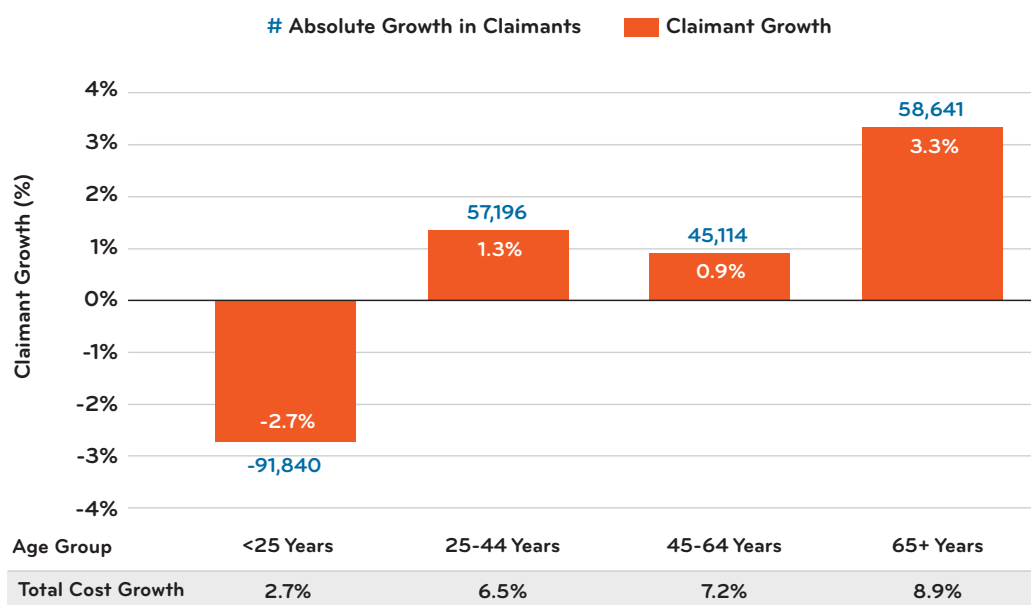
The under-25 age group saw a shift of -2.7%, or 91,840 fewer claimants, from 2024-25. Two-thirds of the decrease was due to fewer under-25 claimants in Ontario (60,966), followed by a decrease of 7,357 in Quebec, and 5,793 in British Columbia. All other provinces saw a small decrease between 1,000 to 5,000 claimants in the under-25 age group, while Alberta saw an increase of 1,925 claimants.





The working-age population saw modest increases in the number of claimants of 1.3% in the 25 to 44 age group and 0.9% in the 45 to 64 age groups, respectively. Although seniors represent a small percentage of private drug plan claimants, the 65+ age group saw the highest increase in claimants at 3.3%, along with the largest increase in cost growth at 8.9%. (See Figure 17)

FIGURE 17: **Claimant Growth by Age Group 2024-2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Value of Canada's Dual Drug Market System

Compared to public coverage, private drug insurance gives millions of working Canadians and their families access to almost twice as many innovative medicines,⁷ nearly twice as fast.⁸ At the individual employer level, drug benefits have been a critical tool for supporting plan member health and attracting and retaining employees. At the national level, this investment in innovation contributes to Canada's attractiveness as a launch destination for new therapies, research, and clinical trials. Over the past decade, an increasing number of cost containment mechanisms have been introduced, such as product listing agreements and prior authorization, that often result in slowing and limiting access to these medicines. Now more than ever, speed and broad access are key for the private market to stand apart from the public system, especially as federal pharmacare legislation for public single-payer, universal pharmacare has the potential to expand.

⁷ Gagnon-Arpin, Isabelle, Wanlin Chen, and Chad Leaver. Understanding the Gap 2.0: A Pan-Canadian Analysis of Prescription Drug Insurance Coverage. Ottawa: The Conference Board of Canada, 2022.

⁸ IQVIA Canada. Private Payer Time to Access Analysis. 2026.



IMPACT OF DAYS' SUPPLY

While drug price is often the primary focus in efforts to reduce claims costs, there are other opportunities to achieve savings that don't compromise breadth and speed of access. One such opportunity is to look beyond the price of the drug and consider how the other elements of a claim, such as non-ingredient costs, impact overall claims costs.

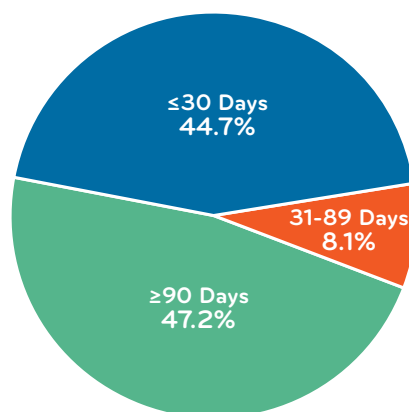
Prescription drug costs and days' supply were examined across all provinces, except Quebec, for three common categories of oral solid drugs which typically include high-volume, lower-cost generic medicines:

1. Antidepressants, antipsychotics, and ADHD medications,
2. Antidiabetic medications,
3. Cardiovascular medications.

Products with possible days' supply limits such as anxiolytics, hypnotics, sedatives, and psychostimulants were excluded from this analysis, since they are often regulated under controlled substances legislation.

Prescriptions with 30 days supply or less continue to represent a large share of claims, making up 44.7% of all private drug plan claims in 2025. Policies and plans are increasingly being designed to encourage longer days' supply. However, this shift has been slow and there remains an opportunity to further realize additional cost savings.

FIGURE 18: **Share of 2025 Claims by Days' Supply Category**



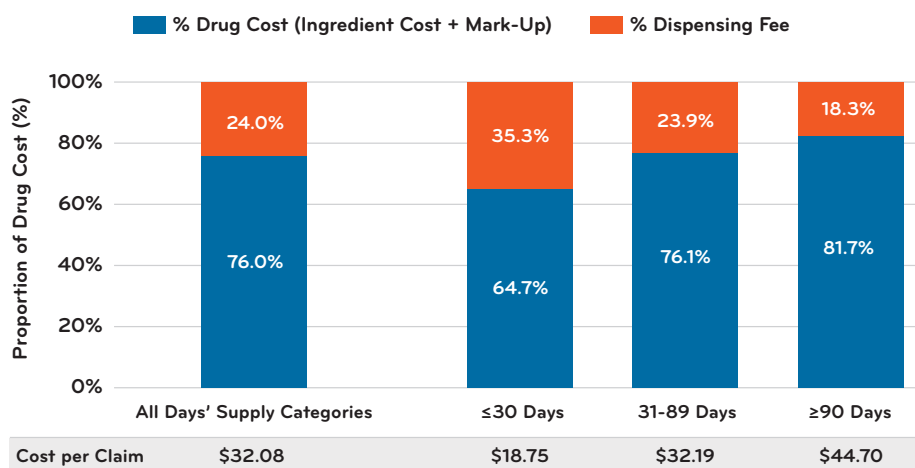
Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Note: Totals may not add up to 100% due to rounding.



Dispensing fees accounted for an average of 24.0% of the cost of a prescription for oral solid drugs across all days' supply categories. Dispensing fees ranged from 35.3% for prescriptions with 30 days supply or fewer to 18.3% for prescriptions with 90 days supply or more. (See Figure 19)

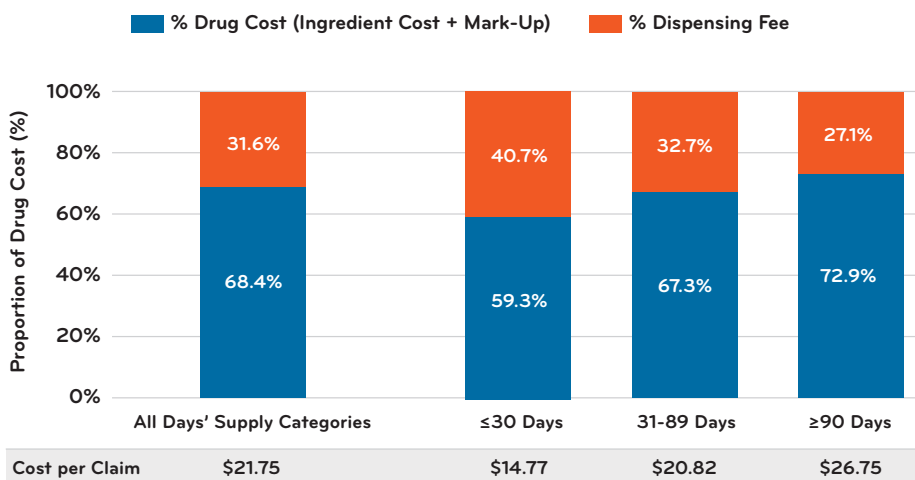
FIGURE 19: **Proportion of Drug Cost and Dispensing Fee for Anti-Depressants, Anti-Psychotics, ADHD Drugs, Antidiabetics and obesity, and Cardiovascular Drugs, 2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

The difference is most pronounced for cardiovascular oral solids, where dispensing fees represented 31.6% of the cost of a prescription across all days' supply categories. This ranged from a high of 40.7% with 30 days or less supply to 27.1% for prescriptions with 90 days or greater supply. (See Figure 20)

FIGURE 20: **Proportion of Drug Cost and Dispensing Fee for Cardiovascular Drugs by Days' Supply Category, 2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.



Where appropriate, increasing the number of days' supply for prescriptions for low-cost chronic medications could result in lower prescription costs and generate overall drug plan cost savings by reducing the average daily treatment cost by up to 40%.⁹

KEY TAKEAWAYS

The 2026 Cost Drivers Report highlights that private drug plan cost growth is being driven by a combination of utilization, changing treatment patterns, and the evolving cost of medicines. For individuals managing benefit plans, the findings point to several considerations when working with plan sponsors on affordability, sustainability, and plan design.

Look beyond high-cost drugs when assessing plan costs

Private drug plan costs increased by 6.7% in 2025, driven primarily by treatments costing less than \$10,000 annually. These drugs accounted for 66.8% of total costs and 51.0% of cost growth, while claims exceeding \$100,000 represented just 0.03% of claims.

Therefore, conversations about cost management should consider the full claims portfolio, rather than focus exclusively on high-cost or specialty drugs. Understanding the underlying drivers of utilization and cost across high-volume therapies can be just as important as managing catastrophic claims.

Chronic disease is where the greatest pressure and opportunity exist

Chronic therapies accounted for 73.9% of private drug plan spending and 78.7% of total cost growth. Antidiabetic and obesity therapies were the largest contributor to growth, followed by biologic disease modifiers and other immunomodulating and immunosuppressive therapies.

This means that drug benefits can, and should, be thought of as part of a broader strategy for managing chronic disease. Supporting appropriate and timely treatment may help employees remain healthier and productive by addressing the conditions responsible for a significant share of plan spending.

Separate utilization trends from true price pressure

The 6.7% increase in total costs reflected both higher utilization and higher cost per claim. Importantly, the drivers differ by treatment-cost category: lower-cost drugs were influenced primarily by higher cost per claim, while utilization was a more significant driver among higher-cost therapies.

For advisors, this means understanding why costs are increasing before recommending a cost-containment response. A strategy designed to address price may have limited impact when utilization is the primary driver, and vice versa.

⁹ Estimated by examining the daily cost (drug cost + dispensing fee) of three 30-day prescription claims compared to one 90-day prescription claim.



Recognize the broader innovation cycle

The decline in the \$25,000–\$100,000 claimant segment alongside growth in the \$10,000–\$25,000 segment reflects the continued evolution of biologic therapies and biosimilar uptake. This demonstrates the changing cost profile of therapies as competition enters the market.

This means innovation should be considered dynamically rather than viewed solely as a source of higher upfront costs. Making new therapies available to plan members as soon as possible can provide earlier access to treatment, while subsequent generic and biosimilar competition creates opportunities for greater affordability over time.

Use days' supply as a practical cost-management opportunity

There is an unrealized opportunity to reduce non-drug costs associated with dispensing patterns. Nearly half of claims for the selected oral solid therapies were dispensed at 30 days or less, while dispensing fees represented an average of 24.0% of prescription costs. Where clinically appropriate, moving toward longer days' supply can reduce the average daily treatment cost by up to 40%.





For advisors, this means not all cost-containment strategies need to restrict access to medicines. Reviewing days' supply and other non-ingredient costs can provide a relatively straightforward opportunity to reduce costs and plan member visits to the pharmacy, while maintaining access to treatment.

Help smaller plans manage volatility

Although very high-cost claims are uncommon (0.03% of all claims in 2025), they can have a disproportionate impact on smaller plan sponsors. The 2023 Cost Drivers Volatility Analysis shows how a single high-cost claim can materially affect the cost experience of a small plan.

This means risk management and pooling remain important components of plan sustainability. Advisors should help employers distinguish between predictable underlying claims trends and the volatility created by infrequent, exceptionally high-cost claims.

The advisor's role is increasingly strategic

The data reinforces the value of looking at drug plans through multiple lenses, including utilization, treatment cost, therapeutic class, demographics, and days' supply. With this information, plan advisors can help plan sponsors better understand the underlying drivers of their drug plan costs and look beyond cost-containment levers alone when evaluating plan value. This includes considering how cost-management strategies can impact the value of broad and timely access to new treatments. Considering the full view allows plan sponsors to assess not only how much their plans cost, but the value they deliver in return.

The opportunity for benefits advisors is to move the conversation from "How do we reduce drug costs?" to "What is driving our costs, and where can we improve value without unnecessarily compromising access?"





DATA SOURCES AND METHODOLOGY

1. The analysis in this report is based on the IQVIA Private Drug Plan Claims database, the largest pan-Canadian private drug plan claims database available. It covers approximately 80% of pay-direct private drug claims in Canada. The database includes nine of the top 10 private insurance carriers, third-party administrators, and benefit plan managers, providing insights from more than 13 million active claimants with over 153 million drug claims. Figures in this report have not been adjusted to represent 100% of the market.
2. Due to changes in data collection and reporting, the results disclosed in this report should not be compared with reports from previous years.
3. Data projection was used for disrupted data from two suppliers to provide the highest capture rate of private drug plans:
 - a. Supplier One had cost, claimant, and claims data missing from 26-Oct-2025 to 31-Dec-2025. The assumed proportion of the missing market in 2025 was approximately 2.6% for costs, 1.1% for claimants, and 2.6% for claims. Costs, claimants, and claims from 01-Jan-2025 to 25-Oct-2025 were divided by 1 minus the above proportions, respectively, to project costs, claimants, and claims for all of 2025.
 - b. Supplier Two had claimant data missing from 01-Jan-2023 to 28-Feb-2023. The assumed proportion of the missing market in 2023 was 1.2% for claimants. Claimants from 01-Mar-2023 to 31-Dec-2023 were divided by 1 minus the above proportion to project claimants for all of 2023.
4. All non-drug products, including non-drug diabetic products, were excluded from all analyses. Examples of non-drug products include needles, bandages, cannabis, administrative PINs, and isopropyl alcohol.
5. Drug claims represent only one component of the overall cost of a private drug benefit plan. The actual cost borne by plan sponsors is influenced by various factors, including the insurer's risk management process, premium setting processes, and pooling methodology.
6. Claims costs are based on eligible amounts, including both the plan-paid and the patient-paid portions, and include drug ingredient costs as well as pharmacy and wholesaler markups. Dispensing fees are not included, except in Quebec. Claims in Quebec were excluded from the cost drivers by days' supply analysis.
7. A "claim" in this analysis is defined as one fill for one drug identification number (DIN) at a given time. The cost of each claim may vary depending on the number of days supplied for each claim.
8. This analysis includes only drug pay-direct claims processed through group or individual private drug plans and does not include cash-paying customers with private coverage.

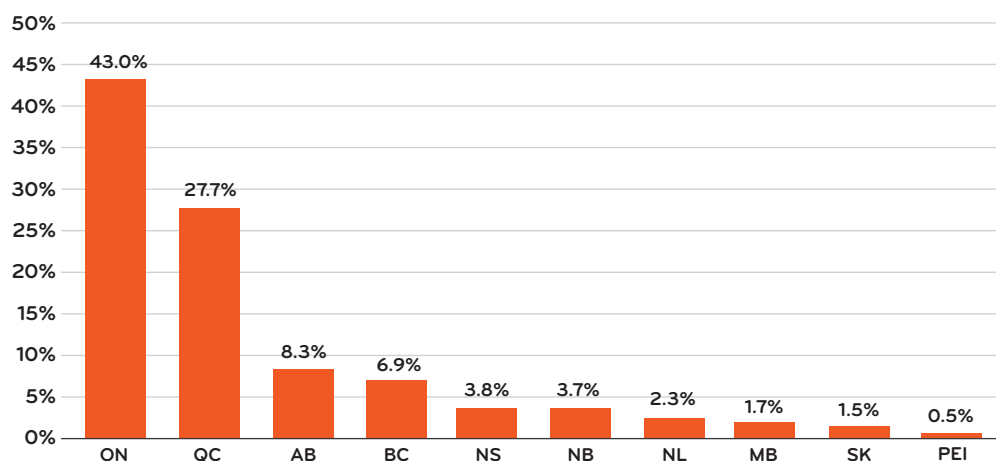
The statements, findings, conclusions, views, and opinions contained and expressed in this publication are based in part on data obtained under license from IQVIA Solutions Canada Inc. All Rights Reserved. The statements, findings, conclusions, views, and opinions contained and expressed herein are not necessarily those of IQVIA Solutions Canada Inc. or any of its affiliated or subsidiary entities.



APPENDIX 1 – GROWTH BY REGION

Most private plan claims costs were in Ontario and Quebec, which made up 70.7% of total costs. Alberta and British Columbia made up a further 15.2% of the private market, and the smaller provinces had the smallest share of the private market. (See Figure 21)

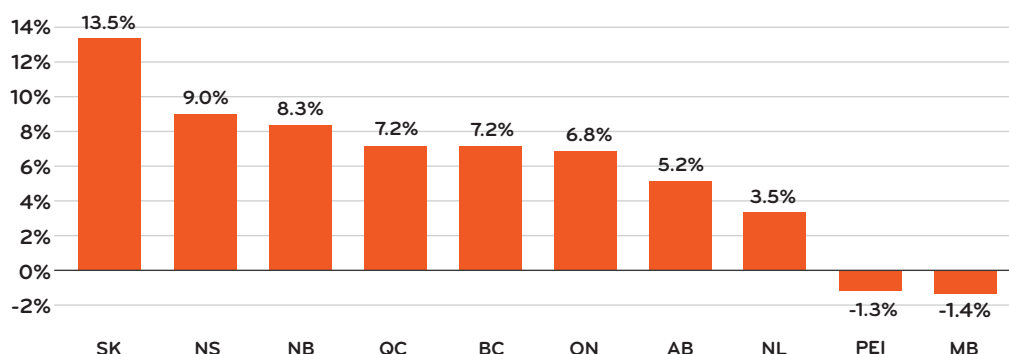
FIGURE 21: **Share of Cost by Region, 2024-2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

Saskatchewan had the highest year-over-year cost growth at 13.5%, followed by Nova Scotia at 9.0%, and New Brunswick at 8.3%. Manitoba and Prince Edward Island saw a decline in private drug plan costs, largely owing to medications shifting to reimbursement under provincial pharmacare programs. (See Figure 22)

FIGURE 22: **Cost Growth by Region, 2024-2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.



APPENDIX 2 – VOLATILITY ANALYSIS

Although high-cost therapies account for a relatively small number of drug claims, they have the potential to create significant cost volatility for private drug plans, particularly among smaller employers with limited claimant populations. As part of the 2023 Cost Drivers Report, an analysis was conducted to better understand this risk by quantifying the prevalence and impact of high-cost drug claims across plan sponsors of different sizes.

Using IQVIA's Canadian Private Drug Plan database, plan sponsors were categorized according to their size, measured by the number of unique annual claimants, and grouped based on whether they had at least one claim for a high-cost drug, defined as a therapy with average annual costs exceeding \$25,000 per patient. The analysis then compared the prevalence of high-cost claims and their effect on median drug costs per claimant across plan sponsor size categories.

The following section is an excerpt from the 2023 Cost Drivers report. It retains the original page numbering and formatting. As a result, the following pages are numbered 13-19.



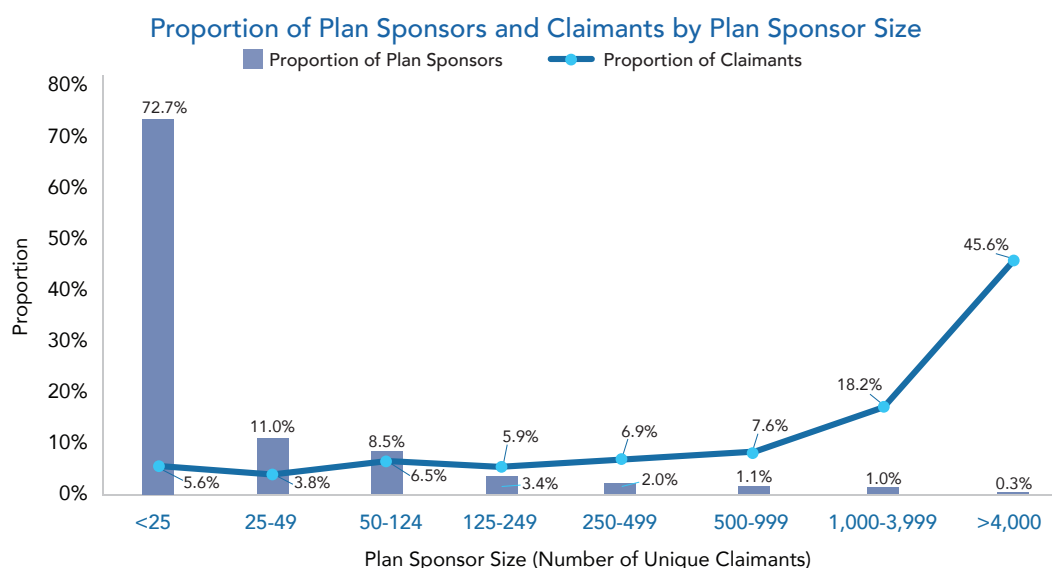
Impact of High-Cost Products on Drug Plans

Smaller plan sponsors outside Quebec remain vulnerable to the financial impact of high-cost drug claims within their benefit plans because of existing risk-sharing and pooling mechanisms.⁴ The impact of high-cost drug claims often leads to substantial increases in their insurance premiums for subsequent years. Since the majority of plan sponsors are smaller in size, high-cost claims have serious financial consequences for a significant portion of plan sponsors.

To evaluate the volatility experienced by drug plan sponsors, we analyzed the impact of high-cost claims data by the size of the plan sponsor as measured by the number of unique claimants. The analysis highlights the need to implement effective risk pooling and insurance strategies. For this analysis, we defined high-cost claims as claims costing \$25,000 or more per year per claimant.

Figure 7 illustrates an inverse relationship between the number of plan sponsors in each size category and their share of total claimants. Almost three-quarters of plan sponsors (72.7%) had 25 claimants or fewer but had a relatively small portion (5.6%) of total claimants. In contrast, only 0.3% of plan sponsors had over 4,000 claimants, yet they accounted for nearly half (45.6%) of all claimants.

Figure 7. Inverse relationship between number of plan sponsors in each size category and share of total claimants



Data source: IQVIA Private Drug Plan (PDP) Claims database

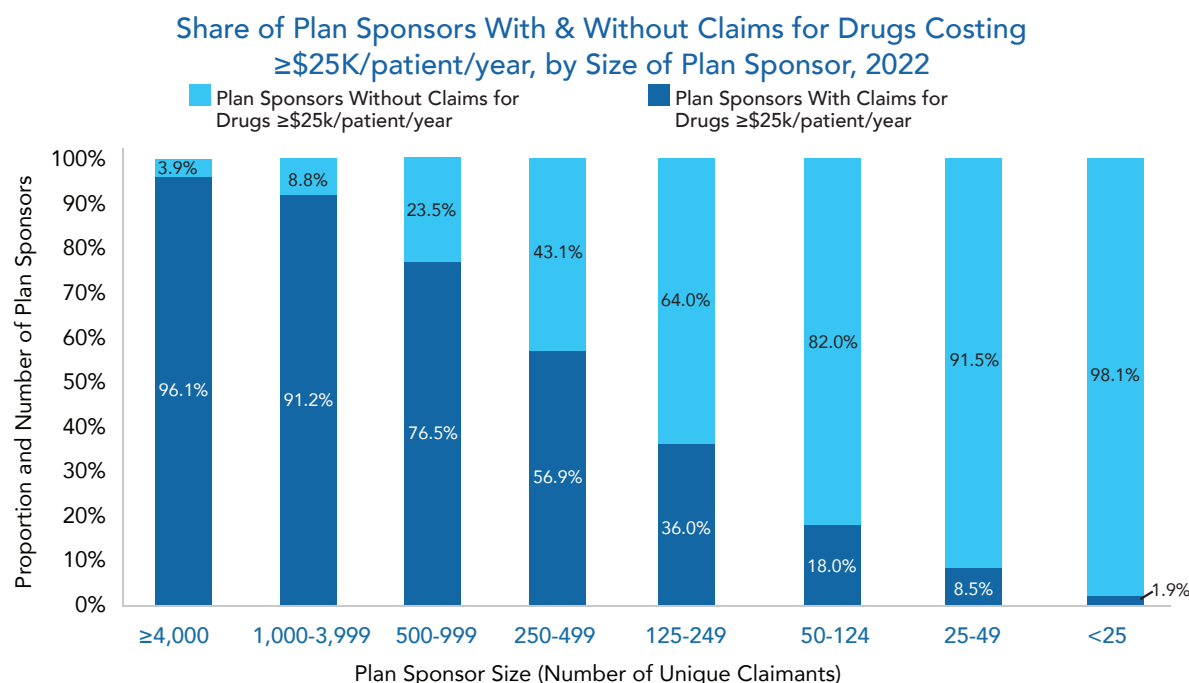
⁴ See Quebec's drug pooling model regime section of this report.



The proportion of plan sponsors having claims for high-cost drugs (>\$25,000 and >\$50,000) is incrementally higher with larger plan sponsors. Notably, 96.1% of larger plan sponsors have at least one claim for drugs costing \$25,000 or more per year per patient (see Figure 8), while 82.8% of them have at least one claim for drugs exceeding \$50,000 per year per patient (see Figure 9). In contrast, smaller plan sponsors encounter fewer high-cost claims, with only 1.9% having claims exceeding \$25,000 and 0.3% having claims exceeding \$50,000.

While this situation may seem positive for smaller plans, for those outside Quebec the consequences of high-cost claims can be significant due to current insurance industry pooling models. Although smaller plans may initially benefit from lower insurance costs, they face a risk of substantial premium increases when they encounter a high-cost drug claim. This risk highlights the importance of proper risk management and pooling mechanisms for smaller plan sponsors that opt for fully insured health benefit plans, so they can navigate the potential financial challenges associated with high-cost claims.

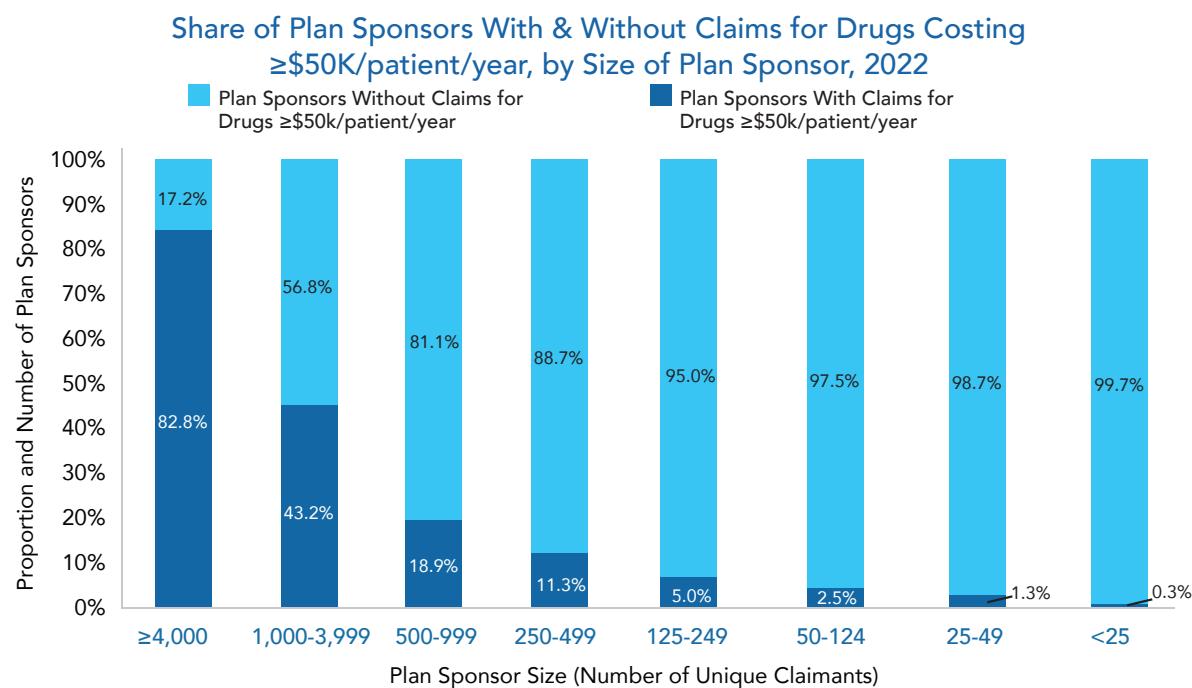
Figure 8. Large plan sponsors have a higher share of claims for drugs that cost over \$25K



Data source: IQVIA Private Drug Plan (PDP) Claims database



Figure 9. Large plan sponsors have a higher share of claims for drugs that cost over \$50K

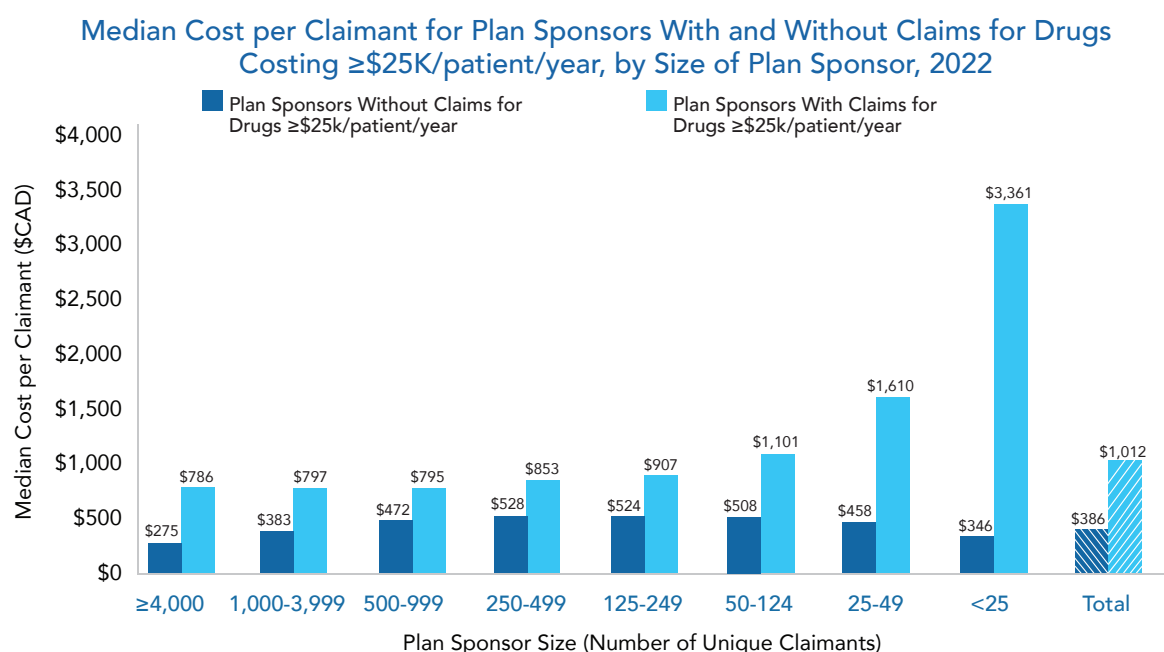


Data source: IQVIA Private Drug Plan (PDP) Claims database



Figures 10 and 11 examine the median cost per claimant by size of plan sponsor with and without high-cost claims. The data demonstrates that for small plan sponsors (with fewer than 25 claimants) that had a claim for drugs costing over \$25,000 per year per patient, the median cost per claimant was 10 times higher than for plan sponsors without such claims. For drugs exceeding \$50,000 per patient per year (Figure 11), the median cost per patient for plan sponsors with fewer than 25 claimants was 20 times higher.

Figure 10. Median cost per claimant up to 10x larger for plan sponsors with a claim for drugs that cost over \$25K

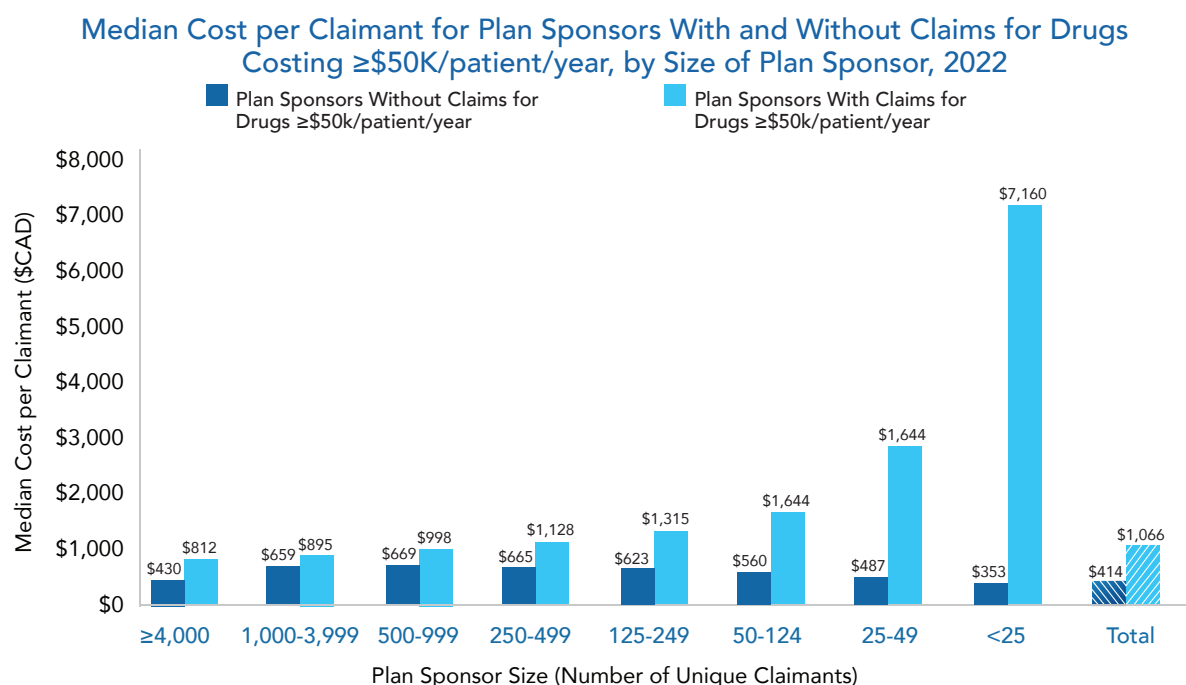


Data source: IQVIA Private Drug Plan (PDP) Claims database



Conversely, for larger plan sponsors (with 500 claimants or more), the median cost per claim was significantly lower regardless of whether they had a high-cost claim. The disproportionate impact on smaller plan sponsors highlights the need for improved risk management and pooling strategies to sustain comprehensive insurance coverage.

Figure 11. Median cost per claimant up to 20x larger for plan sponsors with a claim for drugs that cost over \$50K



Data source: IQVIA Private Drug Plan (PDP) Claims database

Risk management: Time for a change?

The current insurer risk management methods applied outside Quebec to assess risk and determine premiums do not meet the needs of many plan sponsors. To mitigate the risk, oftentimes the plans made available to small plan sponsors do not offer the insurance protection they need in today's market.

Health insurance premium renewals generally follow a transparent process, where the methodology and data used to determine health benefit premiums are shared with the plan sponsor and their plan advisor. This allows plan sponsors to better understand the factors driving their plan's cost and assess the proposed premium.



However, since the pooling methodology combines multiple plan sponsor claims, there is a lack of transparency in how the pool charges are determined. Plan sponsors have limited data to understand how these charges are calculated and whether they offer reasonable protection relative to their costs.

Nevertheless, plan sponsors feel compelled to purchase pooling protection due to the experience-rating of their plans and the potential impact of higher-cost claims. Unfortunately, there are limited pooling options available outside their current health benefit plan insurer.

If the cost of pooling becomes unaffordable for plan sponsors, they may resort to more restrictive drug plan designs, such as plans with maximums or formularies with limited coverage. However, these approaches can prevent plan members from accessing necessary medications for maintaining their health and productivity. Restrictive drug plans also fail to address the underlying issue of sub-optimal risk management.

Spreading overall private drug plan costs equitably across all claimants by the Canadian benefits insurance industry could lead to more affordable and comprehensive coverage for plan sponsors. It could also facilitate faster access to innovative therapies by eliminating the need for extensive reviews that often cause delays. Since the current experience-rating and pooling methodology used by Canadian insurers for individual plans outside Quebec poses a threat to their long-term sustainability, new approaches to mitigate plan sponsor risk should be implemented.

The Quebec Drug Pooling Model

The Quebec drug pooling model has emerged as an example the rest of Canada can learn from. The Quebec Drug Insurance Pooling Corporation (QDIPC) was set up as part of the province's Act Respecting Prescription Drug Insurance in 1997. It ensures that a plan sponsor with a large drug claim will not face excessive cost increases that could threaten its plan's sustainability. All insurers and administrators of employee benefit plans for Quebec residents are required to pool the risks inherent in the cost of pharmaceutical services and medications. In the Quebec model, plans with fewer than 6,000 members are mandated to join the Quebec pool. As a result, they experience less volatility and receive greater protection against high-cost claims compared with plan sponsors in the rest of Canada.

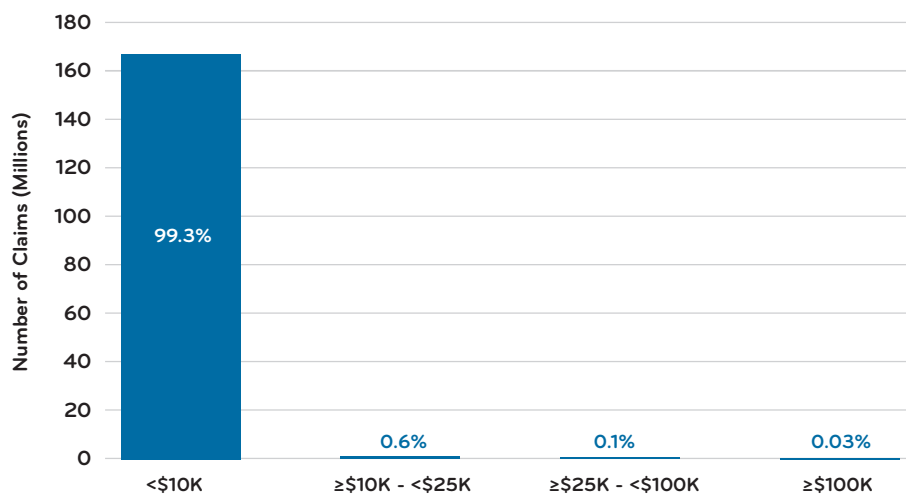


As the data above demonstrates, the current insurance industry risk model outside Quebec that sets premiums and determines pool charges is inconsistent and does not meet the needs of small drug plan sponsors, who collectively comprise up the majority of drug plans and account for a large portion of claimants. Stakeholders need to collaborate to improve risk management and pooling systems to ensure faster access to more comprehensive therapies for patients.



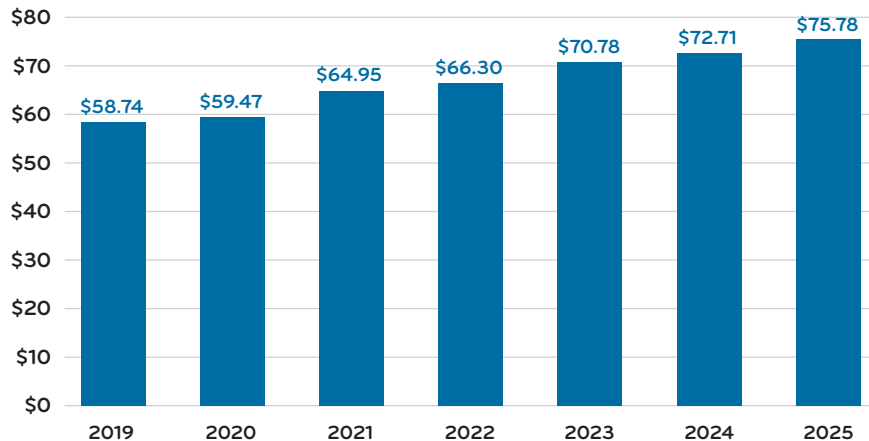
APPENDIX 3 – SUPPLEMENTAL CHARTS

FIGURE 23: **Claims by Treatment Cost Category**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.

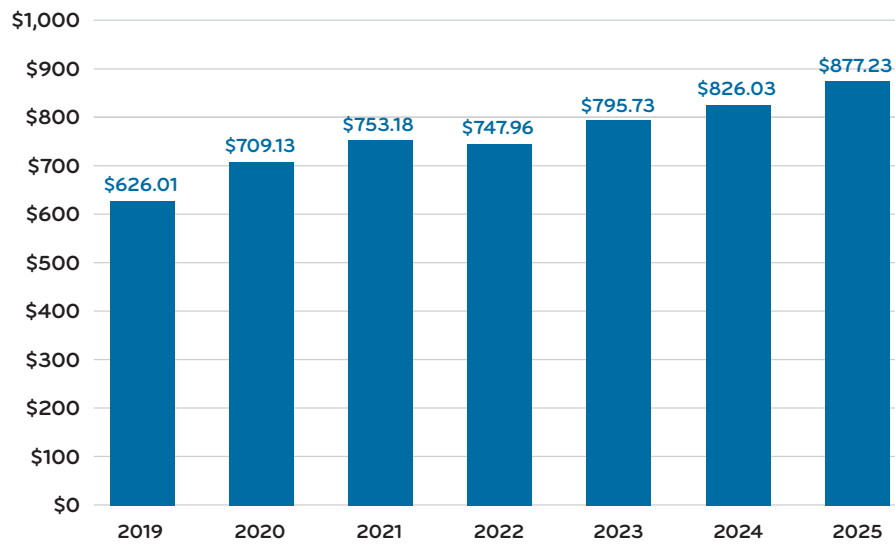
FIGURE 24: **Private Drug Plan Average Cost per Claim, 2019-2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.



FIGURE 25: **Private Drug Plan Average Cost per Claimant, 2019-2025**



Data source: IQVIA Private Drug Plan (PDP) Claims database, 2026.



innovativemedicines.ca