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Reviewing the Administrative and Fiscal Impacts of the Interim Federal Health Program



OFFICE OF THE PARLIAMENTARY BUDGET OFFICER
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The Parliamentary Budget Officer (PBO) supports Parliament by providing economic and financial analysis for the purposes of raising the quality of parliamentary debate and promoting greater budget transparency and accountability.

At the request of the House of Commons Standing Committee on Health, this report provides an expanded analysis of the federal Interim Federal Health Program (IFHP), addressing elements outlined in the Committee's motion adopted February 24, 2026. This report builds on prior work by the Parliamentary Budget Office and reflects updated analysis regarding program design, claimant volumes and administrative factors, factoring in the Budget 2025 changes which introduce co-payments for supplemental health products and services.

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Highlights

Total program costs of the Interim Federal Health Program (IFHP) continue to increase over the projection period due to elevated intake levels, persistent backlogs and rising health-care costs. As of December 2025, more than 300,000 asylum claimants remain in the inventory of cases pending adjudication, five times the 2021 level, with approximately 65 per cent of these claims in the system for over a year since referred to the Immigration Refugee Board of Canada.

Supplemental benefits account for the majority of IFHP spending making up roughly 54 per cent of total program spending in 2024-25. Urgent dental care represented the largest share of spending, followed by prescription medication, with urgent dental expenditures increasing from \$30 million to \$257 million, over five years.

Cost and utilization of the IFHP are geographically concentrated, reflecting differences in refugee settlement patterns. Ontario and Quebec accounted for 88 per cent of the total IFHP spending in 2024-25.

PBO estimates that the introduction of the co-payment framework will reduce federal IFHP costs by \$217 million annually by 2029-30.

PBO estimates that a one-month increase in processing times for asylum claimants could increase annual federal program costs by up to \$72 million in 2026-27, given the current volume of claims in the system.

Policy changes, such as Bill C-12, which affects elements of the asylum and refugee eligibility process, may influence participation in the IFHP. Under an illustrative scenario in which 26 per cent of new asylum claimants are assumed ineligible for coverage, PBO estimates that federal costs could decline by \$220 million annually by 2029-30.

Summary

At the request of the House of Commons Standing Committee on Health, this report provides an expanded analysis of the Interim Federal Health Program (IFHP), addressing elements outlined in the Committee's motion adopted February 24, 2026.

This report builds on prior work by the Parliamentary Budget Office and reflects updated monthly data provided by Immigration, Refugees and Citizenship Canada (IRCC), Immigration and Refugee Board of Canada (IRB), and Canada Border Services Agency (CBSA). As a result, this report has updated analysis regarding program design, claimant volumes and administrative factors, and includes the co-pay for supplemental health products and services announced in Budget 2025.

The co-payment framework announced in Budget 2025 is projected to reduce the federal portion of the IFHP by \$217 million annually, by 2029-30. While these savings are material, they do not offset the broader cost pressures driven by elevated volumes of new claimants. These pressures are compounded by longer durations of IFHP eligibility due to persistent backlogs, rising overall average per-beneficiary spending and health-care costs. In addition, changes in the composition of supplementary health benefits, particularly increased use of urgent dental care, prescription medication, and counselling services, have raised per-beneficiary costs and contributed to growth in program spending.

As of December 2025, over 300,000 asylum claims were pending adjudication and roughly 65 per cent of these pending claims have been in the system for longer than a year. This represents a five-fold increase since 2021 and is anticipated to increase in the near-term due to an influx of claims made between 2023 and 2025.

IFHP eligibility is further extended when claimants pursue appeals before the Refugee Appeal Division (RAD) or the Federal Court, as well as during the completion of a Pre-Removal Risk Assessment (PRRA). On average, about 20 per cent of all claims referred to the IRB are appealed at least once at the RAD. Nearly 50 per cent of claimants who ultimately received a negative decision from the IRB in 2019 remained in the system for more than three years following that decision. As of February 2026, approximately 74,000 "failed refugee claimants", defined as individuals who made a claim for refugee protection in Canada and did not obtain protection, were in the CBSA removals inventory. Failed refugee claimants may remain eligible for IFHP coverage while their cases are being assessed through ongoing immigration or risk-related processes (e.g.,

PRRA), and in some cases until their departure from Canada. Together, these factors substantially lengthen IFHP eligibility for a significant share of unsuccessful claimants.

IFHP costs and utilization are highly geographically concentrated, reflecting differences in refugee settlement patterns. Provinces with larger refugee populations, such as Ontario and Quebec, have the highest IFHP utilization representing 88 per cent of program spending. This study does not review potential implications for hospital networks and health care providers in most affected regions.

Sensitivity analysis conducted in this report demonstrates that the IFHP costs remain highly sensitive to both asylum intake volumes and in turn processing times. PBO estimates that a one-month increase in processing times could increase federal program costs by up to \$72 million in 2026-27, under the co-payment model, given current claim volumes in the system.

Recent policy changes, including Bill C-12, introduce eligibility criteria that may affect participation in the IFHP. To illustrate the potential implications, a scenario was modelled in which approximately 26 per cent of new asylum claimants are assumed ineligible for IFHP coverage under the one-year ineligibility rule. Under this scenario, PBO estimates that total IFHP expenditures could be reduced by approximately \$220 million by 2029-30, under the co-payment scenario. This assumption is illustrative, as individuals found ineligible under Bill C-12 may enter alternative protection processes, such as the PRRA, and may retain IFHP coverage, thereby limiting cost savings.

Background

On February 24, 2026, the House of Commons Standing Committee on Health requested that the Parliamentary Budget Officer (PBO) produce an updated report on the Interim Federal Health Program (IFHP), including further analysis.¹ This report responds to items (a) through (k) outlined in that request.

Specifically, the Committee called for expanded analysis of recent policy changes, program utilization, and cost drivers across provinces and claimant pathways. It also requested the assessment of the program's sensitivity to intake levels and processing times, as well as an assessment of broader fiscal considerations, including average per-beneficiary costs and the tax contributions of asylum seekers and refugees. In addition, the Committee asked the PBO to estimate the cost impacts of the Budget 2025 announcement introducing a new co-payment framework for supplementary health products, services and prescriptions.

The IFHP, funded by Immigration Refugees and Citizenship Canada and administered by Medavie Blue Cross, is a program that provides limited and temporary healthcare coverage to certain groups of foreign nationals who are vulnerable and disadvantaged. Furthermore, IFHP is a payer of last resort, providing coverage only to those without access to provincial or territorial public insurance or private coverage for a given service or product. IFHP does not coordinate with other health insurance plans, except the Canadian Dental Care Plan, where IFHP acts as the first payer.² Previously, the program was provided at little or no direct cost to beneficiaries; however, policy changes announced in Budget 2025 introduced co-payments for certain benefits, representing a shift in the cost sharing structure of the program.

Budget 2025 - New Co-Payment Framework

In Budget 2025, the government announced a new co-payment framework for supplemental health products and services benefits under the IFHP, requiring eligible people (beneficiaries) to contribute a fixed-fee per prescription and a percentage of the cost of supplemental services.³

As of May 1, 2026, IFHP beneficiaries will be responsible for the following co-payments:

- \$4 for each eligible prescription medication filled or refilled under the IFHP; and,

- 30 per cent of the cost of all other eligible supplemental health products and services.

Supplementary health products and services include extended health care such as urgent dental treatment, vision care, counselling services, and assistive devices, among others.⁴ Prescription drug coverage includes medication prescribed by a medical professional. These benefits are governed by a benefit grid that outlines applicable dollar and frequency maximums, prior approval requirements, and any exceptions. Overall, coverage relies primarily on frequency limits, lifetime restrictions and clinical eligibility criteria. The benefit grids are updated periodically to reflect regulatory changes, billing code updates or administrative adjustments and were updated as of April 2026.⁵ Under the co-payment, beneficiaries are directed to pay the new co-payment amounts directly to their health care providers.

Basic health care benefits, including doctor visits, hospital care, ambulance services, labs, diagnostic testing and immigration medical examinations, as well as pre-departure medical services remain fully covered under the IFHP, with no co-payment required.

Bill C-12 - Strengthening Canada's Immigration System and Borders Act

The Government of Canada introduced legislation through Bill C-12, which became law on March 26, 2026, introducing a series of measures related to broader administration, immigration, and security at Canada's borders and points of entry.⁶ The bill amends existing frameworks governing asylum processing, information-sharing between authorities, and federal authorities related to immigration documentation and security-related decision-making.⁷

While Bill C-12 does not directly alter the IFHP, changes brought forward could have several implications for the program. Bill C-12 makes individuals ineligible for an asylum claim to be referred to the IRB, if the claim was made more than one year after their first entry into Canada after June 24, 2020, regardless of whether the individual has since left and returned. These individuals would not be referred to the IRB for a full hearing but would remain eligible to seek protection through the PRRA process. The bill also introduces a fourteen-day ineligibility rule for individuals who enter Canada irregularly, in which claims made more than fourteen days after entry would not be referred to the IRB but would remain eligible for PRRA. Together, these measures could reduce the number of claimants eligible for IFHP coverage and shorten the duration of benefits. The

bill also includes changes to intake and processing timelines, which may affect how long claimants rely on the program, but could increase administrative demands.

Taken together, these changes may reduce the number of individuals eligible for IFHP coverage, shorten the period during which benefits are provided, and shift when and how claimants access the program. While Bill C-12 aims to improve efficiency and system integrity, some measures may pose operational challenges or legal risk.

Table 1 shows that asylum claims increasingly originate from individuals already in Canada with approved temporary resident status rather than from those arriving without prior authorization. Since 2023, claimants with prior temporary resident approval have accounted for an average of 79 per cent of all claims, up from 52 per cent in the pre pandemic period. Among these claimants, the most common prior authorizations were temporary resident visas at 38 per cent, followed by electronic travel authorizations at 11 per cent and study permits at 10 per cent.⁸

Table 1

Total asylum claims received broken down by intake organization and last approved prior temporary resident application type

Year	No Prior Approved Temporary Resident			Prior Approved Temporary Resident		
	CBSA	IRCC	Total	CBSA	IRCC	Total
2016	9,150	2,415	11,565	2,195	10,115	12,310
2017	18,205	14,165	32,370	3,995	14,500	18,495
2018	22,100	3,635	25,735	7,450	21,980	29,430
2019	20,900	1,435	22,335	8,580	33,235	41,815
2020	5,705	670	6,375	2,245	15,125	17,370
2021	8,795	885	9,680	4,250	11,170	15,420
2022	46,330	1,625	47,955	18,230	26,040	44,270
2023	30,260	5,000	35,260	42,580	66,350	108,930
2024	15,265	6,520	21,785	44,185	107,050	151,235
2025	21,565	6,665	28,230	12,485	73,820	86,305

Source:

Parliamentary Budget Office, Immigration, Refugees and Citizenship Canada.

Note:

Prior approved temporary resident status refers to individuals who previously held a temporary resident visa, electronic travel authorization (including eTA-X), study permit, temporary resident permit, visitor record extension, or work permit.

Program Trends and Cost Drivers

Benefit-Level Expenditures and Utilization

Asylum claimants receive basic and supplemental coverage throughout the refugee determination process, from the time a claim is determined eligible until they either transition to provincial or territorial health insurance or, in the case of unsuccessful or “failed” claimants, leave Canada after exhausting all avenues of appeal.⁹ The average duration of IFHP coverage for asylum claimants was roughly four years in 2024-25, up from three years in 2021-22.

Resettled refugees receive IFHP coverage until they transition to provincial or territorial health insurance; typically, within three months of arrival. Supplemental coverage may continue beyond this point, generally up to 12 months after arrival.¹⁰

In 2024-25, total in-Canada IFHP spending across all healthcare categories and beneficiary groups was \$822 million, or approximately \$1,500 per beneficiary on average.¹¹ Since 2019-20, both claims and total spending have increased, with spending, particularly for basic and supplementary benefits, outpacing growth in claims (Table 2).

Across supplementary benefit categories, average utilization, measured as claims per beneficiary, is similar between asylum seekers and resettled refugees, with some variation by service. The most notable difference is in the use of basic health benefits, which is higher among asylum seekers. As a result, differences in overall utilization and spending are largely driven by longer periods of IFHP eligibility and larger eligible populations among asylum seekers.

In 2024-25, average IFHP spending per beneficiary was 80 per cent higher for asylum claimants than for in-Canada resettled refugees, driven primarily by higher utilization of basic health services. Asylum seekers claimed approximately \$724 per beneficiary per year, on basic care compared to \$97 per in-Canada resettled refugees in 2024-25, contributing to a larger overall spending envelope. Appendix A provides a detailed breakdown in spending by benefit type.

These patterns reflect program design. Asylum beneficiaries typically remain eligible for IFHP for longer periods while claims and appeals are processed, extending access to core health services. By contrast, resettled refugees generally receive Pre-Departure Medical Services (PDMS), reducing some health-care needs upon arrival in Canada. In

2024-25, the average PDMS cost per overseas refugee was \$358. When these costs are considered, the difference in per-claimant health-care spending narrows.

Table 2

Total IFHP health expenditures and claims across beneficiary types

Total Spending, \$ thousands	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Basic Benefits	88,534	92,922	128,263	149,439	218,090	329,500
Supplementary Benefits	95,409	100,822	116,062	168,443	285,510	457,742
In-Canada IME	14,084	3,882	11,024	24,783	35,092	34,540
Pre-Departure Medical Services	15,658	4,369	22,024	29,686	29,048	26,515
Total Claims, thousands	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Basic Benefits	1,926	1,511	1,405	1,644	2,449	3,753
Supplementary Benefits	1,340	1,320	1,394	1,879	2,799	4,144
In-Canada IME	168	49	133	319	435	414
Pre-Departure Medical Services	146	35	175	248	196	177

Source:

Parliamentary Budget Office, Immigration, Refugees and Citizenship Canada, Immigration and Refugee Board of Canada.

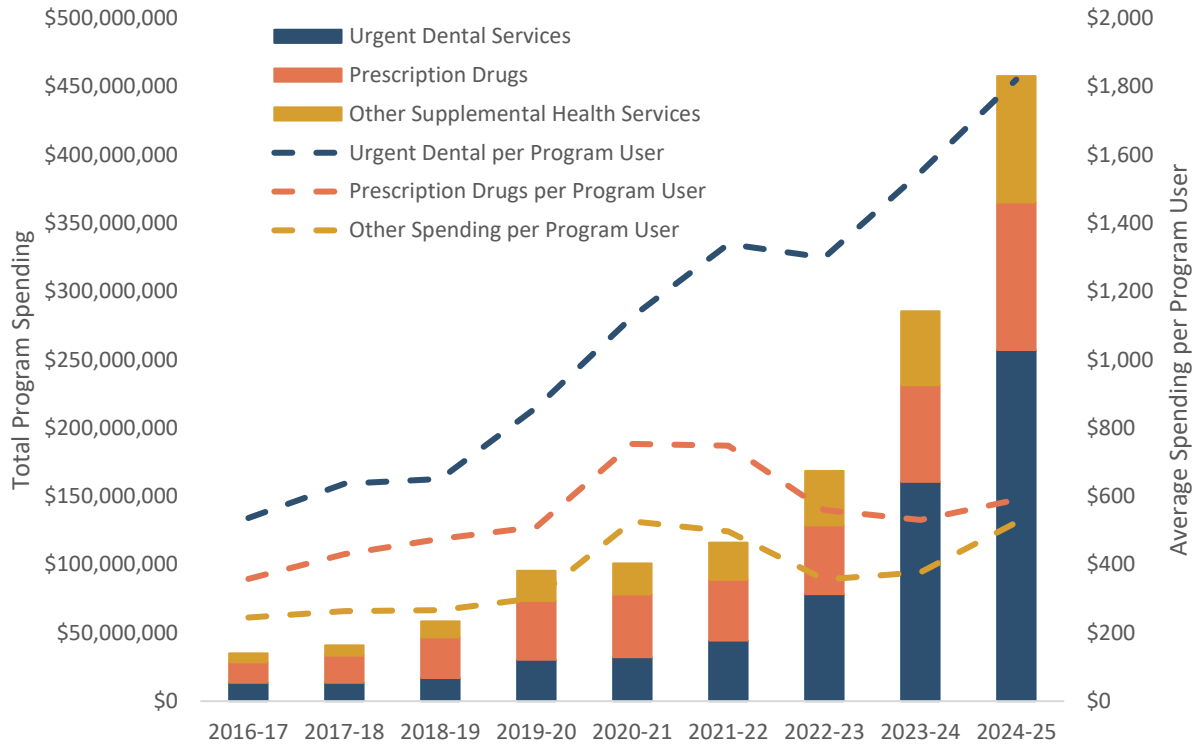
Note:

(1) IME stands for Immigration Medical Exams. (2) Prescription claims are included in the supplementary benefits category.

Trends in Supplementary Benefit Utilization and Costs

Supplemental benefits represent more than half of total IFHP expenditures.¹² Within this category, urgent dental care constitutes the largest share, followed by prescription medication (Figure 1).¹³ Combined, these two categories made up nearly 80 per cent of the supplementary health spending in 2024-25.¹⁴

Figure 1
 IFHP Supplementary Spending: Total Expenditures and Cost per Program User, 2016-17 to 2024-25



Source:

Parliamentary Budget Office, Immigration and Refugee Board of Canada, Immigration, Refugees and Citizenship Canada.¹⁵

Note:

The left axis shows total program spending, while the right axis shows average spending per beneficiary.

Usage patterns vary across the different benefit claims. For instance, prescription drug claims are more frequent and spread across a larger share of beneficiaries, whereas other services tend to be characterized by episodic but higher-cost usage. Over the past decade, the composition of supplementary benefits has shifted. For instance, spending on counselling services saw an increase from less than one percent of total supplementary spending in 2016 to 11 per cent in 2025. These compositional changes play an increasing role in program growth and contributed to upward pressure on average per-beneficiary costs. While per person spending has increased in certain benefit types, rising supplementary spending is mainly driven by growth in the number of eligible

beneficiaries. Appendix A provides a detailed overview of spending across the supplementary categories.

Spotlight: Urgent Dental Care

Urgent dental care makes up a large and growing share of supplementary health benefit under the IFHP, accounting for 56 per cent of this spending in 2024-25. Spending on urgent dental services increased sharply from \$30 million in 2019-20 to \$257 million in 2024-25, driven by both higher use of services and higher average cost per claim.

Data shows that more beneficiaries are using urgent dental services, and those who use them are receiving more care. The number of dental claims rose significantly, from nearly 240,000 claims per year in 2019-20 to more than 1.4 million claims in 2024-25 (an annual growth rate of 43 per cent). Even after accounting for the growing number of beneficiaries, claims per person and the share of beneficiaries using urgent dental services have both increased steadily, contributing to overall spending growth.

At the same time, the cost of each dental claim has also risen over time, across both asylum claimants and resettled refugees, at roughly 7 per cent on average per year between 2019-20 and 2024-25.

Overall, these trends suggest that cost growth is not only driven by more users, but also by a concentration of higher intensity use among a subset of beneficiaries, and highlights how specific cost-drivers play an increasing role in program growth. This study does not review the effectiveness of integrity controls within the IFHP.

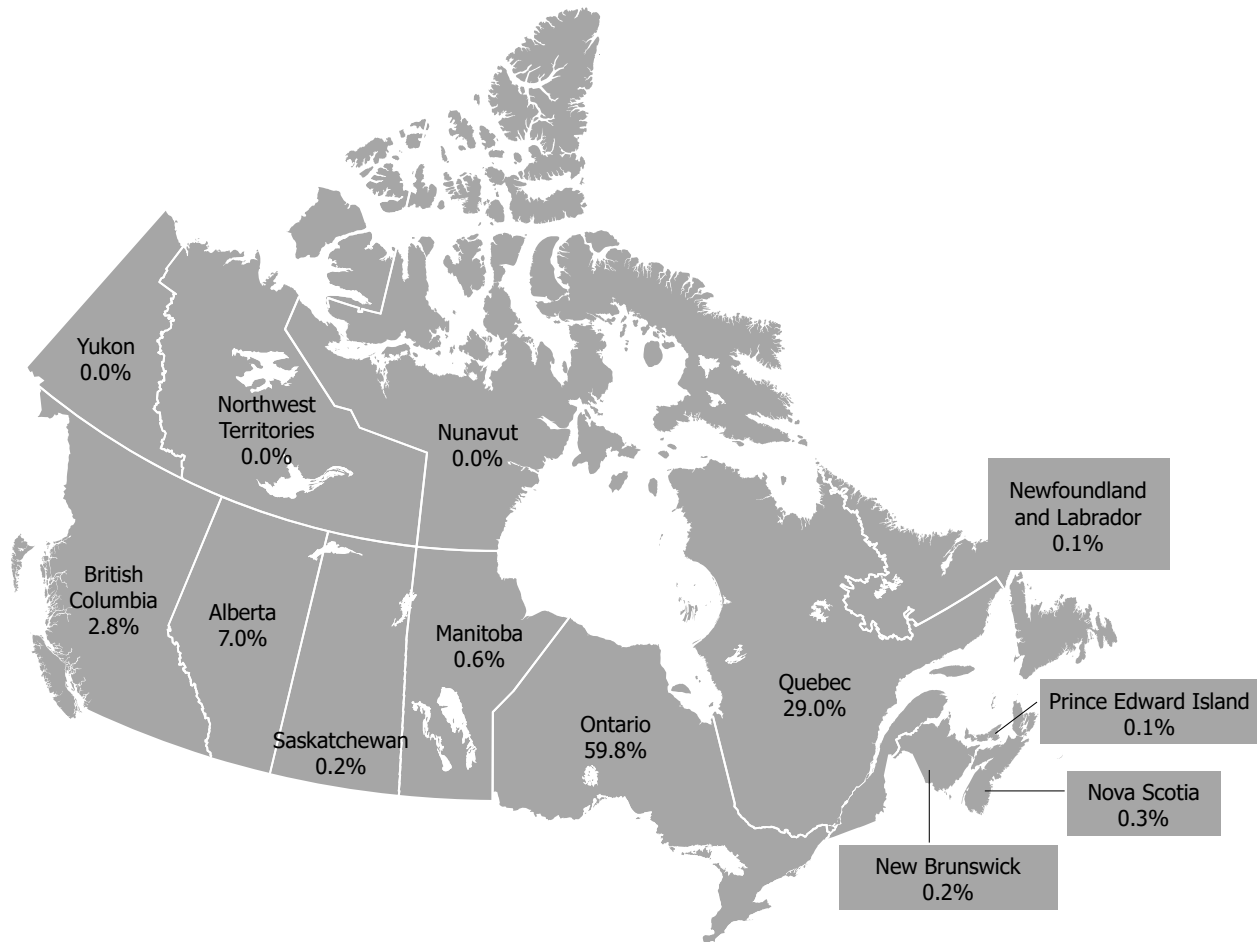
Utilization by Province

The utilization of the IFHP varies significantly by province, reflecting differences in refugee settlement patterns.¹⁶ Provinces with larger refugee populations, such as Ontario and Quebec, have the highest IFHP utilization representing 88 per cent of program spending (Figure 2). Spending recorded in each province may not always reflect where beneficiaries live; instead, it often reflects where they received services. As a result, IFHP usage across Canada presents a patchwork pattern driven by demographic

flows, service availability, and the geography of care delivery rather than uniform national uptake. These data limitations prevented an assessment of impacts on specific hospitals or regions.

Figure 2

Share of IFHP spending by province, based on location of service delivery, 2024-25



Source:

Parliamentary Budget Office, Immigration, Refugees and Citizenship Canada, Immigration and Refugee Board of Canada.

Implications of Different Refugee Pathways and Claimant Volumes

Program costs vary significantly depending on claimant status and the duration of time spent in the system.¹⁷ Longer processing timelines increase the number of beneficiaries

receiving coverage at any given time and extend the period over which services are consumed, making the duration of IFHP coverage a key determinant of total program costs.

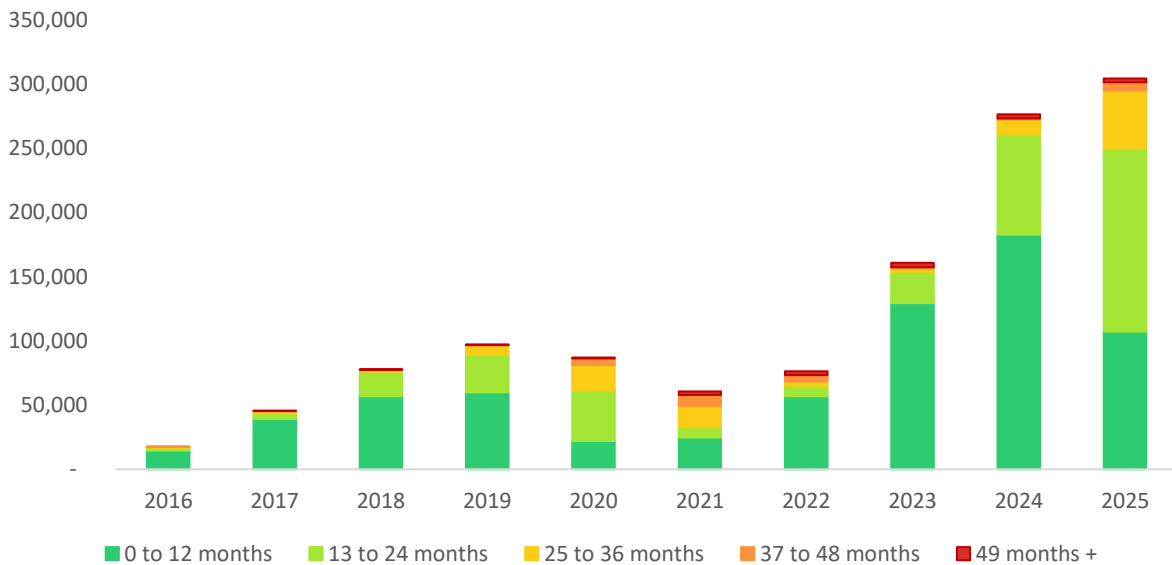
The pathway for resettled refugees differs fundamentally from that of asylum claimants.¹⁸ Resettled refugees are selected and assessed abroad, with admission targets set in the Government’s Immigration Levels Plan, resulting in relatively predictable intake and processing timelines.

By contrast, asylum claims are made after a person has entered Canada, and fluctuate in response to international and domestic factors, contributing to backlogs and longer, less predictable processing times. As a result, asylum claim processing times are a key driver of program costs and the focus of this analysis.

Asylum claim volumes have increased significantly with notable surges linked to global displacement events. Over the past year, the intake of asylum claims has moderated, but remained above processing and determination capacity. In 2025, 105,424 asylum claims were referred, down from 188,165 in 2024.¹⁹ As of December 2025, 304,192 asylum claims were pending adjudication (up five times since 2021) and roughly 65 per cent of these pending claims have been in the system for longer than a year (Figure 3).

Figure 3

Inventory of asylum claims pending adjudication at year-end (December), 2016–2025, by months pending



Source:

Parliamentary Budget Office, Immigration and Refugee Board of Canada.

Note:

Duration refers to the time since claim receipt for claims pending at year-end. Values represent total number of claims in each duration category. In 2025, approximately 18 per cent of claims were in the system for less than 6 months, a further 17 per cent in the system between 6 months to a year and 47 per cent have been in the system between one and two years. The remaining 18 per cent have been in the system more than two years since first referred to the IRB. Of all claims, roughly one per cent have exceeded 60 months in the system.

The share of claims less than six-months old rose sharply to over fifty percent in 2023-24 and 2024-25, reflecting the surge in new claims. As these high-volume cohorts age and exit rate remain constrained, a growing share of claims is expected to move into longer duration categories.

Spotlight: Growing Backlog

The inventory of pending asylum claims continues to grow as recent intake volumes have consistently exceeded processing capacity. As a result, more individuals remain in the system for longer periods, extending average IFHP coverage to about four years and placing sustained upward pressure on program spending. The IRB has acknowledged these pressures, noting that recent periods of exceptionally high intake have resulted in a claim inventory that exceeds funded processing capacity and that the Board remains under resourced to manage current intake and surplus inventory.

Over time, these dynamics are altering the composition of the claimant population. Large cohorts admitted during recent high intake periods are aging within the system, increasing the share of claimants facing longer processing times. The PBO projects that the number of claimants with processing times between 25 and 36 months will rise notably by 2026-27, reflecting elevated past intake and constrained exit rates. As a result, even if new intake stabilizes, existing backlogs are expected to continue driving costs in the near term.

The determination process for an asylum refugee includes multiple layers of review. Rejected claims may be appealed to the RAD, or subject to judicial review by the Federal Court of Canada. On average, between January 2016 to December 2025, inclusive, 18.5 per cent of all claims that were processed by the IRB filed at least one appeal (Table 3).

Among claimants whose applications were rejected by the IRB, roughly 79 per cent of claimants proceed to file at least one appeal.²⁰

Table 3

Volume of claims finalized and number of RAD appeals per claim having a final determination made between January 2016 to December 2025, inclusively

Decision	Volume of Claims
Accepted	286,344
Rejected*	127,976
Total claims finalized	414,320
Number of RAD Appeals	
Appealed once	75,030
Appealed twice	1,714
Appealed three times	37

Source:

Parliamentary Budget Office, Immigration and Refugee Board of Canada.

Note:

(1) Rejected includes rejected, abandoned or withdrawn. (2) Data received from the IRB is based on unique claimants, not decisions. As such, measures will differ from reports where statistics are provided based on decisions.

Table 4 demonstrates the average processing time and backlog for asylum claimants in Canada from referral to final IRB determination. The average time in the system for finalized cases involving at least one appeal is approximately 6 to 12 months longer than cases without an appeal; however, this difference varies depending on the complexity of the case and the appeals pathway. The total average time in the IRB, across all claimant types, that were finalized in 2025 is 19 months.

Table 4

Average processing time from referral to final IRB determination, in months

Fiscal Year	Decisions Not Appealed	Decisions Appealed	Overall Average
2017-18	7	15	8
2018-19	12	21	14
2019-20	13	24	16
2020-21	19	31	22
2021-22	25	32	27
2022-23	19	37	23
2023-24	13	32	16
2024-25	14	25	15
2025-26	18	25	19

Source:

Parliamentary Budget Office, Immigration and Refugee Board of Canada.

Note:

Data for the 2025-26 fiscal year are available up to December 2025.

IFHP eligibility is further extended when claimants pursue appeals before the RAD or the Federal Court, as well as during the completion of a PRRA. Additional delays may occur at the PRRA stage while officials assess risks associated with return to the claimant's country of origin. Nearly 50 per cent of claimants whose refugee claims were initiated in 2019 remained in the removals inventory for more than three years following a negative decision. Adverse conditions in destination countries may lead CBSA to impose measures (e.g., stays or deferrals), delaying removals and resulting in cases remaining in the inventory without resolution for extended periods.²¹

As of December 2025, nearly 74,000 failed refugee claimants were in the CBSA removals inventory (Table 5).²² This includes 22,682 failed claimants in the removals not possible (stayed) inventory, which comprises cases where removals are temporarily suspended due to factors such as litigation stays, pending PRRA decisions or other deferrals.²³

A further 23,429 failed claimants were in the removals in progress inventory, meaning they were subject to an enforceable removal order and could be processed for removal. This includes 11,414 failed claimants subject to an active PRRA bar. At this stage, CBSA

works with the failed claimant and foreign countries to overcome challenges to removal, including but not limited to, the issuance of travel documents.

In addition, 27,759 failed claimants were in the wanted inventory, meaning they were subject to an enforceable removal order who failed to appear for removal proceedings and the CBSA is working to locate the foreign national.

Failed claimants in the removals in progress and wanted inventory may continue to be eligible for IFHP coverage until their departure from Canada. Together, these factors extend IFHP eligibility for failed claimants, as coverage continues following a negative PRRA decision until the failed claimant leaves Canada.²⁴

Finally, 19,579 failed claimants had a removal enforced, meaning their removal order was executed and their departure from Canada was confirmed by CBSA.

Table 5

Distribution of failed refugee claimants by CBSA removal-related status, totals, 2021 to 2025

Calendar Year	2021	2022	2023	2024	2025
Total Removals Inventory	52,275	56,142	58,050	66,441	73,908
Removal Not Possible	13,298	17,287	17,566	17,835	22,682
Removals In Progress	14,649	14,530	16,232	23,953	23,429
Wanted	24,328	24,325	24,252	24,653	27,797
Removals Enforced	5,714	6,139	12,436	14,366	19,579

Source:

Parliamentary Budget Office, Canada Border Services Agency.

Note:

Total removals inventory excludes the not yet actionable inventory (monitoring) which includes, but are not limited to, individuals who have a pending refugee application or who have been recognized as a refugee in Canada.

Projection and sensitivity analysis

In our previous publication, [Projecting the Cost of the Interim Federal Health Program](#), PBO presented a baseline projection assuming no policy changes; therefore, it did not incorporate the Budget 2025 announcement of a co-payment. A detailed description of our baseline analysis and underlying assumptions is provided in our previous report.

The baseline analysis estimated costs and beneficiary counts using high-level annual data. This report builds on that work using more granular information. It draws on a monthly panel dataset of refugee protection cases in Canada from 2016 to 2025, disaggregated by claimant type, appeal activity, and IFHP usage, to assess how changes in population size and composition affect program costs. This approach allows behavioural responses to be incorporated by supplementary benefit category using elasticities from the empirical literature.

The analysis adopts assumptions that are consistent with those used in the [PBO's prior report](#) on the IFHP to project beneficiary counts and costs. However, the availability of additional months of data and greater detail in utilization and claims has resulted in modest revisions to the baseline projections (Appendix B).

Expanding on this baseline, we incorporate a sensitivity analysis to assess not only the central cost trajectory but also the range of potential pressures on the refugee protection system under alternative scenarios.

Fiscal Impact of Co-Payment

The introduction of co-payments for supplemental services is expected to reduce program expenditures through two primary channels.²⁵

1. First, direct cost-sharing through co-payments will generate revenue from beneficiaries.
2. Second, cost-sharing is expected to reduce utilization of services.

Several academic studies were used to estimate the impact of the introduction of a 30 per cent co-payment on spending.²⁶ Studies suggest that the introduction of a co-payment is likely to have a differential impact across benefit type and claimant groups as certain services and populations are more price sensitive than others. For instance,

services that may be considered more discretionary or preventative tend to be sensitive to cost-sharing, particularly in low-income populations.

Based on projected number of beneficiaries and the cost per beneficiary, we estimate that the introduction of the IFHP co-payment will reduce federal program expenditures by \$217 million annually by 2029-30 (Table 6). These savings correspond to an increase in out-of-pocket costs to refugees by \$157.1 million per year by 2029-30. We assume administrative and other expenditures to be 3.4 per cent of the total program costs.

Table 6

Change in federal IFHP cost under co-payment, millions of dollars

Fiscal Year	2025-26	2026-27	2027-28	2028-29	2029-30
Net Change	-	-162.1	-189.1	-203.5	-217.1

Source:

Parliamentary Budget Office, Immigration, Refugees and Citizenship Canada, Immigration and Refugee Board of Canada.

Note:

Totals may not add due to rounding.

Relative to the no-policy-change baseline, PBO estimates that the introduction of the co-payment reduces the federal share of IFHP costs per beneficiary, while increasing out-of-pocket costs per beneficiary to \$231 for asylum seekers and \$255 for in-Canada resettled refugee by 2029-30 (Table 7). Program use is uneven across beneficiaries, concentrating cost impacts among individuals with higher health needs. On average, the co-payment has a larger effect on resettled refugees because basic services, such as physician and hospital care, which account for a large share of asylum-related spending, are not subject to the co-pay.

Table 7
Average IFHP cost per beneficiary under co-payment, dollars

Fiscal Year	Federal IFHP Cost per Beneficiary (net of co-payment)	Refugee Co-payment per Beneficiary	Federal IFHP Cost per Beneficiary (net of co-payment)	Refugee Co-payment per Beneficiary
	Asylum Seekers	Asylum Seekers	Resettled Refugees	Resettled Refugees
2025-26	1,697	0	824	0
2026-27	1,581	202	605	198
2027-28	1,609	216	648	238
2028-29	1,669	224	672	247
2029-30	1,732	231	697	255

Source:

Parliamentary Budget Office, Immigration, Refugees and Citizenship Canada, Immigration and Refugee Board of Canada.

Note:

(1) Federal cost reflects IFHP expenditures net of co-payments; refugee cost reflects the co-payment amount paid out-of-pocket for asylum seekers and in-Canada resettled refugees. (2) Totals may not add due to rounding.

Consistent with behavioural responses in academic studies, the introduction of the co-payment is expected to have resulted in a small temporary increase in utilization immediately prior to implementation, as beneficiaries adjust their care-seeking behaviour ahead of the policy change. Over the long term, studies suggest that higher co-payments can inadvertently increase downstream hospitalization and physician treatment as preventative services are delayed. Given that hospital and physician care remains fully covered, any shift towards higher acute care can represent an upside risk to the federal cost of the IFHP and result in increased pressures to the provincial healthcare system. This potential impact was not modelled in this report but remains an upside risk.

Scenario Analysis

Scenario A: Sensitivity to changes in processing time

Changes in the volumes and processing capacity impact total costs, in particular IFHP costs are sensitive to changes in asylum processing times.²⁷ Based on the projected caseloads and utilization patterns, PBO estimates that a one-month increase in average processing times will raise annual federal IFHP expenditures by approximately \$72 to

\$92 million, with incremental costs scaling proportionally for longer delays under the co-payment scenario (Table 8).

Table 8

Sensitivity of federal IFHP costs to a 30 day increase in asylum processing times, under co-payment scenario, millions of dollars

Fiscal Year	2025-26	2026-27	2027-28	2028-29	2029-30
Net Change	71.8	72.2	79.3	86.0	92.2

Source:

Parliamentary Budget Office, Immigration, Refugees and Citizenship Canada, Immigration and Refugee Board of Canada.

Note:

Totals may not add due to rounding.

Scenario B: Sensitivity to changes in eligible asylum inflows

The introduction of the new claim ineligibility criteria under Bill C-12, which establishes a one-year time limit for individuals to file an asylum claim after their initial entry into Canada may impact the IFHP.²⁸ Individuals with a previously approved temporary resident status made up 79 per cent of asylum claims, on average, since 2023.²⁹

As a proxy, this analysis estimates the share of ineligible applications by identifying asylum claimants with prior approved temporary resident statuses typically associated with longer stays, resulting in 26 per cent of cases being deemed ineligible under the one-year rule.³⁰ Under the assumption that asylum inflows eligible for IFHP decline by 26 per cent, federal program expenditures are projected to fall annually by \$220 million by 2029-30, with savings accruing gradually as lower inflows reduce enrollment and exposure (Table 9).

This assumption is illustrative and represents an upper-bound estimate, as individuals found ineligible at the asylum stage may enter other protection processes, such as PRRA, and retain or regain IFHP coverage. However, access to IFHP in these cases is not automatic and is generally more limited and shorter in duration than during the asylum determination process. As a result, changes in claimant volumes affect costs gradually, and fiscal impacts may be smaller if claimants shift to alternative pathways. Overall, program costs are highly sensitive to intake volumes, but their effects are spread over time due to existing backlogs.

Table 9

Sensitivity of IFHP costs to a 26 per cent reduction in asylum claims under co-pay scenario, millions of dollars

Fiscal Year	Change in government expenditures	Change in refugee out-of-pocket costs	Change in total system cost
2025-26	-	-	-
2026-27	-38.2	-4.9	-43.1
2027-28	-103.1	-13.9	-116.9
2028-29	-160.7	-21.6	-182.3
2029-30	-220.2	-29.4	-249.6

Source:

Parliamentary Budget Office, Immigration, Refugees and Citizenship Canada, Immigration and Refugee Board of Canada.

Note:

Totals may not add due to rounding.

Uncertainty and Risks

Projected IFHP costs are subject to uncertainty, particularly with respect to asylum intake levels, processing capacity, and eligibility duration.³¹ External factors, including geopolitical developments, shifts in migration patterns such as policy changes in the United States, and climate-related displacement, could lead to material deviations from baseline intake assumptions.

Processing capacity remains a key cost driver, as persistent backlogs can extend IFHP coverage durations and raise cumulative expenditures, while improvements could shorten coverage and moderate cost pressures. The baseline projection assumes a gradual stabilization in intake with processing capacity held at current levels, actual outcomes may differ if claim volumes remain elevated or if backlogs persist.³² For instance, a one per cent change in asylum flows could result in a 0.62 per cent change in federal portion of the IFHP in 2029-30. In addition, changes in claimant health needs and service utilization may affect per-beneficiary costs, particularly where benefit limits are absent or vary across fee schedules.

Uncertainty also arises from policy implementation and program design. Changes introduced under Bill C-12 may lead to lower effective participation in the IFHP depending on how they are applied in practice.

The introduction of co-payments is expected to reduce utilization and shift a portion of costs to beneficiaries; however, these measures do not address structural pressures related to intake and processing capacity. Furthermore, the extent to which beneficiaries adjust utilization in response to co-payment or the degree to which eligibility changes reduce effective IFHP participation may differ from assumptions. Additionally, over the long-term, higher co-payments may lead to delayed preventative care resulting in downstream hospitalization or physical care, which may increase federal costs.

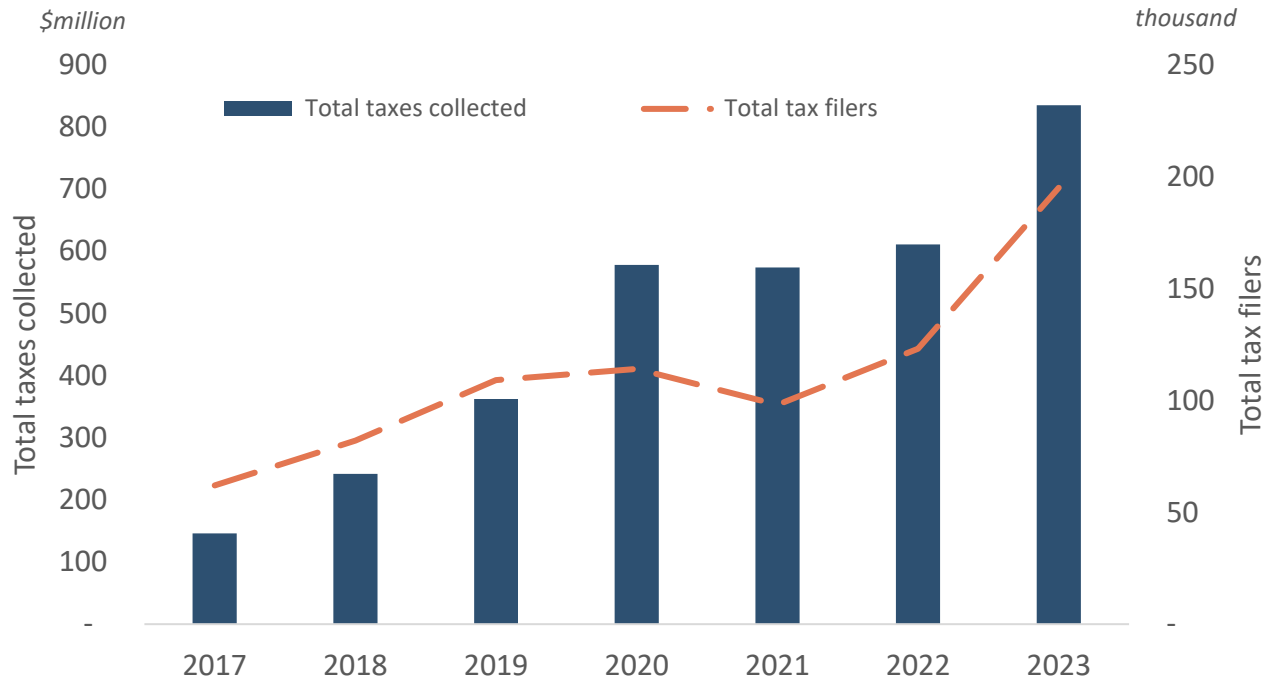
Overall, results are highly sensitive to future asylum intake levels, the pace at which accumulated backlogs are resolved and changes in beneficiary healthcare needs as well as assumptions regarding utilization behaviour, cost growth and the timing and effectiveness of policy implementation. Projected costs are therefore highly sensitive to deviations in intake levels, processing capacity, health care utilization or behavioural responses and may differ materially if underlying assumptions evolve.

Tax contributions of Asylum seekers and refugees

This section examines the contribution of asylum seekers and refugees to federal and provincial tax revenues.³³ PBO used Statistics Canada's Longitudinal Immigration Database (IMDB) to estimate total taxes paid by a subset of identifiable taxpayers who are eligible for the Interim Federal Health Program (IFHP). This group consists of non-permanent residents with a refugee claim who are not in Canada under a "Special Program" that may otherwise exempt them from IFHP eligibility.

The analysis in Table 10 includes federal and provincial income taxes, net contributions to the Canada and Quebec Pension Plans, Employment Insurance deductions, estimated consumption taxes, and Quebec Parental Insurance Plan premiums for those in Quebec. Consumption taxes were estimated by PBO by applying a 7.1 per cent ratio to total income in line with the methodology set out in Crisan, McKenzie, and Mintz (2015).³⁴ Because the IMDB is based on profiles of individuals filing taxes, the estimates presented here may underestimate total federal and provincial taxes paid by asylum seekers and refugees who are also IFHP eligible, for example due to individuals who are working but are not filing taxes.

Figure 4
 Total Federal and Provincial Taxes collected from Asylum Seekers and Refugees



Source:
 Parliamentary Budget Office, Statistics Canada Longitudinal Immigration Database. Reproduced and distributed on an "as is" basis with the permission of Statistics Canada.

Note:
 Sub-population of immigrants who: (1) were not permanent residents, (2) obtained at least one refugee permit, (3) filed taxes, (4) were not part of a Special Program.

Appendix A: Health Benefits by Category and Claimant Type

Table A-1

Total IFHP Health Expenditures by Region, fiscal year 2024-25,
\$ thousands

Asylum Seekers and Others							
	British Columbia	Prairies	Ontario	Quebec	Atlantic Canada	Territories	National
Basic	4,169	22,822	155,248	136,032	701	16	318,987
Prescription Medication	1,176	5,340	50,020	40,232	419	17	97,203
IME	2,429	2,434	17,193	11,807	191	3	34,057
Supplementary	6,326	9,491	208,451	47,723	281	6	272,277
Assistive Device	159	336	5,435	912	1	-	6,843

Vision Care	301	838	7,309	4,435	21	0	12,904
Urgent Dental Care	5,194	6,911	139,728	39,196	208	6	191,242
Other Benefits	76	554	7,565	1,881	10	-	10,085
Counselling	380	817	36,946	607	41	-	38,791
Home Visits	215	35	11,470	692	-	-	12,412

Resettled Refugees							
	British Columbia	Prairies	Ontario	Quebec	Atlantic Canada	Territories	National
Basic	972	1,965	6,774	511	291	-	10,513
Prescription Medication	876	3,677	5,214	327	641	-	10,735
IME	-	-	482	-	-	-	483
Supplementary	7,364	18,656	47,691	1,707	2,109	-	77,527
Assistive Device	211	576	2,870	58	114	-	3,829

Vision Care	357	1,470	2,037	118	148	-	4,130
Urgent Dental Care	5,771	16,192	40,734	1,475	1,653	-	65,825
Other Benefits	141	323	1,050	53	80	0	1,647
Counselling	13	16	775	3	65	-	872
Home Visits	870	79	225	1	48	-	1,224

Source:

Parliamentary Budget Office, Immigration, Refugees and Citizenship Canada.

Note:

Totals may not add due to rounding.

Appendix B: Change in Baseline

Table B-1

Updated PBO baseline projection under a no co-payment scenario

Fiscal Year	2025-26	2026-27	2027-28	2028-29	2029-30
Total Cost (\$ millions)					
New Baseline	975	1,078	1,196	1,292	1,383
Prior PBO Report	989	1,104	1,232	1,376	1,522
Change	-15	-26	-36	-84	-139
Total Beneficiaries (thousands)					
Asylum Beneficiaries	490.9	528.0	569.8	595.2	615.5
Resettled Refugee Beneficiaries	96.9	57.5	57.5	57.5	57.5
Overseas Resettled Refugee Beneficiaries	55.2	37.5	37.3	37.3	37.3

Source:

Parliamentary Budget Office.

Note:

Totals may not add due to rounding.

Note

¹ The Standing Committee on Health requested that the Parliamentary Budget Officer provide the Committee with an updated report on the Interim Federal Health Program within three months. A link to the full request can be found here: [Minutes - HESA \(45-1\) - No. 22 - House of Commons of Canada](#)

² [IFHP Outline of Services - IFHP](#)

³ For full program details and eligibility, please visit the official government's website: [Interim Federal Health Program - Canada.ca](#)

⁴ A comprehensive list of the temporary health care covered can be found on the federal government's website here: [Temporary health care coverage: What is covered - Canada.ca](#)

⁵ Changes to the IFHP benefit are published on the Government of Canada website: [Benefit Grids - IFHP](#). Benefit grids were last updated on April 27, 2026.

⁶ This section responds to part (j) of the motion.

⁷ [Understanding the Strengthening Canada's Immigration System and Borders Act - Canada.ca](#)
[Legislation that strengthens the immigration system and border security receives Royal Assent - Canada.ca](#)

⁸ Averages calculated using totals from 2016 to 2025.

⁹ This section responds to request (b) and (c) of the motion.

¹⁰ Details on coverage can be found on the Government of Canada's website: [When does my Interim Federal Health Program coverage start and when does it end?](#)

¹¹ Excludes administrative costs and pre-departure medical services.

¹² This section responds to request (b) and (h) of the motion.

¹³ IFHP dental coverage provides coverage for emergency care for dental conditions involving pain, infection or trauma. It is not intended to provide on-going regular or

routine dental care. Dental coverage relies heavily on frequency and lifetime limits and “emergency-only” criteria rather than explicit dollar caps across all services.

¹⁴ A comprehensive list of the benefits available and their applicable dollar and frequency maximums, prior approval requirements, and any exceptions can be found: [Benefit Grids - IFHP](#).

¹⁵ [Response from January 26, 2026 for Q-709 - Written Questions - House of Commons of Canada](#)

¹⁶ This section responds to request (c) and (g) of the motion.

¹⁷ This section responds to request (c), (d) and (e) of the motion.

¹⁸ A full description of these processes can be found on the Government of Canada’s website. [How to be resettled in Canada as a refugee - Canada.ca](#)

¹⁹ Volume of claims referred are reported on unique claims.

²⁰ When considering those eligible to file an appeal at the IRB, we only include rejected claims. Total negative decisions would not include abandoned or withdrawn claims.

²¹ [Enforcing removals from Canada](#)

²² Total removal inventory excludes cases categorized as removals not yet actionable, which typically refer to individuals whose whereabouts are known but whose removal is not currently being pursued. These include, but are not limited to, individual who have a pending refugee application or who have been recognized as a refugee in Canada.

²³ Pending PRRA refers to failed claimants (including ineligible and negative IRB decisions) with a stay of removal pending a PRRA. Litigation stay refers to failed claimants with a stay of removal pending RAD or federal court litigation PRRA Bar refers to failed claimants with an active PRRA bar. Other Stay refers to failed claimants with a stay of removal not related to PRRA or RAD litigation. Removals enforced refers to cases where a removal order has been carried out and confirmed by the CBSA meaning the individual has physically departed Canada. These include failed refugee claimants, including those found to be ineligible and those who received a negative decision from the IRB.

²⁴ According to the Government of Canada's website: "If your PRRRA application was rejected, your IFHP coverage will continue until you leave Canada." [Pre-removal risk assessment: Decision on your application - Canada.ca](#)

²⁵ This section responds to request (a) and (h) of the motion.

²⁶ Evidence from the RAND Health Insurance Experiment, a large, randomized study in the United States which examined how cost-sharing affects medical spending, found that moving from free care to a 25 per cent coinsurance rate reduced outpatient spending by 36.9 percent when estimated in logs. Another study, *What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*, documented declines in medical spending ranging from 11.79 percent to 13.80 percent when patients faced higher deductibles. Similarly, the *Gruber Patient Cost Sharing* study examined increases in outpatient cost-sharing for Medicare beneficiaries and found that higher out-of-pocket costs led individuals to delay or forgo necessary treatment and prescription use, ultimately resulting in more costly hospitalizations later. These findings indicate a level of price sensitivity comparable to the RAND results. Additional evidence from *The Impact of Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-For-Service Medicaid Population* showed that introducing prescription copayments reduced utilization by 17.2 percent.

Aron-Dine, Aviva, Liran Einav, and Amy Finkelstein. 2013. "The RAND Health Insurance Experiment, Three Decades Later." *Journal of Economic Perspectives* 27 (1): 197–222.

Zarek C. Brot-Goldberg, Amitabh Chandra, Benjamin R. Handel, and Jonathan T. Kolstad, "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics," NBER Working Paper 21632 (2015).

Chandra, Amitabh, Jonathan Gruber, and Robin McKnight. 2010. "Patient Cost-Sharing and Hospitalization Offsets in the Elderly." *American Economic Review* 100 (1): 193–213.

Hartung DM, Carlson MJ, Kraemer DF, Haxby DG, Ketchum KL, Greenlick MR. Impact of a Medicaid copayment policy on prescription drug and health services utilization in a fee-for-service Medicaid population. *Med Care*. 2008 Jun; 46(6):565-72.

²⁷ This section responds to (d), (e), (i), and (j) of the motion.

²⁸ This section responds to (e), (i), and (j) of the motion.

²⁹ [Transcripts & Minutes - Standing Senate Committee on National Security, Defence and Veterans Affairs \(45th Parliament, 1st Session\)](#) According to IRCC, “We looked at the applications received between the start date, which was June 3, and the end of October to get a sense of the number. It was about 37 per cent, or 19,000 cases out of the 50,000 cases received during that period [that would be ineligible because of the one-year limitation].”

³⁰ This included those with study permits, work permits, and temporary resident permits.

³¹ This section responds to (f) of the motion.

³² [Immigration and Refugee Board of Canada's 2026 to 2027 Departmental Plan - Immigration and Refugee Board of Canada](#) “While Canada is seeing a decrease in refugee claims, recent years of extremely high intake has resulted in a refugee claim inventory that exceeds the IRB's funded processing capacity. The IRB's other three divisions also face increasing volume and complexity of cases. The Board remains under-resourced to manage current intake levels, including surplus inventory.”

³³ This section responds to (k) of the motion.

³⁴ This approach follows Crisan, McKenzie, and Mintz (2015), which measures consumption tax revenues by applying effective tax rates to detailed household expenditure data. The authors state that, “this measure is generated by the commodity tax model (COMTAX) built in SPSPD/M and accounts for eleven different commodity and sales taxes at the federal and provincial levels, including GST, HST, federal import duties, provincial profits on liquor commissions, federal fuel taxes, provincial fuel taxes, provincial sales taxes, etc.” The report outlines a range of consumption tax rates by income quintile and age cohort, which is consistent with the 7.1 per cent ratio applied in this report.

Crisan, Daria and McKenzie, Kenneth and Mintz, Jack, The Distribution of Income and Taxes/Transfers in Canada: A Cohort Analysis (February 10, 2015). SPP Research Paper No. 8, Issue 5.

