



## Information Bulletin no 3

November 17, 2006

For insurers and administrators of employee benefit plans

### Presentation of recent changes to the *Prescription Drug Insurance Act*

Quebec's *Act respecting Prescription Drug Insurance* has been revised following the passage on December 13, 2005 of Bill 130, the *Act Respecting Prescription Drug Insurance and Modifying Various Legislative Provisions*. In this bulletin, the Quebec Drug Pooling Corporation presents the new sections 15.1, 42.1 and 42.2 which have been in effect since August 30, 2006. Insurers and administrators of employee benefit plans offering payments guarantees for the cost of medications to beneficiaries living in Quebec are, naturally, obliged to comply with these sections.

### A glance at the new sections and their impact

The addition of sections **15.1**, **42.1** and **42.2** to the Prescription Drug Insurance Act brings greater precision to the definition of groups eligible for private drug insurance and the conditions for application of the guarantees. Individual insurance contracts based on the characteristics defining group insurance are covered by section 42.2.

These changes have an impact on the composition of groups served by certain insurers and administrators of employee benefit plans operating in Quebec, as well as on the individual insurance products that are offered. The next part of this bulletin presents the three sections in the context of the law, to make them easier to read and understand.

It should be noted that insofar as a group meets the new norms set out in the law, it is subject to the system of pooling risks that is managed by the Corporation. The terms and conditions of pooling described in Information Bulletin 2 will continue to apply.

#### **The legislative changes could also entail changes in the parameters of the pooling system for 2008...**

The Quebec Drug insurance Pooling Corporation is now undertaking a poll of individual and group private insurance policies as well as non-insured employee benefit plans in effect in Quebec that offer prescription drug coverage. The purpose of this poll is to create an up-to-date portrait following the revision of the *Prescription Drug Insurance Act*.

Based on the information it receives, the Corporation will determine whether it is appropriate to modify the parameters of the risk pooling system, including the size of groups subject to pooling, thresholds above which pooling must apply, and pooling factors. The Corporation will advise you of any changes.

In such case, the Compliance Certificate attesting to the integrity of the information submitted by participants for pooling would be adjusted accordingly.

For more information on the current structure and operation of the risk pooling system, refer to Information Bulletin 2.

**Excerpts from the Act respecting Prescription Drug Insurance, updated as of October 2, 2006  
(Sections 15.1, 42.1 and 42.2 came into effect on August 30, 2006)**

**CHAPTER III**

**APPLICATION OF THE BASIC PLAN**

**DIVISION I**

**MANDATORY NATURE OF PLAN**

Eligible persons.

**15.** The Board shall provide coverage for the following eligible persons:

- 1) persons 65 years of age or over who are not members of a group insurance contract or employee benefit plan that is applicable to a group with private coverage within the meaning of section 15.1 and that includes basic plan coverage, and who are not beneficiaries under such a contract or plan;
- 2) persons or families eligible under a last resort financial assistance program provided for in the Act respecting income support, employment assistance and social solidarity (chapter S-32.001) or receiving an allowance paid under the second paragraph of section 67 of the Social Aid Act (Statutes of Québec, 1969, chapter 63), and holding a valid claim booklet issued by the Minister of Employment and Social Solidarity pursuant to section 70 of the Health Insurance Act (chapter A-29);
- 3) persons 60 years of age or over and less than 65 years of age who hold a valid claim booklet issued by the Minister of Employment and Social Solidarity pursuant to section 71 of the Health Insurance Act;
- 4) all other eligible persons who are not required to become members of a group insurance contract or employee benefit plan applicable to a group with private coverage within the meaning of section 15.1, and in whose respect no person is required, in accordance with section 18, to ensure coverage as beneficiaries under such a contract or plan.

*1996, c. 32, s. 15; 1997, c. 63, s. 138; 1998, c. 36, s. 173; 2001, c. 44, s. 30; 2005, c. 40, s. 3.*

Interpretation.

**15.1.** For the purposes of this Act, a “group with private coverage within the meaning of section 15.1” means a group formed for purposes other than contracting insurance coverage for its members and composed of persons eligible for the basic plan who

- 1) are part of the group on the basis of current or former employment or belong to
  - (a) a professional order,
  - (b) a professional association whose membership consists of members of one or more professional orders,

*(c) an association whose membership consists of persons engaged in the same trade or occupation, or*

*(d) a union or association of employees*

*that offers coverage under a group insurance contract or employee benefit plan or under an individual insurance contract concluded on the basis of one or more of the distinctive characteristics of group insurance to, makes such coverage available to or facilitates such coverage for its active members or retirees, either directly or through a legal person; and*

2) qualify for coverage under the group insurance contract or employee benefit plan applicable to the group, which includes coverage for the cost of pharmaceutical services and medications.

*2005, c. 40, s. 4.*

Obligatory participation.

**16.** All persons who are eligible for the basic plan, other than those referred to in paragraphs 1 to 3 of section 15, and who are part of a group with private coverage within the meaning of section 15.1 must become members under the group insurance contract or employee benefit plan applicable to the group for coverage at least equivalent to the basic plan coverage.

Exceptions.

The obligation to become a member does not apply to a person who, as a spouse, a child or a person suffering from a functional impairment, already benefits from coverage for the cost of pharmaceutical services and medications under a group insurance contract or employee benefit plan referred to in the first paragraph.

*1996, c. 32, s. 16; 2005, c. 40, s. 5.*

(...)

Group insurance contract.

**38.** No insurer may, in transacting insurance of persons, conclude or maintain in force a group insurance contract including coverage for accident, illness or disability for a group of persons referred to in section 16 unless, for the duration of the contract, coverage at least equal to the coverage under the basic plan is provided to the group under the clauses of

- 1) the contract;
- 2) a group insurance contract otherwise binding the policy-holder; or
- 3) an employee benefit plan administered by or on behalf of the policy-holder.

Membership.

In addition, insurers must accept the membership of every eligible person 65 years of age or over who applies therefor and of every eligible person required to become a member of such a contract pursuant to section 16, as regards basic plan coverage, on payment of the applicable premium.

Coverage.

Such insurers must also provide coverage to the persons to whom an eligible person referred to in the second paragraph is required, under section 18, to ensure that coverage is provided.

1996, c. 32, s. 38.

*The following provisions are not in force:*

*The words "otherwise binding the policy-holder" in subparagraph 2 of the first paragraph and the words "administered by or on behalf of the policy-holder" in subparagraph 3 of the same paragraph.*

*The above provisions will come into force on the date or dates to be fixed by the Government (1996, c. 32, s. 119).*

Employee benefit plan.

**39.** No person may establish or maintain in force an employee benefit plan including coverage for accident, illness or disability for a group of persons referred to in section 16 unless, for the period of application of the plan, coverage at least equal to the coverage under the basic plan is provided to the group under the clauses of

- 1) the employee benefit plan;
- 2) an employee benefit plan otherwise binding the plan administrator; or
- 3) a group insurance contract binding the plan administrator.

Membership.

In addition, plan administrators must, as regards basic plan coverage, accept the membership of every eligible person 65 years of age or over who applies for membership and of every eligible person required to become a member of such a plan pursuant to section 16, on payment of the applicable contribution.

Coverage.

Such plan administrators must also provide coverage to the persons to whom an eligible person referred to in the second paragraph is required, under section 18, to ensure that coverage is provided.

1996, c. 32, s. 39.

*The following provisions are not in force:*

*the words "otherwise binding the plan administrator" in subparagraph 2 of the first paragraph and the words "binding the plan administrator" in subparagraph 3 of the first paragraph.*

*The above provisions will come into force on the date or dates to be fixed by the Government (1996, c. 32, s. 119).*

(...)

Coverage.

**42.** Where a group insurance contract or employee benefit plan includes coverage for the cost of pharmaceutical services and medications for a group with private coverage within the meaning of section 15.1, the insurer or plan administrator must provide coverage to all members of the group.

Coverage.

In such a case, the insurer or plan administrator must provide coverage for all the persons to whom the members of the group are required to ensure that coverage is provided.

Exception.

This section does not apply in the case of a person 65 years of age or over who elects not to become a member of such a contract.

*1996, c. 32, s. 42; 2005, c. 40, s. 12.*

Non-members.

**42.1.** If a group insurance contract or employee benefit plan applicable to a group with private coverage within the meaning of section 15.1 includes coverage for the cost of pharmaceutical services or medications, that coverage under the contract or plan may not be offered to, made available to or maintained for persons who are not members of the group although they may have the same employment or engage in the same profession, trade or occupation as the members of that group.

*2005, c. 40, s. 13.*

Individual insurance.

**42.2.** No individual insurance contract that includes coverage for accident, illness or disability and has one or more of the distinctive characteristics of group insurance may be offered to, made available to or maintained for a group of persons to whom section 16 applies, or facilitated for such persons by any means whatsoever, unless it includes coverage at least equivalent to the basic plan coverage.

Distinctive characteristics.

A uniform annual premium, coverage offered regardless of the risk associated with state of health, rates or financial arrangements based on the history of the group, a contract negotiated between an insurer and an intermediary on behalf of the group and any other condition or circumstance specified by regulation are considered to be distinctive characteristics of group insurance.

Contract.

A contract that must include coverage at least equivalent to the basic plan coverage under this section is governed by the provisions of this Act that are applicable to a group insurance contract. The insurer or the policy-holder and the persons who are part of the group to whom the contract is offered or made available or for whom it is maintained must fulfill all their respective obligations under this Act.

*2005, c. 40, s. 13.*

§ 3. — *Pooling of risks*

Pooling of risks.

**43.** All insurers transacting group insurance and all administrators of employee benefit plans who provide coverage for the cost of pharmaceutical services and medications must pool the risks arising from the basic plan coverage they provide according to the terms and conditions they determine.

Terms and conditions.

The terms and conditions must be communicated by the representatives of the insurers and administrators, in writing, to the Minister not later than 1 November each year. Failing that, the terms and conditions shall be determined by government regulation for the period it indicates.

*1996, c. 32, s. 43.*

### **In the Next Issue**

Since this third edition of the Corporation's Information Bulletin has dealt with the recent changes to the *Prescription Drug Insurance Act*, the next bulletin will deal with communication of the parameters of risk pooling to clients, which was initially intended to be the subject of this bulletin.



Ed. Note: This information bulletin does not have the force of law. It represents the point of view of the *Société de compensation en assurance médicaments du Québec/Quebec Drug Pooling Corporation* on various subjects based on the *Act Respecting Prescription Drug Insurance and Modifying Various Legislative Provisions* and on the Drug Insurance Information Bulletins issued to date by the *Régie de l'assurance-maladie du Québec*.