



THE advantage™

THE STUFF YOU NEED TO KNOW...

JUNE 2015

Spring is in full swing, and so are governments. They've been busy in the past few months passing new legislation and implementing policy changes that impact our industry. So, we know this month's issue of The advantage is a bit lengthy, but we thought it was important to let you know what was happening on the legislative front, and what this means for your benefit plan.

Inside This Issue:

- Psychotherapy and homeopathy regulation in Ontario
- Hydrocortisone status change
- Quebec update - Bill 28
- New lancet claim submission process

HEALTH PROFESSIONAL REGULATION IN ONTARIO – PSYCHOTHERAPY AND HOMEOPATHY

As of April 1, 2015, psychotherapy and homeopathy became regulated health professions in Ontario. For psychotherapists, the *Psychotherapy Act, 2007* was proclaimed and the College of Registered Psychotherapists of Ontario was established, while the College of Homeopaths of Ontario was established for homeopaths through the *Homeopathy Act, 2007*.

Each College is a self-regulatory body mandated to regulate the practice of psychotherapy and homeopathy respectively, and to ensure that practitioners meet certain licensing and professional requirements. As of April 1, 2015, psychotherapy and homeopath practitioners must be registered with their respective College in order to practice their professions.

WHAT DOES THIS MEAN FOR YOUR PLAN?

If your plan provides coverage for homeopathic services, GSC can no longer reimburse claims from homeopaths who are not registered with their College. Similarly, a plan member's psychotherapist must be registered with their College in order for their psychotherapy claim to be paid under your benefit plan.

Plan members who may have had their claims from their homeopath or psychotherapist reimbursed in the past will no longer have their claims accepted if their practitioner is not registered and in good standing with their College.

We recognize transitioning to this new adjudication process will take some time, so we are **allowing a two month grace period to give plan members time to ensure their provider is registered with their College**. For now, there will be no change in the way we process psychotherapy and homeopath claims, and GSC will continue to accept claims from any practitioner who is registered with GSC as an eligible provider.

After **August 1, 2015**, GSC will only reimburse claims from psychotherapists and homeopaths who are registered and in good standing with their College.

GETTING THE WORD OUT...

To explain the upcoming change, we have prepared the attached plan member communication which you can share with your plan members in Ontario. This information will also be available on our website.

Other tips to ensure your plan members aren't seeing an unregistered health provider:

- Advise your plan members to ask their health provider if he or she is registered with their College.
- Direct plan members to the Colleges' website where they can check the status of their health provider. The Colleges have made a list of registered practitioners publicly available:
 - Psychotherapy: <http://www.crpo.ca>
 - Homeopathy: www.collegeofhomeopaths.on.ca

HYDROCORTISONE STATUS CHANGE EFFECTIVE JULY 1, 2015

Starting **July 1, 2015**, topical creams and ointments that contain hydrocortisone of 1% or less will no longer be eligible for coverage as a drug benefit. As well, compound products that use hydrocortisone 1% cream or ointment to compound with (mixing the hydrocortisone 1% cream or ointment with another covered topical cream or ointment) will no longer be eligible.

Why are we doing this? This is in response to a recent Health Canada directive that re-categorized products containing hydrocortisone of 1% or less as a natural health product. Health Canada has flipped the Drug Identification Number (DIN) for these products to Natural Product Numbers (NPN), requiring GSC to follow suit.

This means that as of July 1, 2015 we are no longer able to reimburse claims for topical creams and ointments with hydrocortisone of 1% or less. Common skin products that will no longer be accepted are Hyderm 1% cream, Cortoderm 1% ointment, and Dermaflex 1% cream and lotion. We are aware that this is a change for plan members, so we have created the attached plan member communication to explain what's changing and why. Please share this communication with your plan members. This information will also be available on our website.

BILL 28 AND THE CHANGING DRUG LANDSCAPE IN QUEBEC

On April 21, 2015, the Quebec government sanctioned Bill 28, *An Act mainly to implement certain provisions of the Budget Speech of 4 June 2014 and return to a balanced budget in 2015-2016*, which in turn, amended the *Act respecting prescription drug insurance* (the "Act").

Yes, that is quite a mouthful. What does this actually mean? If you have plan members in Quebec, the new legislation introduces a number of changes that will have a direct impact on your drug plan. Here's what we know so far:

REIMBURSEMENT OF BRAND NAME DRUGS TO THE LOWEST COST DRUG

Effective **October 1, 2015**, the Regie de l'assurance maladie (RAMQ) and private drug plans will be permitted to limit reimbursement of brand name drugs to the lowest cost generic equivalent, if the plan provides for it. That means that if you have generic substitution as part of your drug plan, this cost containment provision can now be applied to your Quebec plan members. This changes the current situation where private drug plans are required to pay the full cost of the drug even if there is a generic equivalent available.

We are cautiously optimistic that this will translate to positive cost savings for GSC drug plans in Quebec. However, there is still quite a bit we don't know yet as the Quebec government has to introduce regulations that will detail how this will be applied. For example, it is unclear whether this new rule will be applied to the full cost of the drug (i.e., the manufacturer list price and pharmacy fees) or just to the manufacturer's listed price.

PHARMACY SERVICES

Effective **June 20, 2015**, private drug plans will be required to reimburse certain pharmaceutical services related to drugs that are on the RAMQ formulary. The legislation lists a number of pharmaceutical services that pharmacists are now authorized to provide:

- Renew a physician's prescription
- Prescribe a medication when no diagnosis is required
- Prescribe laboratory analyses in a community pharmacy
- Adjust a physician's prescription:
 - Modify the form, dosage or quantity of a prescribed medication
 - Modify the dose of a prescribed medication to achieve therapeutic targets
 - Modify the dose of a prescribed medication to ensure the safety of a patient
- Substitute the prescribed medication with another of the same therapeutic sub-group, if the prescribed medication is completely unavailable in Quebec
- Prescribe a medication for a minor condition (where the diagnosis and treatment are known)
- Administer a medication in order to demonstrate proper usage

What's not known yet? Only some of these pharmaceutical services will be covered by RAMQ (and therefore by private drug plans) – but we don't know which ones yet. New regulations are expected to detail which services will be covered, how much pharmacists can charge for these services, and the parameters of coverage for these services.

There is still quite a bit of uncertainty with this new legislative change and we are waiting for a lot more information to better understand the impact to you and your drug plan. We are closely monitoring the situation in Quebec and we will update you as soon as we have more information.

NEW STREAMLINED SUBMISSION PROCESS FOR PHARMACIES AND PRESCRIPTION REQUIREMENT FOR LANCET CLAIMS

As part of our continuous effort to make benefits as uncomplicated as possible for our health providers, GSC has launched a new process for pharmacists to submit claims for lancets (a diabetic supply item). Don't worry...there is no impact to your benefit plan. So what's changing? We're making it easier for pharmacists to submit lancet claims to GSC on behalf of plan members.

As of **June 1, 2015**, when a plan member goes to the pharmacy to fill their prescription for lancets, the pharmacist can submit the claim on their behalf through their regular drug claims system – regardless of whether lancets are covered as a drug benefit or extended health services (EHS) benefit under the provisions of your plan. Previously, pharmacists would have had to determine how lancets were covered under the plan member's plan, and use either their drug claims system or providerConnect™ to submit the claim, depending on how they were categorized. Now, pharmacists only need one system to submit both diabetic drugs and lancet claims.

This means a better, streamlined approach for pharmacies – which translates to better service for plan members.

Plan members will now need a prescription when lancets are being dispensed by a pharmacist in order for their claim to be reimbursed. This is because the pharmacy will be billing the claim through their drug claim system and providing an official prescription receipt – therefore a prescription needs to be on file. For the most part, a prescription for lancets accompanies the prescription for diabetic medication so we expect that most plan members will not be impacted by this change. We are sending a personalized letter to plan members who have submitted lancet claims without a prescription in the past to advise them of this new requirement. In addition, starting April 15, 2015, we attached a special message on lancet claim statements to let impacted plan members know of the new process and requirements. But don't worry – if someone misses these advance warnings, we'll let one claim slide with a First Claim Forgiveness policy – so they will know for next time.