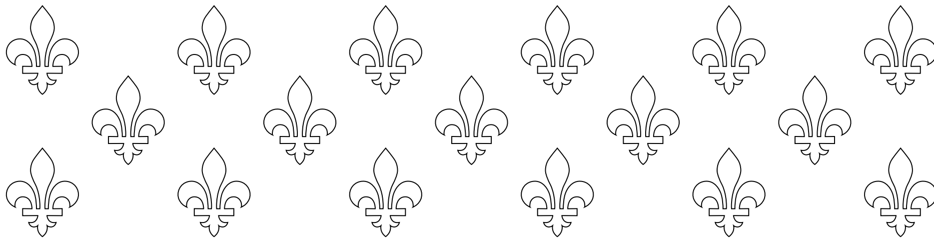

NATIONAL ASSEMBLY

SECOND SESSION THIRTY-FIFTH LEGISLATURE

Bill 33

(1996, chapter 32)

An Act respecting prescription drug insurance and amending various legislative provisions

Introduced 15 May 1996
Passage in principle 12 June 1996
Passage 19 June 1996
Assented to 20 June 1996

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EXPLANATORY NOTES

This bill establishes a basic prescription drug insurance plan designed to provide all persons in Québec with reasonable and fair access to the medications required by their state of health.

Under the plan, every person residing in Québec who is registered with the Régie de l'assurance-maladie du Québec (the "Board") will benefit from basic coverage for the cost of pharmaceutical services and medications. Coverage will be provided by the Board for all persons who currently benefit from the pharmaceutical services plan administered by the Board and for persons who do not qualify for membership in a group to which a group insurance contract or employee benefit plan applies. Coverage for all other eligible persons will be provided by insurers transacting group insurance and by private-sector employee benefit plans.

The bill sets out the contributions to be made to the financing of the basic plan by the persons covered, who may be required to pay a co-insurance amount of not more than 25% of the cost of the pharmaceutical services and medications provided up to a maximum contribution of $750 for a one-year reference period.

Under the bill, basic plan coverage is mandatory. Persons qualifying for membership in a group to which a group insurance contract or employee benefit plan including basic plan coverage applies are required to join the group and ensure coverage for their spouse, their children and, in certain cases, any handicapped persons domiciled with them. No group insurance contract or employee benefit plan providing coverage for accident, illness or invalidity may be established unless it also includes coverage for pharmaceutical services and medications at least equal to the coverage under the basic plan.

With respect to the coverage provided by the Board, the bill fixes the amount of the premium and the deductible amount and provides for reduced premiums, deductibles and maximum contributions for

low-income families. The Government is given the power to change the amount of the premium and the deductible annually.

With respect to the coverage provided under group insurance contracts or employee benefit plans, the bill provides that premiums and contributions will, where applicable, continue to be determined by the parties. The bill also contains provisions to ensure continuity of coverage.

The risks borne under group insurance contracts and employee benefit plans will be pooled using the methods determined by the insurers and plan administrators concerned and communicated to the Minister. If not so determined, the methods will be determined by the Government.

The bill requires the Minister of Health and Social Services to draw up a medication policy, the main objectives of which are set out in the bill, and authorizes the Minister to establish an advisory group in connection with the policy.

The bill reiterates, with some changes, the provisions of the Health Insurance Act relating to the list of medications. The list will be used as a reference for all the medications covered by the Board and by group insurance contracts and employee benefit plans; only the Board, however, will be bound by the prices set out in the list. The provisions concerning the advisory council known as the Conseil consultatif de pharmacologie are also reiterated in the bill, although the composition of the council is changed to include a pharmacoeconomics expert and a representative of the Minister.

A review committee on the use of medications is established, with the function of promoting the appropriate use of medications. The review committee will include representatives of various areas of medical practice, pharmacists and academics, and will, in particular, ensure that use review procedures for medications are assessed.

The bill requires the Minister to make a report to the Government, three years after the bill comes into force, on its implementation. The report will be tabled in the National Assembly and examined by the appropriate parliamentary committee.

Provisions are inserted into the Act respecting the Régie de l'assurance-maladie du Québec to govern collection of the premium for coverage provided by the Board, and the applicable reductions. The provisions will be applied by the Minister of Revenue.

The same Act is also amended to create the prescription drug insurance fund into which the amounts paid to the Minister of Revenue or recovered by the Board in connection with the prescription drug insurance plan will be paid, and out of which the amounts required to pay for the services and medications covered by the Board as regards its new clientele will be taken, together with administration and interest charges.

Lastly, the bill includes consequential amendments and penal provisions.

LEGISLATION AMENDED BY THIS BILL:

– Health Insurance Act (R.S.Q., chapter A-29);

– Act respecting the Commission des affaires sociales (R.S.Q., chapter C-34);

– Act respecting the Régie de l'assurance-maladie du Québec (R.S.Q., chapter R-5);

– Act respecting health services and social services (R.S.Q., chapter S-4.2);

– Act respecting health services and social services for Cree Native persons (R.S.Q., chapter S-5);

– Act to amend the Health Insurance Act (1992, chapter 19).

Bill 33

An Act respecting prescription drug insurance and amending various legislative provisions

THE PARLIAMENT OF QUÉBEC ENACTS AS FOLLOWS:

CHAPTER I

ESTABLISHMENT AND PURPOSE

1. A basic prescription drug insurance plan is hereby established.

2. The purpose of the basic plan is to ensure that all persons in Québec have reasonable and fair access to the medication required by their state of health.

To that end, the plan provides for a minimum level of coverage for the cost of pharmaceutical services and medications, and for the financial contribution required of persons or families covered by the plan depending, in particular, on their economic situation.

3. Coverage under the basic plan shall be provided by the Régie de l'assurance-maladie du Québec, hereinafter referred to as the Board, or by the insurers transacting group insurance or the administrators of private-sector employee benefit plans, as provided by this Act.

4. "Insurer" means a legal person holding a licence issued by the Inspector General of Financial Institutions that authorizes it to transact insurance of persons in Québec.

"Employee benefit plan" means a funded or unfunded uninsured employee benefit plan that provides coverage that may otherwise be obtained under an insurance contract of insurance of persons.

CHAPTER II

BASIC PLAN COVERAGE

DIVISION I

ELIGIBILITY

5. Every person who is a resident of Québec within the meaning of the Health Insurance Act (R.S.Q., chapter A-29) and who is duly registered with the Board in accordance with that Act is eligible for the basic plan.

6. The classes of persons determined by government regulation who are otherwise entitled to coverage under another Act of Québec, an Act of the Parliament of Canada or the laws of another province of Canada or another country or under a program administered by a government or by a government department or agency that is determined by government regulation to be at least equivalent to the coverage of the basic plan, are not covered by the basic plan.

DIVISION II

COVERAGE

7. The basic plan provides coverage to every eligible person for the cost of pharmaceutical services and medications provided in Québec, to the extent provided for in this Act, regardless of the risk associated with that person's state of health.

8. Coverage under the basic plan includes, to the extent provided for by this Act, the services required to fill or renew a prescription and the medications entered on the list of medications drawn up by the Minister under section 60, when provided in Québec by a pharmacist on the prescription of a physician, a medical resident or a dentist. Certain medications on the list, specified by government regulation, shall be covered only in the cases, on the conditions and for the therapeutic indications determined in the regulation.

The same coverage applies when a person obtains medications in a pharmacy outside Québec from a person legally authorized to practise as a pharmacist in the place concerned and with whom the Board has entered into an individual agreement for that purpose, if the pharmacy is situated in a region bordering on Québec and if no pharmacy situated in Québec within a radius of 32 kilometres of that pharmacy provides services to the public.

In addition, coverage includes, in the cases and on the conditions and for the classes of persons determined by government regulation, the medications specified in the regulation that are provided as part of the services provided by an institution within the meaning of the Act respecting health services and social services (R.S.Q., chapter S-4.2) or the Act respecting health services and social services for Cree Native persons (R.S.Q., chapter S-5) or any other institution recognized for that purpose by the Minister that is situated outside Québec in a region bordering on Québec.

9. Coverage under the basic plan does not include the cost of pharmaceutical services and medications that an eligible person may obtain, and to which that person is otherwise entitled, pursuant to an Act of Québec, an Act of the Parliament of Canada or the laws of another province of Canada or another country, or under a program administered by a government or by a government department or agency.

DIVISION III

FINANCIAL PARTICIPATION

10. Unless exempted by the Act, an eligible person must pay any applicable annual premium or assessment.

11. A person may be required to make a contribution towards the payment of the cost of the pharmaceutical services and medications provided each time a prescription is filled or renewed, until the maximum contribution for the reference period is reached. The contribution may consist of a deductible amount and a co-insurance payment.

The deductible amount is the portion of the cost of pharmaceutical services and medications borne entirely by the person covered by the plan during the reference period.

The coinsurance payment is the portion of the cost of pharmaceutical services and medications borne by the person covered by the plan until the maximum contribution is reached.

The maximum contribution is the total amount borne by the person covered beyond which the cost of pharmaceutical services and medications is borne entirely by the Board or by an insurer or employee benefit plan, as the case may be.

12. The coinsurance percentage to be borne by an eligible person shall not exceed 25% of the cost of pharmaceutical services and medications.

13. The maximum contribution for a reference period of one year shall not exceed $750 per adult; this amount includes any amounts paid by the adult as a deductible amount and coinsurance payment for a child of the adult or a person suffering from a functional impairment who is domiciled with the adult.

14. If a change occurs in an eligible person's situation, the contribution to be paid is the contribution applicable to the person's new situation at the time of obtaining a pharmaceutical service or medication.

CHAPTER III

APPLICATION OF THE BASIC PLAN

DIVISION I

MANDATORY NATURE OF PLAN

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 applicable to a group of persons determined on the basis of current or former employment status, profession or habitual occupation and that includes basic plan coverage, and who are not beneficiaries under such a contract or plan;

(2) persons or families receiving benefits under a last resort assistance program pursuant to the Act respecting income security (R.S.Q., chapter S-3.1.1), or receiving an allowance paid under the second paragraph of section 67 of the Social Aid Act (1969, chapter 63), and holding a valid claim booklet issued by the Minister of Income Security pursuant to section 70 of the Health Insurance Act;

(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 Income Security 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 of persons determined on the basis of current or former employment status, profession or habitual occupation, and in whose respect no person is required, in accordance with section 18, to ensure coverage as beneficiaries under such a contract or plan.

16. All eligible persons, other than persons to whom paragraphs 1 to 3 of section 15 apply, who by reason of current or former employment status, profession or habitual occupation qualify for membership in a group to which a group insurance contract or employee benefit plan including coverage for the cost of pharmaceutical services and medications applies, must become members of that group for at least the basic plan coverage.

The obligation to become a member of such a group does not apply to a person who, as a spouse, a child or a person suffering from a functional impairment, 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.

17. For the purposes of this Act,

(1) "child" means

(1) an eligible person under 18 years of age in whose respect a person exercises parental authority;

(2) a spouseless eligible person 25 years of age or under who attends an educational institution on a full-time basis as a duly registered student, and in whose respect a person would exercise parental authority were the person a minor;

"person suffering from a functional impairment" means a spouseless eligible person of full age suffering from a functional impairment, referred to in a government regulation, that has existed since before the person's eighteenth birthday, who receives no benefits under a last resort assistance program pursuant to the Act respecting income security, and who is domiciled with a person who would exercise parental authority were the person a minor;

"educational institution" means a legal person or a body providing instruction at the secondary, college or university level;

(2) "spouse" must be construed in accordance with section 2.2.1 of the Taxation Act (R.S.Q., chapter I-3).

18. Eligible persons other than persons to whom section 15 applies must ensure that the same coverage is provided to the following persons as beneficiaries of the group insurance contract or employee benefit plan of which they are members by reason of current or former employment status, profession or habitual occupation:

(1) their children;

(2) persons suffering from a functional impairment who are domiciled with them.

Such persons must also ensure that the same coverage is provided to their spouse, unless the latter is already a beneficiary under a group insurance contract or employee benefit plan referred to in the first paragraph.

The same applies to persons 65 years of age and over who are members of a group insurance contract or employee benefit plan referred to in paragraph 1 of section 15.

DIVISION II

PROVISIONS APPLICABLE TO PERSONS COVERED BY THE BOARD

§ 1. — *Registration*

19. Persons to whom paragraph 4 of section 15 applies must register with the Board on the conditions and in the manner prescribed by government regulation.

Where pharmaceutical services or medications are provided to persons referred to in the said paragraph 4 who are not duly registered with the Board, they may apply to the Board for the reimbursement of the cost of the services or medications in the manner prescribed in section 33, provided that they register with the Board and that the services and medications were provided in the three months preceding registration.

20. Persons to whom paragraphs 1, 3 and 4 of section 15 apply must register their children and persons suffering from a functional impairment who are domiciled with them with the Board, unless another person is required to ensure that coverage is provided to the children or to the impaired persons as beneficiaries under a group insurance contract or employee benefit plan.

21. Any change relating to the information provided in support of the registration of a person, a child of the person or a person suffering from a functional impairment who is domiciled with the person must be notified to the Board, by the person, within 30 days of the change.

§ 2. — *Coverage*

22. The Board shall pay the cost of the pharmaceutical services determined by government regulation according to the tariff established by an agreement under section 19 of the Health Insurance Act, in addition to the cost of the services rendered to fill or renew a prescription.

It shall also pay the cost of medications according to the price indicated in the list of medications drawn up by the Minister pursuant to section 60 and, with respect to medications provided by an institution, according to the price established in that list.

§ 3. — *Premium and contribution*

23. The amount of the annual premium for persons to whom coverage is provided by the Board shall be determined in accordance with section 37.6 of the Act respecting the Régie de l'assurance-maladie du Québec. It shall not exceed $175 per eligible person.

The $175 limit may be revised annually by government regulation.

24. The following persons are exempted from payment of the premium for a given month:

(1) a child in whose respect parental authority, during that month, was exercised by a person to whom paragraph 1, 3 or 4 of section 15 applies, or would have been exercised had the child been a minor;

(2) a person suffering from a functional impairment who, during that month, was domiciled with a person to whom section 15 applies;

(3) a person to whom paragraph 2 or 3 of section 15 applies.

25. Eligible persons who remain outside Québec during an entire calendar year, and who retain their status as residents of Québec under the Health Insurance Act despite their absence from Québec, are exempted from payment of the premium for that year in the cases and on the conditions prescribed by government regulation.

26. The deductible amount shall be $100 per year, divided into equal parts for each quarter. The amount may be revised annually by government regulation.

27. The coinsurance percentage shall be 25%.

28. The maximum contribution shall be $200 per year, divided into equal parts for each quarter, for

(1) persons 65 years of age and over receiving the maximum amount of guaranteed monthly income supplement under the Old Age Security Act (R.S.C. 1985, chapter O-9);

(2) persons to whom paragraph 2 or 3 of section 15 applies.

The maximum contribution shall be $500 per year, divided into equal parts for each quarter, for persons 65 years of age and over who receive a fraction of the maximum amount of guaranteed monthly income supplement under the Old Age Security Act.

The maximum contribution shall be $750 per year, divided into equal parts for each quarter, for all other persons.

29. Children and persons suffering from a functional impairment are exempted from the payment of any contribution.

30. A person referred to in section 15 shall, unless exempted, contribute towards the payment of the cost of the pharmaceutical services and medications provided,

(1) by paying, when a prescription is filled or renewed, all or part of the cost of the pharmaceutical services and medications obtained, according to the terms and conditions prescribed by government regulation, until the applicable deductible amount for the quarter has been reached;

(2) by paying, once the deductible amount has been reached, only the portion of the cost to be borne as a coinsurance payment with respect to the cost of the pharmaceutical services and medications obtained, until the maximum contribution fixed for the quarter has been reached.

31. Any person providing pharmaceutical services and medications covered by the basic plan to a person referred to in section 15 must require from that person payment of the applicable contribution.

32. Once the maximum contribution required from a person for the quarter has been entirely paid, the person is exempted, for the remainder of the quarter, from any payment to a pharmacist or institution, as the case may be, for pharmaceutical services and medications covered by the basic plan, unless the amount of the maximum contribution applicable at the time the pharmaceutical services and medications are provided is greater than the contribution paid up to that time as a result of a change in the person's situation.

33. When a person referred to in section 15 exacts payment from the Board, in accordance with section 12 of the Health Insurance Act, of the cost of covered pharmaceutical services and medications furnished by a non-participating pharmacist referred to in section 30 of that Act, or the reimbursement of the cost of pharmaceutical services and medications obtained without presenting a health-insurance card or claim booklet in accordance with section 13.1 of that Act, the Board shall

(1) apply the deductible amount applicable to the beneficiary to the payment or reimbursement;

(2) deduct from the payment or reimbursement the portion of the cost to be borne by the beneficiary in the form of a coinsurance payment for those services and those medications until the maximum contribution for the quarter has been reached.

DIVISION III

COVERAGE BY THE PRIVATE SECTOR

§ 1. — *Application*

34. This division applies to all persons eligible for the basic plan to whom section 15 does not apply. It also applies to insurers transacting group insurance and to the administrators of an employee benefit plan.

§ 2. — *Obligations relating to coverage*

35. Despite any stipulation to the contrary, every group insurance contract and every employee benefit plan providing coverage for the cost of pharmaceutical services and medications in case of illness, accident or disability is deemed to provide basic plan coverage.

36. Despite any stipulation to the contrary, a group insurance contract or an employee benefit plan that includes basic plan coverage is divisible for that part of the coverage.

37. No person may, as regards the part of coverage corresponding to the basic plan, refuse to allow a person to become a member of a group insurance contract or employee benefit plan on the grounds of the specific risk associated with the age, sex or state of health of the person, the person's spouse or child, or a person suffering from a functional impairment who is domiciled with the person.

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.

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.

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.

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.

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.

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.

40. Insurers must sent to the Board, by way of electronic filing or of a computer-generated medium, in accordance with section 16.1 of the Act respecting the Régie de l'assurance-maladie du Québec, the information, prescribed by government regulation, that is required for the purposes of this Act in relation to a person's membership in a group insurance contract, in the manner determined by the regulation.

This section, adapted as required, applies to administrators of an employee benefit plan.

41. For the purposes of the basic plan, no person may, with respect to group insurance or an employee benefit plan, determine a group on the basis of the age, sex or state of health of plan members.

42. Where a group insurance contract or employee benefit plan includes coverage for the cost of pharmaceutical services and medications for a group of persons determined on the basis of current or former employment status, profession or habitual occupation, the insurer or plan administrator must provide coverage to all the persons having that current or former employment status, profession or habitual occupation.

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.

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.

§ 3. — *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.

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.

§ 4. — *Premiums and assessments*

44. The premium or assessment pertaining to basic plan coverage that is stipulated in a group insurance contract or employee benefit plan shall be negotiated or agreed to by the parties.

The same applies to any contribution in the form of a deductible amount or coinsurance payment, subject to sections 12 and 13.

§ 5. — *Continuity of coverage*

45. As regards basic plan coverage, every group insurance contract is renewed by operation of law each year on the contract's date of expiry, for the premium or assessment fixed pursuant to subdivision 4, unless the insurer, the policy-holder or the plan member has given notice to the contrary. Any notice of non-renewal or of a change in the premium or assessment from the insurer must be sent to the last known address of the plan member not later than 30 days preceding the date of expiry.

46. No insurer may, as regards that part of coverage that corresponds to the basic plan, invoke against a policy-holder, beneficiary or plan member any policy clause or Civil Code provision under which the insurer would otherwise be authorized to deny or reduce coverage.

47. No insurer may cancel a contract, with regard to the basic plan coverage, unless the policy-holder or the plan member fails to pay the premium or assessment. In such a case, the cancellation may not take effect until 30 days have elapsed since the date on which the insurer sent a notice of intent to the last known address of the policy-holder or plan member.

48. No administrator of an employee benefit plan may terminate basic plan coverage of the cost of pharmaceutical services and medications until 30 days have elapsed since the date on which the administrator sent a notice of intent to the last known address of all the members of the plan.

49. Where employees who are members of a group insurance contract or of an employee benefit plan providing basic plan coverage are involved in a lockout, strike or other work stoppage, the insurer or the administrator of the plan must maintain coverage during a period of at least 30 days from the date on which the lockout, strike or work stoppage began.

50. An eligible person must inform the insurer or the administrator of the employee benefit plan concerned of any change of address without delay. Where no notice of change of address has been received, the last address given by the plan member to the insurer or the administrator of the employee benefit plan is presumed accurate.

CHAPTER IV

ADMINISTRATIVE PROVISIONS

DIVISION I

POLICY RESPECTING MEDICATIONS

51. A policy respecting medications shall be drawn up by the Minister of Health and Social Services.

The policy shall endeavour to integrate the use of medications into the overall set of actions intended to improve the health and well-being of the population, in particular by means of a basic prescription drug insurance plan, and, subject to the availability of financial resources, shall pursue the following main objectives:

(1) fair and reasonable access to the medications required by the state of health of each person;

(2) appropriate use of medications;

(3) better information and training for the public and health professionals;

(4) the implementation of effective and efficient strategies and actions.

52. The Minister may establish an advisory group to advise the Minister on the policy, and designate its members.

DIVISION II

CONSEIL CONSULTATIF DE PHARMACOLOGIE

53. An advisory council on pharmacology, known as the Conseil consultatif de pharmacologie, is hereby established.

The advisory council shall be composed of a president and of six other members, of whom four must be experts in pharmacology, one an expert in pharmacoeconomics and one a representative of the Minister.

The president must be a physician and member of the Collège des médecins du Québec, or a pharmacist and member of the Ordre des pharmaciens du Québec.

54. The members of the advisory council shall be appointed by the Government for a term not exceeding three years and shall remain in office, at the expiry of their term of office, until reappointed or replaced.

55. The fees, allowances or salaries and, where applicable, additional salaries of the members of the advisory council shall be fixed by the Government, as shall the fees of any consultants and experts consulted by the advisory council.

56. The Minister shall assign a secretary to the advisory council together with the other public servants and employees necessary to its operations ; they shall be selected from among the public servants and employees of the Ministère de la Santé et des Services sociaux.

57. The function of the advisory council shall be to assist the Minister in updating the list referred to in section 60 and, for that purpose, to advise the Minister on the therapeutic value of each medication and on the reasonableness of the price charged for it.

The functions of the advisory council shall also include making recommendations to the Minister on the use of medications and the evolution of prices and on any other matter submitted by the Minister to the council in the field of pharmacology.

58. In exercising its functions, the advisory council may require accredited manufacturers and wholesalers, or manufacturers and wholesalers who have applied for accreditation, to provide

information on the pharmacological and therapeutic aspects of a medication, and information on the price of the medications they offer for sale.

59. The advisory council shall have a right of access to the information obtained by the Board pursuant to section 20 of the Act respecting the Régie de l'assurance-maladie du Québec that it requires for the purposes of sections 63 and 65. Such information must not allow any eligible person to be identified.

DIVISION III

LIST OF MEDICATIONS

§ 1. — *Establishment and updating*

60. The Minister shall draw up a list of the medications the cost of which is covered by the basic plan. The list may also include certain supplies that the Minister considers essential for the proper administration of prescription drugs.

Only a medication from a manufacturer accredited by the Minister may be considered for entry on the list. However, the Minister may enter on the list the medication of a manufacturer who has not been granted accreditation if the medication is unique and essential.

The list shall, in particular, indicate generic names, brand names and manufacturer's names for each medication covered by the basic plan and the conditions on which the medication may be obtained from a manufacturer or wholesaler accredited by the Minister, and the manner in which the price of each medication provided as part of the services provided by an institution in accordance with the third paragraph of section 8 is established.

The list shall also, in cases where medications are provided by a pharmacist and coverage is provided by the Board, indicate the price of the medications sold by a manufacturer or wholesaler accredited by the Minister, the manner in which the price of each medication is established, and the maximum amount, where applicable, for which payment is covered under the basic plan, in the cases and on the conditions determined by the Minister.

The list shall also contain exceptional medications, determined by government regulation, the cost of which is covered by the basic plan in the cases and on the conditions prescribed in the regulation, in particular as regards therapeutic indications.

61. The list shall be updated periodically after consultation with the Conseil consultatif de pharmacologie.

The list and every update of the list shall be published by the Board in the manner it considers appropriate. They shall come into force on the date of publication by the Board.

§ 2. — *Accreditation of wholesalers and manufacturers*

62. The Minister may, for the purposes of the list of medications, grant accreditation to a manufacturer or wholesaler on the conditions he determines by regulation.

63. The Minister may, following a report from the Conseil consultatif de pharmacologie, temporarily withdraw accreditation from a drug manufacturer or wholesaler who fails to comply with the conditions or commitments prescribed by ministerial regulation.

In the case of a manufacturer, the withdrawal of accreditation shall entail the exclusion from the list of all the medications produced by the manufacturer for a period of three months.

In the case of a wholesaler, the Board, insurers and the administrators of employee benefit plans shall cease to reimburse the payment of the medications sold by the wholesaler, for a period of three months.

If the manufacturer or wholesaler has been subject to temporary disaccreditation in the five preceding years, the periods prescribed in the second and third paragraphs shall be extended to six months for any subsequent withdrawal.

64. A manufacturer or wholesaler referred to in section 63 shall, for the period of temporary withdrawal, repay to the Board,

(1) in the case of a manufacturer, the difference between the price paid by the Board and the price the manufacturer had undertaken to guarantee;

(2) in the case of a wholesaler, the difference between the price paid by the Board and the price corresponding to the wholesaler's commitment prescribed by ministerial regulation;

(3) in either case, the expenses incurred to advise health care professionals of the temporary withdrawal of recognition from the manufacturer or wholesaler.

The failure of a manufacturer or wholesaler to comply with the first paragraph is deemed to constitute a breach of commitment.

65. The Minister may also, following a report of the Conseil consultatif de pharmacologie, withdraw the accreditation of a manufacturer or wholesaler permanently if the manufacturer or wholesaler has, in the five preceding years, been subject to two temporary withdrawals and has again failed to comply with the conditions and commitments prescribed by ministerial regulation.

66. A manufacturer or wholesaler whose recognition has been permanently withdrawn may submit a new application for recognition. However, in addition to complying with the conditions prescribed by ministerial regulation, the manufacturer or wholesaler must, before being again granted recognition, repay the following amounts to the Board:

(1) in the case of a manufacturer, the difference between the price paid by the Board and the price the manufacturer had undertaken to guarantee;

(2) in the case of a wholesaler, the difference between the price paid by the Board and the price corresponding to the wholesaler's commitment prescribed by ministerial regulation;

(3) in either case, the expenses incurred to advise health care professionals of the permanent withdrawal of recognition from the manufacturer or wholesaler.

67. The Minister shall give prior notice of not less than 30 days of the acts alleged against a manufacturer or wholesaler before withdrawing accreditation.

The manufacturer or wholesaler may present observations before the expiry of the 30-day period.

68. A manufacturer or wholesaler whose accreditation has been temporarily or permanently withdrawn pursuant to section 63 or 65 may appeal to the Commission des affaires sociales within 30 days of notification of the decision.

69. A decision by the Minister to withdraw an accreditation shall take effect on the date of publication of a notice containing the decision in the *Gazette officielle du Québec*, and the three-month or six-month period of temporary withdrawal shall be calculated from that date.

70. No notice may be published by the Minister under section 69 before the expiry of the period of appeal provided for in section 68 or, if an appeal is filed, before the Commission has made a decision.

DIVISION IV

COMITÉ DE REVUE DE L'UTILISATION DES MÉDICAMENTS

71. A review committee on the use of medications, known as the Comité de revue de l'utilisation des médicaments, is hereby established.

The review committee shall be composed of a president, a vice-president and not more than seven other members.

The members of the review committee shall be appointed by the Government as follows:

(1) three members shall be physicians in clinical practice, of whom one shall be designated by the Collège des médecins du Québec, one by the Fédération des médecins omnipraticiens du Québec, and one by the Fédération des médecins spécialistes du Québec, but of whom none shall hold a full-time position with those organizations;

(2) two members shall be pharmacists in clinical practice, of whom one shall be designated by the Ordre des pharmaciens du Québec and one by the Association québécoise des pharmaciens propriétaires, but of whom neither shall hold a full-time position with those organizations;

(3) one member shall be designated by the deans of Québec's faculties of medicine;

(4) one member shall be designated by the directors or deans of Québec's schools and faculties of pharmacy;

(5) one member shall be a pharmacist designated by the body known as the Réseau de revue d'utilisation des médicaments en établissement.

A member of the Ordre des pharmaciens du Québec, designated by the Board, shall also be a member of the committee but without the right to vote.

The president and vice-president of the review committee must be either the physician designated by the Collège des médecins du

Québec or the pharmacist designated by the Ordre des pharmaciens du Québec.

72. The function of the review committee shall be to promote the appropriate use of medications. To that end, it shall

(1) engage in procedures for the review of the use of medications;

(2) propose training, information and awareness programs to improve drug prescribing and dispensing practices in cooperation and in conjunction with various intervenors, including the professional orders and the Conseil consultatif de pharmacologie;

(3) make recommendations to the various intervenors in order to improve the use of medications, without encroaching upon their respective responsibilities.

The review committee must ensure that the use review procedures are assessed by an independent person or body having regard to the expected results, efficiency, efficacy and economic and health impacts.

73. The members of the review committee shall be appointed for a term of not more than four years.

No member may serve more than three consecutive terms.

At the expiry of their term, the members of the review committee shall remain in office until reappointed or replaced.

74. The quorum at meetings of the review committee shall be five members, including the president or the vice-president. In the case of a tie-vote, the president or the vice-president shall have the casting vote.

75. The fees, allowances or salaries or, where applicable, the additional salaries of the members shall be fixed by the Government, as shall the fees of any consultants and experts consulted by the review committee.

76. The Board shall pay the fees, allowances and salaries referred to in section 75. It shall also, subject to the availability of resources, provide the administrative support and data processing services required for the work of the review committee.

77. The review committee shall provide all the information required by the Minister regarding its operations.

The review committee shall, each year, submit to the Minister a plan of its activities for the ensuing year and, not later than 31 March each year, submit a report on and assessment of its activities for the year ending on the preceding 31 December.

DIVISION V

REGULATIONS

78. In addition to the regulatory powers otherwise conferred on it by this Act, the Government may, after consulting the Board, make regulations to

(1) determine, for the purposes of section 6, the classes of persons who are otherwise entitled to coverage equivalent to basic plan coverage;

(2) determine, for the purposes of section 22, the services required for pharmaceutical reasons and provided by a pharmacist that are covered by the basic prescription drug insurance plan provided by the Board, and prescribe the frequency with which certain services must be provided to remain covered; the frequency may vary in the cases and on the conditions it determines;

(3) determine the cases, conditions and therapeutic indications in and for which the cost of certain medications included in the list drawn up by the Minister under section 60 is covered by the basic plan; the conditions may vary according to whether the coverage is provided by the Board or under a group insurance contract or an employee benefit plan;

(4) determine the cases in which and conditions on which the medications determined by the Government, that are provided as part of the services provided by an institution within the meaning of the Act respecting health services and social services or the Act respecting health services and social services for Cree Native persons or by any other institution recognized for that purpose by the Minister that is situated outside Québec in a region bordering on Québec, are covered for the classes of persons it determines;

(5) prescribe the cases in which and conditions on which eligible persons who remain outside Québec during the entire year, and who retain their status as persons resident in Québec under the Health

Insurance Act despite their absence from Québec, may be exempted from payment of the premium for that calendar year;

(6) list the types of impairment which constitute functional impairment for the purposes of section 17;

(7) revise the amount of the annual premium provided for in section 23;

(8) revise the amount of the deductible amount provided for in section 26;

(9) prescribe, for the purposes of section 40, the information that the Board may require from an insurer transacting group insurance or the administrator of an employee benefit plan, and prescribe the manner in which such information may be communicated;

(10) determine, for the purposes of section 43, the terms and conditions on which the risks arising from the basic plan coverage must be pooled, and the period during which they are to apply;

(11) determine the provisions of a regulation the contravention of which constitutes an offence.

A regulation made under this section shall have effect, with respect to health care professionals bound by a valid agreement and despite any contrary stipulation contained in the agreement, on the date or dates fixed in the regulation.

79. A regulation made under subparagraph 3 of the first paragraph of section 78 is not subject to the requirements concerning publication and date of coming into force contained in sections 8 and 17 of the Regulations Act (R.S.Q., chapter R-18.1).

80. The Minister may, after consulting the Conseil consultatif de pharmacologie, make regulations to

(1) determine the conditions governing the accreditation of a manufacturer or wholesaler of medications;

(2) determine the content of the commitment to be signed by a manufacturer or wholesaler to be granted accreditation;

(3) determine rules to regulate the practices of manufacturers and wholesalers with regard to medication pricing.

CHAPTER V

PENAL PROVISIONS

81. Every person making a statement that the person knows, or ought to have known, to be incomplete or to contain false or misleading information or transmitting an incomplete document or a document containing false or misleading information in order

(1) to obtain a pharmaceutical service or medication to which the person is not entitled, or

(2) to receive a payment or reimbursement without entitlement or in excess of the amount to which the person is entitled,

is guilty of an offence and is liable to a fine of not less than $100 and not more than $1,000.

82. Every person who assists or who incites, advises, encourages, allows, authorizes or orders another person to commit an offence referred to in section 81 is guilty of an offence.

A person convicted of an offence under this section is liable to the same penalty as that provided for in section 81.

83. Every person who contravenes a provision of sections 37 to 42 is guilty of an offence and is liable to a fine of not less than $500 and not more than $5,000.

84. Every insurer and every person administering an employee benefit plan who, in contravention of section 43, fails or neglects to pool the risks presented by insured members is guilty of an offence and is liable to a fine of not less than $1,000 and not more than $10,000.

85. Every person who contravenes a provision of a regulation the contravention of which constitutes an offence is liable to a fine of not less than $100 and not more than $1,000.

CHAPTER VI

MISCELLANEOUS PROVISIONS

86. The Minister shall, not later than (*insert here the date occurring three years after the date of coming into force of this section*), present a report to the Government on the application of this Act and on the opportunity of amending it.

The report shall be tabled in the National Assembly within 15 days or, if the Assembly is not sitting, within 15 days of resumption. The report shall be examined by the appropriate committee of the National Assembly.

87. The Minister of Health and Social Services is responsible for the administration of this Act.

CHAPTER VII

AMENDING PROVISIONS

HEALTH INSURANCE ACT

88. Section 1 of the Health Insurance Act (R.S.Q., chapter A-29) is amended by striking out the figure "69.1," in the first line of subparagraph *k* of the first paragraph.

89. Section 3 of the said Act is amended

(1) by replacing the third paragraph by the following paragraph:

"The Board also assumes, in accordance with the provisions of this Act and the regulations and subject to the Act respecting prescription drug insurance and amending various legislative provisions (1996, chapter 32), the cost of the services determined by regulation that are required for pharmaceutical reasons and furnished by pharmacists, the cost of medications furnished by pharmacists on the prescription of a physician, a resident in medicine or a dentist and, where applicable, the cost of medications provided as part of the services provided by an institution in accordance with the third paragraph of section 8 of the Act respecting prescription drug insurance and amending various legislative provisions, on behalf of every beneficiary who is an eligible person within the meaning of that Act and who

(*a*) is 65 years of age or over and is not a member of a group insurance contract or employee benefit plan applicable to a group of persons determined on the basis of current or former employment status, profession or habitual occupation and that includes basic plan coverage, and is not a beneficiary under such a plan, or

(*b*) holds a valid claim booklet issued under section 70, or

(*c*) is not required to become a member of a group insurance contract or employee benefit plan referred to in paragraph *a* and in

whose respect no person is required, in accordance with section 18 of the said Act, to ensure coverage as a beneficiary under such a contract or plan.";

(2) by replacing the fourth paragraph by the following paragraph:

"The Board also assumes, in accordance with the provisions of this Act and the regulations and subject to the Act respecting prescription drug insurance and amending various legislative provisions, the cost of the services determined by regulation that are required by pharmacy and furnished by pharmacists, the cost of medications furnished by pharmacists on the prescription of a physician, a resident in medicine or a dentist and, where applicable, the cost of medications provided as part of the services provided by an institution in accordance with the third paragraph of section 8 of the Act respecting prescription drug insurance and amending various legislative provisions, to every beneficiary who is an eligible person within the meaning of that Act and who holds a valid claim booklet issued under section 71.";

(3) by replacing the words "and the Hospital Insurance Act (chapter A-28)" in the fourth line of the eleventh paragraph by the words ", the Hospital Insurance Act (chapter A-28) and the Act respecting prescription drug insurance and amending various legislative provisions."

90. Sections 4 to 4.10 of the said Act are repealed.

91. Section 10 of the said Act is amended

(1) by inserting the words ", except the pharmaceutical services and medications referred to in the third and fourth paragraphs of section 3," after the word "health" in the third line of the first paragraph;

(2) by inserting, after the first paragraph, the following paragraphs:

"Notwithstanding the first paragraph, the cost of filling or renewing a prescription and the cost of the medications provided to an eligible person, within the meaning of the Act respecting prescription drug insurance and amending various legislative provisions, outside Québec by a person legally authorized to practise as a pharmacist in the place concerned and with whom the Board has

entered into an individual agreement for that purpose, may be reimbursed if the services and medications are furnished in a pharmacy situated in a region bordering on Québec and if no pharmacy situated, in Québec, within a radius of 32 kilometres of that pharmacy provides services to the public.

The same applies to the cost of medications provided, outside Québec, to an eligible person within the meaning of the Act respecting prescription drug insurance and amending various legislative provisions, as part of the services provided by an institution, in accordance with the third paragraph of section 8 of that Act.";

(3) by replacing the word "second" in the first line of the third paragraph by the word "fourth".

92. Division II.0.1 of the said Act, comprising sections 14.3 to 14.8, is repealed.

93. Section 15 of the said Act is amended by replacing the words "section 14.3" in the fourth line of the fifth paragraph by the words "the Act respecting prescription drug insurance and amending various legislative provisions".

94. Section 22.0.2 of the said Act is replaced by the following section:

"**22.0.2** The amount charged by the pharmacist pursuant to section 31 of the Act respecting prescription drug insurance and amending various legislative provisions is deemed to be charged as remuneration. The Board shall deduct that amount from the remuneration payable under an agreement entered into under section 19."

95. Section 22.1.0.1 of the said Act is replaced by the following section:

"**22.1.0.1** To be entitled to remuneration by the Board, a pharmacist or, where applicable, an institution must indicate to the Board, on the statement of fees or claim for payment, that the contribution referred to in section 31 of the Act respecting prescription drug insurance and amending various legislative provisions has been collected.

The statement of fees or claim for payment must be submitted to the Board by the pharmacist or institution even if the entire cost of the insured services provided has been charged to that beneficiary

in accordance with the Act respecting prescription drug insurance and amending various legislative provisions.

Before providing an insured service to a beneficiary, a pharmacist or institution must, to be entitled to remuneration by the Board, obtain prior authorization for payment from the Board by transmitting a statement of fees or claim for payment to the Board by interactive electronic means, in accordance with the conditions prescribed by regulation under section 16.1 of the Act respecting the Régie de l'assurance-maladie du Québec (chapter R-5)."

96. Section 22.2 of the said Act is amended by adding, after the fifth paragraph, the following paragraph:

"For the purposes of this Act and within the scope of the basic prescription drug insurance plan, the second, third, fourth and fifth paragraphs, adapted as required, apply to an institution."

97. Section 37 of the said Act is amended by inserting the words "the third and fourth paragraphs of section 3 and" after the word "to" in the first line.

98. Division IV of the said Act, comprising sections 39 and 40, is repealed.

99. Section 66.0.1 of the said Act is amended

(1) by replacing the words "section 40" in the first line by the words "sections 57 and 58 of the Act respecting prescription drug insurance and amending various legislative provisions";

(2) by replacing the words "the third paragraph of that section" in the second line by the words "section 59 of that Act".

100. Section 67 of the said Act is amended by inserting, after the first paragraph, the following paragraph:

"No person may use, for purposes other than those provided for by this Act, any information obtained by the Board."

101. Section 69 of the said Act is amended

(1) by replacing the figure "4" in the second line of subparagraph *f* of the first paragraph by the words "60 of the Act respecting prescription drug insurance and amending various legislative provisions";

(2) by striking out subparagraph *m*.2 of the first paragraph;

(3) by striking out subparagraph *u* of the first paragraph;

(4) by replacing the words ", *i*.1 or *u*" in the first line of the third paragraph by the words "or *i*.1".

102. Section 69.0.2 of the said Act is amended by striking out the letter "*u*," in the first line.

103. Section 69.1 of the said Act is repealed.

ACT RESPECTING THE COMMISSION DES AFFAIRES SOCIALES

104. Section 21 of the Act respecting the Commission des affaires sociales (R.S.Q., chapter C-34) is amended by replacing the words "4.8 of the Health Insurance Act" in the second line of paragraph *k*.1 by the words "68 of the Act respecting prescription drug insurance and amending various legislative provisions (1996, chapter 32)".

ACT RESPECTING THE RÉGIE DE L'ASSURANCE-MALADIE DU QUÉBEC

105. Section 20 of the Act respecting the Régie de l'assurance-maladie du Québec (R.S.Q., chapter R-5) is amended by replacing the words "69.1 of the Health Insurance Act (chapter A-29)" in the seventh line of the first paragraph by the words "80 of the Act respecting prescription drug insurance and amending various legislative provisions".

106. The said Act is amended by inserting, after section 37, the following:

"DIVISION I.1

"PRESCRIPTION DRUG INSURANCE

"§ 1. — *Interpretation*

"**37.1** In this division and the regulations, unless the context indicates otherwise,

"beneficiary" means an individual referred to in section 5 of the Act respecting prescription drug insurance and amending various legislative provisions (1996, chapter 32);

"dependent child" of an individual for a year means a person in whose respect the individual deducts for the year, in accordance with sections 752.0.1 to 752.0.7 of the Taxation Act (chapter I-3), an amount under section 752.0.1 of that Act pursuant to paragraph *b* of the said section 752.0.1, or could deduct such an amount if the individual was a Québec resident for the purposes of that Act on 31 December of that year;

"due date" means, in respect of an individual for a year,

(*a*) where the individual died after 31 October in the year and before 1 May in the immediately following year, the day that is 6 months after the day of death, and

(*b*) in any other case, 30 April in the immediately following year;

"family income" of an individual for a year means the amount by which the aggregate of the following amounts exceeds the amount determined in section 37.4 in respect of the individual for the year:

(*a*) the total income of the individual for the year; and

(*b*) the total income, for the year, of the individual's spouse during the year or if, at the end of the year, the individual and the person who was the individual's spouse during the year are living apart following the breakdown of their marriage, the total income of the individual's spouse for the year during the time they were married and were not living apart;

"global income" of an individual for a year means the amount by which the family income of the individual, for the year, exceeds the aggregate of $3,450, or such other amount as may be prescribed for the year, and

(*a*) $1,650, or such other amount as may be prescribed for the year, if the individual had a spouse during the year; or

(*b*) $2,600, or such other amount as may be prescribed for the year, if the individual had no spouse during the year but had one dependent child for the year; or

(*c*) $2,800, or such other amount as may be prescribed for the year, if the individual had no spouse during the year but had two or more dependent children for the year;

"individual" means an individual within the meaning of Part I of the Taxation Act, other than a trust within the meaning of section 1 of that Act;

"Minister" means the Minister of Revenue;

"month" means a calendar month, that is the period from the first day of a month to the last day of that month;

"regulation" means a regulation made by the Government under this division;

"total income" of an individual for a year means the individual's total income for the year determined in accordance with subparagraph *c* of the first paragraph of section 776.29 of the Taxation Act;

"year" means the calendar year.

"**37.2** The rules provided for in section 2.2.1 of the Taxation Act, adapted as required, apply to this division and the regulations.

"**37.3** For the purposes of this division, except section 37.7, where an individual had more than one spouse during a year,

(*a*) the individual is deemed to have had only one spouse during the year;

(*b*) the person who was the spouse of the individual on the last day of the year or, if the individual had no spouse at that time, the last person to have been his spouse during the year is deemed to have been the spouse of the individual during the year; and

(*c*) the individual is deemed not to have been the spouse during the year of any person other than the person referred to in paragraph *b*.

"**37.4** The amount referred to in the definition of "family income" in section 37.1 with respect to an individual for a year is equal to five times the total of the amounts that the individual and, where applicable, the individual's spouse during the year deduct under sections 752.0.1 to 752.0.7 of the Taxation Act for that year, excepting the amounts deducted under section 752.0.1 of the said Act pursuant to paragraph *i* or *j* of that section, for that year, and excepting the amounts deducted by the spouse for that year under

section 752.0.1 of that Act pursuant to paragraph *a* of that section, and under the first part of that part of that section preceding that paragraph.

For the purposes of the first paragraph, the amount that the individual deducts under section 752.0.1 of the Taxation Act pursuant to paragraph *a* of that section, for the year, is deemed to be equal to the amount that the individual could deduct under that paragraph for that year if, during the year, the individual's spouse had no income.

"**37.5** For the purposes of section 37.4, where an individual is not resident in Québec on 31 December of a year, for the purposes of the Taxation Act, a reference to an amount deducted by the individual for that year means an amount that, had the individual been resident in Québec on 31 December of that year, could have been deducted by the individual for that year.

"§ 2. — *Amount payable by an individual*

"**37.6** An individual must pay for a year, on the due date, an amount equal to the lesser of

(*a*) the aggregate of 1/12 of $175, or of such amount as may be determined for the year by government regulation under the second paragraph of section 23 of the Act respecting prescription drug insurance and amending various legislative provisions, for each month of the year during which the individual is a beneficiary other than a beneficiary referred to in section 37.7, and

(*b*) the amount determined in respect of the individual for the year using the formula

$$A (B \times C).$$

For the purposes of the formula set out in subparagraph *b* of the first paragraph,

(*a*) A is

i. 2%, if the individual has a spouse during the year; or

ii. 4%, in all other cases;

(*b*) B is the global income of the individual for the year;

(*c*) C is the quotient obtained by dividing the number of months referred to in subparagraph *a* of the first paragraph by 12.

“**37.7** A beneficiary referred to in subparagraph *a* of the first paragraph of section 37.6 is an individual who

(*a*) is a person benefitting from the coverage provided for by the basic prescription drug insurance plan established by the Act respecting prescription drug insurance and amending various legislative provisions under a group insurance contract or employee benefit plan applicable to a group of persons determined on the basis of current or former employment status, profession or habitual occupation;

(*b*) is a person referred to in section 6 or 25 of the Act respecting prescription drug insurance and amending various legislative provisions;

(*c*) is a child within the meaning of paragraph 1 of section 17 of the Act respecting prescription drug insurance and amending various legislative provisions;

(*d*) is a person suffering from a functional impairment within the meaning of paragraph 1 of section 17 of the Act respecting prescription drug insurance and amending various legislative provisions;

(*e*) receives benefits under a last resort assistance program pursuant to the Act respecting income security (chapter S-3.1.1) or is the recipient of an allowance paid under the second paragraph of section 67 of the Social Aid Act (1969, chapter 63), and also holds a valid claim booklet issued by the Minister of Income Security pursuant to section 70 of the Health Insurance Act (chapter A-29);

(*f*) is 60 years of age or over and less than 65 years of age and holds a valid claim booklet issued by the Minister of Income Security pursuant to section 71 of the Health Insurance Act.

“**37.8** An individual who has so elected, in prescribed form containing the prescribed information, shall pay for a year, on the due date, the amount that the individual’s spouse during the year would, were it not for this section, pay for the year under section 37.6.

Where an individual has made an election under the first paragraph, the individual's spouse during the year is deemed to have no amount to pay for the year under the said section 37.6.

"§ 3. — *Miscellaneous provisions*

"**37.9** An individual who is required to pay an amount under section 37.6 or 37.8 shall file with the Minister a prescribed form containing the prescribed information on or before the date on which he is required to file, under section 1000 of the Taxation Act, a fiscal return for the year or on which he would be required to file such a return if tax were payable by the individual for that year under Part I of that Act.

"**37.10** Except where inconsistent with this division, sections 1004 to 1014, 1025 to 1026.0.1, 1026.2 and 1037 to 1079 of the Taxation Act, adapted as required, apply to this division.

Notwithstanding the first paragraph, sections 1025 to 1026.0.1 of the Taxation Act do not apply to section 37.8.

"**37.11** An individual who is not required, under Part I of the Taxation Act, to make partial payments of his tax payable under that Part for a year is not required to make partial payments of the amount payable by him for the year under section 37.6.

"**37.12** The Minister may require a public body or a person belonging to one of the classes of persons he determines to send to him such information as he determines, except nominative information of a medical nature, by way of electronic filing or of a computer-generated medium, subject to the terms and conditions he determines.

For the purposes of the Act respecting prescription drug insurance and amending various legislative provisions, the Board is entitled to examine the information obtained by the Minister from any person providing coverage under the basic insurance plan, concerning the coverage provided to an individual under a group insurance contract or employee benefit plan including basic plan coverage.

"**37.13** The Government may make regulations

(*a*) to determine an amount which may be prescribed for the purposes of any provision of this division;

(*b*) to require any person included in one of the classes of persons it determines to file any return it may prescribe relating to any information necessary for the establishment of an assessment provided for in this division and to send, where applicable, a copy of such a return or of a part thereof to any person to whom the return or part thereof relates and to whom it indicates in the regulation;

(*c*) to generally prescribe the measures required for the application of this division.

"**37.14** The regulations made under this division come into force on the date of their publication in the *Gazette officielle du Québec* and, where they so provide, may take effect on any date subsequent or prior to such publication; in the latter case, however, the date shall not be prior to (*insert here the date of coming into force of this section*).

"**37.15** This division is a fiscal law within the meaning of the Act respecting the Ministère du Revenu."

107. The said Act is amended by inserting, after section 40, the following:

"DIVISION II.1

"PRESCRIPTION DRUG INSURANCE FUND

"**40.1** A fund to be known as the prescription drug insurance fund is hereby established in which the following sums shall be deposited:

(*a*) the sums remitted by the Minister of Revenue under sections 37.6 and 37.8;

(*b*) the sums recovered by the Board with respect to pharmaceutical services and medications furnished to a person referred to in paragraph 4 of section 15 of the Act respecting prescription drug insurance and amending various legislative provisions;

(*c*) the sums paid by the Minister of Finance under section 40.5;

(*d*) the interest deriving from the sums referred to in paragraphs *a*, *b* and *c*.

"**40.2** The following sums shall be taken out of the fund:

(*a*) the sums required to pay the cost of the pharmaceutical services and medications furnished to a person referred to in paragraph 4 of section 15 of the Act respecting prescription drug insurance and amending various legislative provisions;

(*b*) the amount payable to the Minister of Revenue and to the Board for the administration expenses shown in the budgetary estimates approved by the Government in accordance with section 40.4;

(*c*) interest charges and the reimbursement of advances and loans paid under section 40.5.

"**40.3** The aggregate of the sums paid into the fund in accordance with section 40.1 must, in the long term, cover the payment of the expenses listed in section 40.2.

"**40.4** The Government shall approve, annually, the budgetary estimates for the prescription drug insurance fund which shall be submitted to the Minister of Health and Social Services by the Board not later than the first day of December preceding the beginning of the fiscal year covered by the estimates. The estimates must, in particular, include the elements listed in sections 40.1 and 40.2.

"**40.5** The Minister of Finance may, with the authorization of the Government and subject to the conditions it determines, advance to the fund sums taken out of the consolidated revenue fund.

In addition to the borrowing powers provided for in the Act respecting the Régie de l'assurance-maladie du Québec, the Board may, in its capacity as manager of the fund, borrow sums taken from the Financing Fund of the Ministère des Finances from the Minister of Finance.

"**40.6** The management of the sums constituting the fund shall be entrusted to the Board.

"**40.7** The fiscal year of the fund ends on 31 March.

"**40.8** The sums referred to in section 40.1 shall be deposited as and when they are collected with one or more banks within the meaning of the Bank Act (Revised Statutes of Canada, 1985, chapter B-1) or the Québec Savings Banks Act (Revised Statutes of Canada, 1970, chapter B-4), or with a savings and credit union within the meaning of the Savings and Credit Unions Act (chapter C-4.1).

"**40.9** The Board must, not later than 31 July each year, present a financial report on the operations of the fund for the preceding fiscal year to the Minister of Health and Social Services. The report shall be tabled in the National Assembly within 30 days or, if the Assembly is not sitting, within 30 days of resumption."

108. Section 42 of the said Act is replaced by the following section:

"**42.** The Minister of Health and Social Services is entrusted with the application of this Act, except Divisions I and I.1 of Chapter IV, the application of which is entrusted to the Minister of Revenue, and Divisions II and III of that Chapter, the application of which is entrusted to the Minister of Finance."

ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES

109. Section 116 of the Act respecting health services and social services (R.S.Q., chapter S-4.2) is amended by replacing the words "39 of the Health Insurance Act (chapter A-29)" in the sixth line of the first paragraph by the words "53 of the Act respecting prescription drug insurance and amending various legislative provisions (1996, chapter 32)".

ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES FOR CREE NATIVE PERSONS

110. Section 150 of the Act respecting health services and social services for Cree Native persons (R.S.Q., chapter S-5) is amended by replacing the words "39 of the Health Insurance Act (chapter A-29)" in the fourth line of the first paragraph by the words "53 of the Act respecting prescription drug insurance and amending various legislative provisions (1996, chapter 32)".

ACT TO AMEND THE HEALTH INSURANCE ACT

111. Sections 9, 10 and 11 of the Act to amend the Health Insurance Act (1992, chapter 19) are repealed.

CHAPTER VIII

TRANSITIONAL AND FINAL PROVISIONS

112. The Government may, not later than 31 December 1996, make a regulation under section 78 or section 113 even if the regulation has not been published as required by section 8 of the

Regulations Act (R.S.Q., chapter R-18.1). Such a regulation shall come into force, notwithstanding section 17 of that Act, on the date of its publication in the *Gazette officielle du Québec* or on any later date fixed in the regulation. Such a regulation may, if it so provides, apply to any class of eligible persons it determines and from any date not prior to 20 June 1996.

113. The Government may make any transitional provision to prescribe, with regard to the persons or classes of persons referred to in Division I of Chapter III of this Act, for the reference period it determines,

(1) what is to be done with the contributions referred to in section 14.3 of the Health Insurance Act, as it read before being repealed by section 92 of this Act, paid by a beneficiary from a date determined in the regulation;

(2) the date of the expiry of a proof of exemption issued by the Board during a period determined in the regulation in accordance with sections 14.7 and 14.8 of the Health Insurance Act, as they read before being repealed by section 92 of this Act;

(3) the cases in which the Board shall issue proof of exemption and the validity period of such proof;

(4) the amount of and cases in which the Board shall effect a reimbursement to an eligible person referred to in section 15;

(5) the conditions to be met by a pharmacist to be entitled to remuneration from the Board for the pharmaceutical services and medications referred to in section 8 provided by the pharmacist;

(6) the percentage of the cost of pharmaceutical services and medications that remains chargeable to an eligible person and the amount of the maximum contribution payable by the person, and to provide for cases of exemption with or without conditions; the coinsurance percentage and the maximum contribution for a reference period may vary according to classes of persons and within classes of persons.

114. The provisions of the regulations made by the Government or by the Minister under the third paragraph of section 39, subparagraphs *f* and *u* of the first paragraph of section 69 and section 69.1 of the Health Insurance Act that are repealed by this Act shall continue to have effect until they are amended, replaced or repealed under this Act.

The list of medications drawn up by the Minister before (*insert here the date of coming into force of section 60*) is valid until replaced pursuant to this Act.

115. The Conseil consultatif de pharmacologie established under the Health Insurance Act is continued and its members remain in office until the appointment of the members of the new council established under section 53 of this Act.

116. The Government may, by regulation, not later than (*insert here the date that occurs one year after the date of coming into force of this section*), make any other transitional provision to remedy any omission and ensure the implementation of the basic prescription drug insurance plan as soon as possible after the plan is established by this Act.

A regulation made under this section is not subject to the publication requirements set out in section 8 of the Regulations Act. It shall come into force on the date of its publication in the *Gazette officielle du Québec* or on any later date fixed in the regulation, notwithstanding section 17 of that Act. A regulation may, once published and where it so provides, apply from any date not prior to the date of coming into force of this section.

117. Where, by reason of the first paragraph of section 37.10 of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 106,

(1) section 1025 of the Taxation Act applies, for 1997, for the purpose of computing the payments payable for the year by an individual referred to in section 37.6 of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 106, Division I.1 of Chapter IV of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 106, is deemed, for the purposes of the said section 1025, to have been in force since 1 January of the year preceding the year of the coming into force of section 106 of this Act;

(2) section 1026 of the Taxation Act applies, for 1997 and 1998, for the purpose of computing the payments payable for the year by an individual referred to in section 37.6 of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 106, Division I.1 of Chapter IV of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 106, is deemed, for the application of the said section 1026

(*a*) to 1997, to have been in force since 1 January of the second year preceding the year of the coming into force of section 106 of this Act;

(*b*) to 1998, to have been in force since 1 January of the year preceding the year of the coming into force of section 106 of this Act.

118. When ordering the coming into force of a provision of this Act, the Government may determine the date or dates on which the provision takes effect in respect of the classes of persons it determines.

119. The provisions of this Act come into force on the date or dates to be fixed by the Government.