



NATIONAL ASSEMBLY

SECOND SESSION

THIRTY-FIFTH LEGISLATURE

Bill 33

An Act respecting prescription drug insurance and amending various legislative provisions

Introduction

Introduced by
Mr Jean Rochon
Minister of Health and Social Services



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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 will benefit from basic coverage for the cost of pharmaceutical services and medications. For the persons who currently benefit from the pharmaceutical services plan administered by the Board, coverage will continue to be provided by the Board, and for all other eligible persons, coverage will be provided by private-sector insurers and under employee benefit plans.

The bill defines the contribution to be made to the plan's funding by the persons provided with coverage. Each person will pay a premium and will also bear part of the cost of the pharmaceutical services and medications received by paying a deductible amount and coinsurance payments, until the ceiling amount for the reference period has been reached. The Government will be responsible for fixing, by regulation, the applicable amounts of the premium, deductible, coinsurance payment and ceiling amount, and the reference period.

Low-income families, the elderly and children will benefit from exemptions, reductions and compensations, according to circumstances, to lessen the financial contribution expected of them.

The bill requires every person who is not covered by the Board to hold an individual insurance contract or to be a member of a group insurance plan or employee benefit plan that provides coverage that is at least equivalent to that of the basic plan. Insurers, market intermediaries in insurance of persons and administrators of employee benefit plans who offer coverage for the cost of pharmaceutical services and medications will be required to offer basic plan coverage.

In the private sector, the risks arising from individual insurance contracts will be pooled, as will the greatest risks arising from group insurance plans and employee benefit plans. Insurers and plan administrators will provide coverage for the risks pooled according to their share of the total number of persons in whose respect risks have been pooled, whether in the field of individual insurance, on the one hand, or the field of group insurance and employee benefit plans, on the other.

The bill provides for the establishment of a premium for individual insurance contracts providing basic plan coverage for the cost of pharmaceutical services and medications that will include a uniform risk-premium cost and the administrative costs charged by each insurer.

The amount of the risk-premium cost for a year will be fixed by the Government, after consulting insurers, to reflect the average foreseeable cost of services and medications for that year calculated according to generally recognized actuarial assumptions. The amount of the administrative costs will be established by each insurer.

The premiums and assessments for group insurance contracts and employee benefit plans will continue to be determined, where applicable, by the parties. Continuity of coverage, in the private sector, will become mandatory under the bill.

The bill adopts, with some changes, the provisions of the Health Insurance Act relating to the drug list, which will become the basis for coverage provided both by the Board and by the private sector. The provisions of the Act relating to the advisory council for pharmacology are also transferred to the bill, and the council's membership is extended to include an expert in pharmacoeconomics and a representative of the Minister.

A committee to review the use of medications is also established, with the function of ensuring optimal use of medications. Its membership will include representatives of the medical, pharmaceutical and university communities, and it will also be responsible for assessing the program to review the use of medications.

The bill introduces new provisions into the Health Insurance Act defining the procedure for collecting the premium for the basic plan, setting out penalties for failure to pay, and specifying the

applicable reductions and compensations. These provisions will be administered by the Minister of Revenue.

The Health Insurance Act is also amended to create a fund, to be known as the Fonds de l'assurance-médicaments, into which the amounts remitted to the Minister of Revenue as premiums or penalties will be paid, and out of which the sums paid as compensation under the basic prescription drug insurance plan will be taken.

The bill also 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);
- Taxation Act (R.S.Q., chapter I-3);
- Act respecting the Ministère du Revenu (R.S.Q., chapter M-31);
- 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 private-sector insurers and employee benefit plans, in accordance with the provisions of this Act.

4. "Insurer" means a legal person or a group of natural or legal persons 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 is administered by or on behalf of an employer or group of employers.

CHAPTER II

BASIC PLAN COVERAGE

DIVISION I

ELIGIBILITY

5. Every person who is a resident or deemed 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 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 the cost of the services, determined by government regulation, that are required for pharmaceutical reasons and are provided by a pharmacist, according to the tariffs established in an agreement under section 19 of the Health Insurance Act.

Coverage also includes the cost of medications provided by a pharmacist on prescription by a physician, a medical intern or a dentist, and that are included in the list of medications drawn up by the Minister under section 58 according to the price indicated on the list and, for certain medications, subject to the conditions prescribed by government regulation.

In addition, coverage includes, in the cases and on the conditions and for the classes of persons determined by government regulation, the cost of services and medications 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).

Coverage may include, in the cases and on the conditions determined by government regulation, the cost of pharmaceutical services and medications provided, outside Québec, in a pharmacy designated by regulation that is situated in a region contiguous to an area of Québec in which the population does not have access to such services and medications, if they are provided by a person legally authorized to practise in that region as a pharmacist and with whom the Minister has concluded an agreement for that purpose.

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 other 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 or by government regulation, an eligible person must pay any applicable annual premium or assessment.

11. Unless exempted by the Act or by government regulation, an eligible person must also contribute to the payment of the cost of the pharmaceutical services and medications provided, each time a prescription is filled or renewed, until a ceiling amount is reached; the contribution shall consist of a deductible amount and a co-insurance payment for each period of reference.

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 ceiling amount is reached.

The ceiling amount is the contributory 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 amount of the premium or assessment shall be fixed according to terms and conditions which vary according to whether coverage is provided by the Board or by the private sector and, in the latter case, according to whether coverage is provided under an individual or a group insurance contract, or under an employee benefit plan.

13. The deductible amount, coinsurance portion and ceiling amount shall be fixed by government regulation, for the reference period, according to the classes of persons it determines in the regulation.

14. The deductible amount and the ceiling amount may be revised periodically. If no revision is made during a year in respect of an amount, it shall be adjusted in the manner prescribed by government regulation for the following year.

15. 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.

The cost of all the pharmaceutical services and medications borne by an eligible person for a reference period must be taken into account in calculating the deductible amount and ceiling amount, even if a change in the person's status, income, insurer, plan or coverage has occurred during that period.

An insurer or an administrator of an employee benefit plan, and the Board, must transmit, on request, to any person providing coverage following a change in status, insurer, plan or coverage, any information concerning the premium and necessary to determine the contribution and ceiling amount for the period.

16. The following persons are exempted from the payment of a premium:

(1) persons and families receiving benefits under a last resort assistance program provided for in the Act respecting income security (R.S.Q., chapter S-3.1.1) or that are the recipients of an allowance paid under the second paragraph of section 67 of the Social Aid Act (1969, chapter 63), if they hold a valid claim booklet issued by the

Minister of Income Security pursuant to section 70 of the Health Insurance Act;

(2) 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, and the child of such a person.

An income-related reduction of the premium shall apply to low-income persons who are 65 years of age or over, and compensation for the payment of the premium or assessment shall be granted to low-income persons and families. According to income, the reduction or compensation may compensate all or only part of the amount of the premium or assessment. The method of calculating the amount and the rules governing the application of the reduction and compensation are set out in subparagraph *b* of the first paragraph of section 37.5 and in sections 37.6 and 37.7 of the Act respecting the Régie de l'assurance-maladie du Québec (R.S.Q., chapter R-5).

17. A child who is an eligible person is exempted from the payment of any contribution.

For the purposes of this Act, "child" means a person who is

(1) under 18 years of age or 18 years of age or over and is in full-time attendance at a school or university, and is

(2) domiciled with the person exercising parental authority, or who would exercise parental authority if the person was a minor.

CHAPTER III

APPLICATION OF THE BASIC PLAN

DIVISION I

COVERAGE BY THE BOARD

§ 1. — *Persons covered*

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

(1) persons 65 years of age or over;

(2) persons or families receiving benefits under a last resort assistance program pursuant to the Act respecting income security

or that are the recipients of an allowance paid under the second paragraph of section 67 of the Social Aid Act, if they hold 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, and the child of such a person.

§ 2. — *Premium and contribution*

19. The premium applicable to a person 65 years of age or over and the terms and conditions of payment are determined according to Division 1.1 of Chapter IV of the Act respecting the Régie de l'assurance-maladie du Québec.

20. A person referred to in section 18 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 reference period 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 ceiling amount fixed for the reference period has been reached.

21. Any person providing pharmaceutical services and medications covered by the basic plan to a person referred to in section 18 must require from that person payment of the applicable contribution.

22. Once the contribution required of a person has been entirely paid, the person is exempted, for the remainder of the reference period, 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 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.

23. When a person referred to in section 18 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 ceiling amount for the period of reference has been reached.

DIVISION II

COVERAGE BY THE PRIVATE SECTOR

§ 1. — *Application*

24. This division applies to all persons eligible for the basic plan who are not governed by Division I. It also applies to insurers, and to persons responsible for the administration of an employee benefit plan.

§ 2. — *Mandatory coverage*

25. Every eligible person, unless covered as a spouse or child, must hold an individual insurance contract or be a party to a group insurance contract or be a member of an employee benefit plan that covers at least the cost of the pharmaceutical services and medications covered by the basic plan.

For the purposes of this Act, “spouse” has the meaning given in section 2.2.1 of the Taxation Act (R.S.Q., chapter I-3).

26. Despite any stipulation to the contrary, every insurance contract and every employee benefit plan providing coverage for the cost of pharmaceutical services and medications in case of illness or accident is deemed to provide, as regards coverage, contribution and ceiling amount, benefits at least as advantageous for the insured persons, the members or the beneficiaries as the benefits provided under the basic plan.

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

28. No person may, as regards the part of coverage corresponding to the basic plan, refuse to insure an eligible person or refuse to include a person in a group insurance plan or employee benefit plan on the grounds of the specific risk associated with the age, sex or state of health of the person or the person's spouse or child.

29. Persons exercising parental authority over a child or who would exercise parental authority if the child were a minor, are responsible for ensuring that the child is covered by the basic plan. The same applies to tutors exercising parental authority over a minor child.

No separate premium or assessment may be charged for such children in addition to the premium or assessment charged to the person responsible for ensuring coverage, except if the latter is a person referred to in paragraph 1 of section 18.

The obligation under the first paragraph applies also to a person referred to in paragraph 1 of section 18.

30. Eligible persons may ensure basic plan coverage for their spouses, if they are eligible, on payment of the applicable premium or assessment for spousal coverage.

31. Every insurer and every market intermediary in insurance of persons offering individual or group insurance contracts providing coverage for the payment of the cost of pharmaceutical services and medications must offer the basic plan.

In addition, insurers must accept the proposal or application of every eligible person, as regards basic plan coverage, on payment of the applicable premium.

32. Every person administering, as an employer or otherwise, an employee benefit plan providing coverage for pharmaceutical services and medications must offer members and beneficiaries the coverage provided by the basic plan.

In addition, plan administrators must, as regards basic plan coverage, accept the membership of every eligible person on payment of the applicable contribution.

33. Every insurer must, upon the conclusion or renewal of an insurance contract or on accepting the membership of a person in a group insurance contract, issue a certificate of insurance to the insured person or member. The certificate must set out

- (1) the name and address of the insurer;
- (2) the name and address of the insured person or member;
- (3) the social insurance number of the insured person or member;
- (4) the type of coverage;
- (5) the name of the spouse covered, if applicable;
- (6) the period of validity of the insurance;
- (7) any other particular prescribed by government regulation.

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

34. 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.

35. 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 employment status, profession or any other link to a particular class of persons, the insurer or plan administrator must provide coverage to all the persons in the employee, professional or other class on the basis of which the group is determined.

Any person belonging to a class of persons that the insurer or administrator is bound to cover in accordance with the first paragraph must become a member of the group insurance plan or, as the case may be, the employee benefit plan and pay the applicable assessment, unless that person is covered as regards basic coverage under another group insurance contract or employee benefit plan.

§ 3. — *Pooling of risks*

36. Insurers must pool all the risks arising from the basic plan coverage offered under individual insurance contracts.

As regards group insurance contracts, insurers must pool the risks presented by the members to whom pharmaceutical services and medications are provided, in a year, for an amount in excess of the amount set as the highest ceiling amount for the deductible amount and the coinsurance payment.

37. Each insurer shall insure pooled risks up to the proportion that the persons insured by the insurer, or the members of the insurer's plan, are of the total number of persons insured or the total number of plan members, as the case may be, in whose respect risks have been pooled.

38. For the purposes of sections 36 and 37, a person administering an employee benefit plan as an employer or otherwise is considered to be an insurer transacting group insurance.

§ 4. — *Premiums and assessments*

39. In the field of individual insurance, the premium that may be charged for a year shall be equal to the risk-premium cost, to which may be added administrative costs relating to basic plan coverage.

40. In the field of individual insurance, the amount of the premium shall vary according to the four following types of coverage:

- (1) single adult coverage;
- (2) adult and spouse coverage;
- (3) single adult and child coverage;
- (4) adult, spouse and child coverage.

41. In the field of individual insurance, the risk-premium cost for a year shall correspond, for each type of coverage, to the average foreseeable cost of pharmaceutical services and medications for that year determined, according to generally-accepted actuarial calculations, on the basis of the cost of the services and medications provided to eligible persons under 65 years of age during the 12-month period ending on 1 July of the preceding year.

The amount shall be fixed by the Government, on the recommendation of the Inspector General of Financial Institutions, after consulting the groups of persons required to pool the risks

arising from basic plan coverage. The amount may be revised each year in the same manner.

The amount of the administrative costs relating to the basic plan coverage shall be established by each insurer.

The two amounts must appear on the insurance contracts.

42. In the field of individual insurance, no insurer may require an insured person to pay the premium relating to basic plan coverage for the year otherwise than by equal and consecutive monthly payments.

43. The 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.

44. In individual insurance contracts as well as in group insurance contracts, the insurer must state separately the amount of the premium or assessment that pertains to the basic plan. The amount must be clearly indicated on any document issued by the insurer setting out the premium required for basic plan coverage.

§ 5. — *Continuity of coverage*

45. As regards basic plan coverage, every insurance contract is renewed by operation of law each year on the contract's date of expiry, for the premium fixed pursuant to subdivision 4, unless the insurer, the insured person, 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 from the insurer must be sent to the last known address of the insured person 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 the insured person, policy-holder 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 insured person, 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 insured person, 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 beneficiaries of the plan.

49. Where employees who are members of a group insurance contract or the beneficiaries of an employee benefit plan providing basic plan coverage are involved in a strike, lockout or 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 strike, lockout or work stoppage began.

50. An eligible person must inform, in writing, the Board or 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 appearing on the insurance certificate is presumed accurate.

CHAPTER IV

ADMINISTRATIVE PROVISIONS

DIVISION I

CONSEIL CONSULTATIF DE PHARMACOLOGIE

51. 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 eight other members, of whom four must be experts in pharmacology, one an expert in pharmacoeconomics, one a representative of the Minister and one a functionary of the Board. One other member shall be appointed after consultation with groups representing insurers in the field of insurance of persons.

52. 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.

53. 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.

54. 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.

55. The function of the advisory council shall be to assist the Minister in updating the list referred to in section 58 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.

56. 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.

57. 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 61 and 63. Such information must not allow any person to be identified.

DIVISION II

LIST OF MEDICATIONS

§ 1. — *Establishment and updating*

58. The Minister shall draw up a list of the medications the cost of which is covered by the basic plan.

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 the generic names, brand names, manufacturer's names, availability, price and price fixing methods in respect of each medication and the maximum amount,

where applicable, covered by 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 and prior authorization.

59. 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

60. 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.

61. 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.

62. A manufacturer or wholesaler referred to in section 61 must, for the period of temporary withdrawal, repay to the Board, the insurer or the administrator of the employee benefit plan, as the case may be, the following amounts:

(1) in the case of a manufacturer, the difference between the costs paid by them and the price the manufacturer had agreed to charge;

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

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

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

63. 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.

64. A manufacturer or wholesaler whose accreditation has been permanently withdrawn may submit a new application for accreditation. However, in addition to complying with the conditions prescribed by ministerial regulation, the manufacturer or wholesaler must, before being again granted accreditation, repay to the Board, the insurer or the administrator of the employee benefit plan, as the case may be, the following costs:

(1) in the case of a manufacturer, the difference between the costs paid by them and the price the manufacturer had agreed to charge;

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

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

65. 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.

66. A manufacturer or wholesaler whose accreditation has been temporarily or permanently withdrawn pursuant to section 61 or 63 may appeal to the Commission des affaires sociales within 30 days of notification of the decision.

67. 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.

68. No notice may be published by the Minister under section 67 before the expiry of the period of appeal provided for in section 66 or, if an appeal is filed, before the Commission has made a decision.

DIVISION III

COMITÉ DE REVUE DE L'UTILISATION DES MÉDICAMENTS

69. A review committee on the use of medication, 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 selected from a list of at least three names supplied by the Collège des médecins du Québec, one from a list of at least three names supplied by the Fédération des médecins omnipraticiens du Québec, and one from a list of at least three names supplied 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 selected from a list of at least three names supplied by the Ordre des pharmaciens du Québec and one from a list of at least three names supplied 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 designated by the Comité de revue de l'utilisation des médicaments en établissements.

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 offices of president and vice-president shall be held in rotation by a physician and by a pharmacist, selected from among the physicians appointed after consultation with the Collège des médecins du Québec and from among the pharmacists appointed after consultation with the Ordre des pharmaciens du Québec.

70. The functions of the review committee shall be to promote the optimal use of medications. To that end, it shall

(1) select the medications or classes of medications to be reviewed;

(2) see to the determination of indications for the use of the medications under review, on the basis of such scientific studies, opinions and reports as are produced by the Conseil consultatif de pharmacologie and, if necessary, with the collaboration of consultants and experts;

(3) use appropriate means to inform health care professionals and other intervenors of the indications that have been determined for the use of the medications;

(4) analyze and assess in non-nominative form, using such means as the database of the Board, the drug prescribing and dispensing profiles of health care professionals with regard to the indications for use determined;

(5) ask the Board or the professional orders concerned, according to circumstances, to forward to the health care professionals their drug prescribing and dispensing profiles or any other information;

(6) develop training, information and awareness programs to improve drug prescribing and dispensing practices in cooperation

and in conjunction with various intervenors, including the Conseil consultatif de pharmacologie;

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

(8) cause the drug use review program to be assessed by an independent person or body with regard to expected results, efficiency, efficacy and economic and health impacts of such program.

71. 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.

72. 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.

73. 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.

74. The activities of the review committee secretariat shall be assumed by the personnel of the Board.

The Board shall assume the payment of the fees, allowances or salaries and travelling and lodging expenses referred to in section 73, and the cost of providing the administrative support needed to allow the review committee to perform its functions.

75. 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 IV

REGULATIONS

76. 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 otherwise entitled to coverage equivalent to basic plan coverage;

(2) determine, from among the services required for pharmaceutical reasons and provided by a pharmacist, those which are covered by the basic prescription drug insurance plan, 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) prescribe the conditions subject to which the cost of certain medications is covered;

(4) determine the cases and circumstances in which pharmaceutical services and medications 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 are covered for the classes of persons it determines;

(5) determine the cases and conditions according to which the cost of pharmaceutical services and medications provided outside Québec in accordance with the fourth paragraph of section 8 is covered under the basic plan;

(6) prescribe the cases and conditions according to which an eligible person may be exempted from payment of any applicable annual premium or contribution;

(7) fix, for a determined period of reference, the deductible amount and the portion of the cost of pharmaceutical services and medications to be borne by an eligible person, together with the ceiling amount for such contribution, and prescribe cases of exemption, with or without conditions; the deductible amount, coinsurance payment and ceiling amount for a reference period may vary according to classes of persons and within a class of persons, and according to whether coverage is provided by the Board, under an individual or group insurance contract, or under an employee benefit plan;

(8) prescribe the manner in which deductible amounts and ceiling amounts borne by an eligible person for a reference period, if not revised, are to be adjusted each year;

(9) determine any other particular to be included on the insurance certificate referred to in section 33;

(10) determine the cases, conditions and therapeutic indications in respect of which the cost of certain medications entered on the list drawn up by the Minister under section 58 is covered under the basic plan, and the cases in which prior authorization from the Board or from any other person is required in each case;

(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.

77. A regulation made under subparagraph 10 of the first paragraph of section 76 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).

78. The Minister may, after consulting the advisory council, 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

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

document containing false or misleading information, or using an insurance certificate after its cancellation or expiry 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 liable to a fine of not less than \$100 and not more than \$1,000.

80. Every person who assists or who incites, advises, encourages, authorizes or orders another person to commit an offence referred to in section 79 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 79.

81. Every person who violates a provision of section 28, 31, 32 or 33 is liable to a fine of not less than \$200 and not more than \$1,000.

82. Every insurer and every person administering an employee benefit plan who, in violation of section 36, 37 or 38, fails or neglects to pool the risks presented by insured persons and plan members in the manner prescribed in those sections, is liable to a fine of not less than \$1,000 and not more than \$10,000.

83. Every person who contravenes a provision of a regulation the violation 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

84. This Act is public policy.

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

CHAPTER VII

AMENDING PROVISIONS

HEALTH INSURANCE ACT

36. 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.

37. 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 (*insert here the year and chapter number of that Act*) 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 services and medications provided as part of the activities of 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

(a) is 65 years of age or older, or

(b) holds a valid claim booklet issued under section 70.”;

(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 services and 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 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.”

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

89. Section 10 of the said Act is amended 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.

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

91. 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”.

92. Section 19 of the said Act is amended

(1) by inserting the words “and of the Act respecting prescription drug insurance and amending various legislative provisions” after the word “Act” in the first line of the first paragraph;

(2) by adding, at the end of the eleventh paragraph, the following: “For the purposes of the basic prescription drug insurance plan established by the Act respecting prescription drug insurance and amending various legislative provisions, the agreement shall also bind the insurers in insurance of persons and the administrators of employee benefit plans to which that Act applies.”;

(3) by inserting, after the thirteenth paragraph, the following paragraph:

“The Minister shall form an advisory negotiation committee composed of persons designated by the Minister who will include persons whom the Minister considers to be representative of insurers transacting insurance of persons in Québec. The committee shall participate in the formulation of the clauses of an agreement dealing with the remuneration of services the cost of which is covered by the basic prescription drug insurance plan.”

93. The said Act is amended by inserting, after section 19, the following section:

“19.0.0.1 For the purposes of this division, the provision of pharmaceutical services and medications by a pharmacist to an eligible person under the basic prescription drug insurance plan is an insured service. Similarly, the provision of a service or a medication referred to in the third paragraph of section 8 of the Act respecting prescription drug insurance and amending various legislative provisions is also an insured service.”

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 21 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 21 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 “and the third paragraph of section 8 of the Act respecting prescription drug insurance and amending various legislative provisions,” after the figure “13.2” 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 55 and 56 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 57 of that Act”.

100. 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 “58 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*”.

101. Section 69.0.2 of the said Act is amended by striking out the letter “*u*,” in the first line.

102. Section 69.1 of the said Act is repealed.

ACT RESPECTING THE COMMISSION DES AFFAIRES SOCIALES

103. 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 “66 of the Act respecting prescription drug insurance and amending various legislative provisions (*insert here the year and chapter number of that Act*)”.

TAXATION ACT

104. Section 1045 of the Taxation Act (R.S.Q., chapter I-3) is amended by replacing the second paragraph by the following paragraph:

“For the purposes of the first paragraph, the unpaid tax of an individual shall be reduced by the amount of reimbursement, refund or compensation, as the case may be, to which the individual is entitled for the year under section 220.3 of the Act respecting municipal taxation (chapter F-2.1), section 37.6, 37.7 or 37.11 of the Act respecting the Régie de l’assurance-maladie du Québec (chapter R-5), section 78 of the Act respecting the Québec Pension Plan (chapter R-9), the Act respecting real estate tax refund (chapter R-20.1) and section 358 of the Act respecting the Québec sales tax (chapter T-0.1).”

ACT RESPECTING THE MINISTÈRE DU REVENU

105. Section 94.5 of the Act respecting the Ministère du Revenu (R.S.Q., chapter M-31) is amended by replacing the second paragraph by the following paragraph:

“The refund contemplated in the first paragraph is, for a year, equal to the aggregate of the amounts to which the individual considers himself so entitled for that year under section 220.3 of the Act respecting municipal taxation (R.S.Q., chapter F-2.1), section 37.6, 37.7 or 37.11 of the Act respecting the Régie de l’assurance-maladie du Québec (R.S.Q., chapter R-5), Part I of the Taxation Act (R.S.Q., chapter I-3), section 78 of the Act respecting the Québec Pension Plan (R.S.Q., chapter R-9), the Act respecting real estate tax refund (R.S.Q., chapter R-20.1) and section 358 of the Act respecting the Québec sales tax (R.S.Q., chapter T-0.1).”

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

106. Section 2 of the Act respecting the Régie de l'assurance-maladie du Québec (R.S.Q., chapter R-5) is amended by inserting, after subparagraph *h* of the second paragraph, the following subparagraph:

“(h.1) allow access, by the Minister of Revenue or his authorized representative and for the purposes of the Act respecting prescription drug insurance and amending various legislative provisions (*insert here the year and chapter number of that Act*), to the register of beneficiaries established for the purposes of the Health Insurance Act;”.

107. Section 20 of the said Act 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 “78 of the Act respecting prescription drug insurance and amending various legislative provisions”.

108. 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 who is a beneficiary within the meaning of subparagraph *g.1* of the first paragraph of section 1 of the Health Insurance Act as well as a person belonging to a prescribed class;

“child” of an individual at any time means a child of the individual or of his spouse during the year, except where an individual exercises, at that time, dative tutorship to the person in respect of the child, or a person in respect of whom the individual exercises dative tutorship to the person,

(a) who is under 18 years of age or 18 years of age or over and is in full-time attendance at a school or university; and

(b) whose domicile is that of the individual;

“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;

“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;

“net income” of an individual for a year means his net income for the year determined under section 28 of the Taxation Act;

“regulation” means a regulation made by the Government under this division;

“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 For the purposes of this division and the regulations, any amount included under section 37 of the Taxation Act in computing the income of an individual from an office or employment for a year in respect of insurance coverage provided for in subdivision 2 of Division II of Chapter III of the Act respecting prescription drug insurance and amending various legislative provisions paid or granted by an employer, is deemed to have been paid as such by the individual in respect of the year.

“§ 2. — Premium payable by an individual

“37.5 A beneficiary to whom subparagraph *a* of the third paragraph of section 3 of the Health Insurance Act applies during a year shall pay for that year, on the due date, a premium equal to the amount by which

(a) the aggregate of the prescribed amount for each month of the year during which the beneficiary is 65 years of age or over, exceeds

(b) the reduction for the year equal to the prescribed amount.

However, subparagraph *a* of the first paragraph does not apply in respect of a month during which the individual

(a) reaches 65 years of age;

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

(c) is a person belonging to a prescribed class.

The prescribed amount referred to in subparagraph *a* of the first paragraph may be revised annually or, if no revision is made, it shall be index-linked in the manner prescribed by regulation.

“§ 3. — Compensation granted to an individual

“37.6 Where, for a year, the amount determined in respect of an individual under subparagraph *b* of the first paragraph of section 37.5 exceeds the amount determined in respect of the individual

under subparagraph *a* of the first paragraph of that section, the individual is entitled, for the year, to compensation equal to that excess amount.

“37.7 An individual, other than an individual referred to in section 37.5 or an individual described in section 37.8, who has paid or is deemed to have paid an amount in respect of a year to enable a beneficiary who is the individual, his spouse or a child to be granted the insurance coverage provided for in subdivision 2 of Division II of Chapter III of the Act respecting prescription drug insurance and amending various legislative provisions, is entitled for the year to compensation equal to the prescribed amount.

“37.8 An individual to whom section 37.7 refers is an individual exempt from tax for the year referred to in that section under section 982 or 983 of the Taxation Act or paragraphs *a* to *d* of section 96 of the Act respecting the Ministère du Revenu (chapter M-31).

“§ 4. — Penalty payable by an individual

“37.9 An individual shall pay for a year, on the due date, a penalty equal to the prescribed amount for each month in the year throughout which the individual, or a child dependent on the individual, is a beneficiary who is not covered as required under subdivision 2 of Division II of Chapter III of the Act respecting prescription drug insurance and amending various legislative provisions.

The first paragraph does not apply in respect of a particular month during which the individual fulfils the following conditions:

(*a*) he is under 18 years of age, including the month in which he reaches that age, or 18 years of age or over and is in full-time attendance at a school or university; and

(*b*) his domicile is that of an individual of whom he would be a child if the definition of “child” in section 37.1 were read without reference to paragraphs *a* and *b* of that definition.

“37.10 For the purposes of section 37.9, a child is deemed to be dependent on the individual of whom he is the child at that time.

However, where a child is dependent on more than one individual at any time during a year, the following rules apply to determine the individual in respect of whom the child is dependent at any time in a year:

(a) where an individual deducts an amount in respect of the child for the year under sections 752.0.1 to 752.0.7 of the Taxation Act, the individual, except where his spouse during the year deducts an amount in respect of that child for the year under those sections;

(b) where an individual and his spouse during the year deduct an amount in respect of the child for the year under sections 752.0.1 to 752.0.7 of the Taxation Act, the individual whose net income for the year exceeds the net income, for the year, of his spouse during the year or where, at the end of the year, the individual and his spouse during the year are living separate and apart from each other by reason of a breakdown of their marriage, the net income of the spouse for the year during the marriage while they were not living separate and apart;

(c) where an individual and his spouse during the year do not deduct any amount in respect of the child for the year under sections 752.0.1 to 752.0.7 of the Taxation Act, the individual whose net income for the year exceeds the net income, for the year, of his spouse during the year or where, at the end of the year, the individual and his spouse during the year are living separate and apart from each other by reason of a breakdown of their marriage, the net income of the spouse for the year during the marriage while they were not living separate and apart;

(d) where paragraphs a to c do not apply, the individual who receives in respect of the child a family allowance under section 14 of the Act respecting family assistance allowances (chapter A-17) or, where no family allowance is paid in respect of the child, the individual who was receiving in respect of the child such an allowance immediately before the child reached 18 years of age.

“§ 5. — *Election*

“37.11 Where, for a year, the aggregate of amounts to which an individual would be entitled under section 37.6 or 37.7 exceeds the aggregate of amounts payable by him under sections 37.5 and 37.9, but for this section, the individual may renounce, in prescribed form containing the prescribed information, the excess amount to his spouse during the year.

Where an individual renounces in accordance with the first paragraph for a year,

(a) the individual is deemed not to have an amount payable, for the year, under section 37.5 or 37.9;

(b) the individual is deemed not to be entitled, for the year, to an amount under sections 37.6 and 37.7; and

(c) the individual's spouse during the year is deemed to be entitled, for the year, to compensation equal to the excess amount determined in the first paragraph in respect of the individual for the year.

“37.12 Where, for a year, the aggregate of the amounts payable by an individual under sections 37.5 and 37.9 exceeds the aggregate of amounts to which he would be entitled under sections 37.6 and 37.7, but for this section, the individual and his spouse during the year may jointly elect, in prescribed form containing the prescribed information, to have the excess amount payable by the individual's spouse.

Where an election is made for a year by an individual and his spouse during the year pursuant to the first paragraph,

(a) the individual is deemed not to have an amount payable, for the year, under section 37.5 or 37.9;

(b) the individual is deemed not to be entitled, for the year, to an amount under sections 37.6 and 37.7; and

(c) the individual's spouse during the year shall pay for the year, on the due date, the excess amount determined in the first paragraph in respect of the individual for the year.

“§ 6. — Miscellaneous provisions

“37.13 An individual who is required to pay an amount under section 37.5, 37.9 or 37.12 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.

“37.14 Every individual who wishes to obtain the compensation to which he is entitled for a year under section 37.6, 37.7 or 37.11 shall apply therefor to the Minister in prescribed form containing the prescribed information.

“37.15 The Minister shall, with dispatch, examine the application referred to in section 37.14 sent to him for a year and determine the amount of compensation to which the individual is entitled for that year.

“37.16 After examination of an application under section 37.14 for a year, the Minister shall send a notice of assessment to the individual who filed the application and make the payment of compensation for that year.

“37.17 The Minister is not bound by the information provided in an application under section 37.14, and may determine the amount of compensation to which the individual is entitled on the basis of information from another source.

“37.18 Except where inconsistent with this division, sections 1004 to 1014, 1025 to 1026.0.1, 1026.2 and 1030 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 sections 37.9 and 37.12.

“37.19 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 premium payable by him for the year under section 37.5.

“37.20 The compensation provided for in section 37.6, 37.7 or 37.11 is deemed to be a refund for the purposes of the Act respecting the Ministère du Revenu.

“37.21 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 by way of electronic filing or of a computer-generated medium, subject to the terms and conditions he determines.

The first paragraph does not apply to nominative information of a medical nature.

“37.22 The Government may make regulations

(a) to determine a class of persons or an amount which may be prescribed for the purposes of any provision of this division, including the rules relating to the determination of such a class or amount;

(b) to prescribe the manner in which the prescribed amount referred to in subparagraph *a* of the first paragraph of section 37.5 shall, if not revised, be index-linked;

(c) 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;

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

“37.23 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*).

“37.24 This division is a fiscal law within the meaning of the Act respecting the Ministère du Revenu.”

109. 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 37.5, 37.9 and 37.12 and interest from such sums;

(b) the sums paid by the Minister of Health and Social Services out of the appropriations granted for that purpose by the Parliament;

(c) the sums paid by the Minister of Finance under section 40.4.

“40.2 The sums taken out of the fund shall be the sums required

(a) to pay the amounts of compensation payable by the Minister of Revenue under sections 37.6, 37.7 and 37.11;

(b) to pay the amount payable to the Minister of Revenue for the administration expenses determined by the Government under section 40.3;

(c) to remit to the insurers and the administrators of the employee benefit plan referred to in sections 36 and 38 of the Act respecting prescription drug insurance and amending various legislative provisions, to the extent determined by the Government, a part of the amounts collected as penalty amounts by the Minister of Revenue under section 37.9 to take into account the pooling of risks and the apportionment thereof under section 37 of that Act.

“40.3 The Government shall determine the annual amount of the administration expenses payable to the Minister of Revenue and the dates on which they shall be paid to him.

It shall also determine the costs chargeable to the fund.

“40.4 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.

“40.5 The management of the sums constituting the fund shall be entrusted to the Minister of Finance. The sums shall be paid to the order of the Minister of Finance and deposited with the financial institutions he designates.

Notwithstanding section 13 of the Financial Administration Act (chapter A-6), the Minister of Health and Social Services shall keep the books of account for and record the financial commitments chargeable to the fund. The Minister shall also certify that such commitments and the payments arising therefrom do not exceed, and are consistent with, the available balances.

“40.6 Sections 22 to 27, 33, 35, 45, 47 to 49, 49.2, 51, 57 and 70 to 72 of the Financial Administration Act, adapted as required, apply to the fund.

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

“40.8 Notwithstanding any provision to the contrary, the Minister of Finance shall, in the event of a deficiency in the consolidated revenue fund, pay out of the fund the sums required for the execution of a judgment against the Crown that has become *res judicata*.”

110. 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

111. 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 “51 of the Act respecting prescription drug insurance and amending various legislative provisions (*insert here the year and chapter number of that Act*)”.

ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES FOR CREE NATIVE PERSONS

112. 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 “51 of the Act respecting prescription drug insurance and amending various legislative provisions (*insert here the year and chapter number of that Act*)”.

ACT TO AMEND THE HEALTH INSURANCE ACT

113. 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

114. The Government may, not later than 31 December 1996, make a regulation under section 76 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 (*insert here the date of assent to this Act*).

115. The Government may, in a regulation made under section 114, 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 90 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 90 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 18;

(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 supplied by the pharmacist.

116. 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 same rule applies to the list of medications drawn up by the Minister pursuant to that Act.

117. The Conseil consultatif de pharmacologie established under the Health Insurance Act is continued and is deemed, from (*insert here the date of coming into force of section 51 of this Act*), to be the Conseil consultatif de pharmacologie established under this Act.

118. 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.

119. Where, by reason of the first paragraph of section 37.18 of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 108,

(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 37.5 of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 108, Division 1.1 of Chapter IV of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 108, 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 109 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 37.5 of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 108, Division 1.1 of Chapter IV of the Act respecting the Régie de l'assurance-maladie du Québec, enacted by section 108, 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 108 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 108 of this Act.

120. 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.

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