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Benefits Bulletin

Benefit News to Keep You in the Know and the Now

January 2016

Drug Channel Waste: Refill Frequency

Whenever a drug is prescribed, there are many opportunities to find cost efficiencies: substituting a lower-cost alternative prescription, having it filled at a lower-cost pharmacy, adhering to the treatment plan, etc. One opportunity to find saving is with the refill frequency for maintenance medications.

Maintenance medications are those that are taken on a regular basis over a long period of time to manage a known condition. Medications to manage blood pressure or cholesterol are examples.

Group plans typically limit prescriptions for acute conditions to a 30 day quantity and to 3 months for maintenance medications. Some maintenance drugs are limited to less frequent refills due to their nature (ex. anti-psychotic agents). However, in some instances the pharmacy dispenses less than the maximum quantity thereby requiring the patient to have the prescription refilled on a more frequent basis and incurring unnecessary dispensing fees.

To address this waste in the drug channel, some insurance companies, such as Greenshield Canada, are putting a limit on the number of refills allowed in a year. If a pharmacist tries to submit a claim for less than a 3 month supply, they will get an error notice that the quantity submitted is below the allowable limits.

Certain maintenance medications are excluded from this practice including drugs that require more frequent monitoring, new prescriptions, patients who are taking five or more maintenance medications or are in a long-term care facility.

In addition to lowering the incidence of dispensing fees, this will also make it more convenient for patients and will hopefully help with adhering to the treatment plan which is another culprit of drug channel waste.

Pharmacies have already been advised of this change and it is expected that they will modify their dispensing practices accordingly.

Pharmacy Professional Services

The scope of the services provided by pharmacists in Quebec has been expanded. Since June 1, 2015, pharmacists have been able to:

- Extend a prescription;
- Adjust a prescription to reach certain therapeutic targets;
- Prescribe drugs when no diagnosis is required;

- Prescribe drugs for minor conditions when the diagnosis and treatment is known.

These services are covered by RAMQ, the provincial public plan in Quebec. RAMQ requires that where a private plan is in place (i.e. employer-sponsored plans), it must cover at least 66% of the cost up to the out-of-pocket maximum (currently $85.75/month or $1,029/year). Once the employee has reached the out-of-pocket maximum, the plan must pay 100% of the costs.

Insurance companies have just recently begun reimbursing plan members for these services as a second bill clarifying the first was just passed in November. Plan members can submit claims for these services retroactive to the original legislation date of June 20, 2015.

Co-Ordination of Benefits

When an employee has health and/or dental benefits through their spouse's employer's plan, they may elect to co-ordinate benefits. This means that amounts that are not fully reimbursed by one plan can be submitted to the other for additional reimbursement.

Some insurance companies are changing their claims adjudication guidelines as they pertain to the second submission. Previously, they would pay based on the submitted amount (i.e. the amount not covered by the first insurance company). Under the new guidelines, they will pay based on the reasonable and customary amount of the original claim.

For example, an employee's spouse has a claim for $80 but the reasonable and customary amount is $75. The spouse's plan pays $60 leaving $20 to be submitted to the employee's plan. If the employee's plan reimbursed at 100%, under previous guidelines, the insurance company would pay $20. Under the new guidelines, the insurance company is considering only the reasonable and customary amount so they will pay ($75-$60) $15. The patient is out of pocket $5 which is the difference between what the provider billed for the service and the reasonable and customary amount.

This event occurs only when the provider is charging more than what is considered reasonable and customary. If the provider charged the reasonable and customary amount, the patient would not have any out-of-pocket expenses (beyond any deductible and co-insurance amounts provided for in the plan).

Changes to the TFSA Contribution Limit

Effective January 1, 2016, the Federal government rolled the TFSA contribution limit back from $10,000 to $5,500. Investors who have not used the entire $10,000 of the 2015 contribution room will be able to carry forward the unused amount for future use.

Quiz Corner

Put your mental mettle to the test and a $50 prize in your pocket!

Edward has 15 coins totalling $30. He dropped one coin and lost two. He has $26. Explain.

Send your answer to: info@gmsinsurance.com or by fax to 905-670-4146.

Our November Quiz Whiz was Larry Zwaiman who knew the correct answer was:

Silence

Congratulations!