ONTARIO PHARMACISTS ASSOCIATION

Advocating Excellence in Practice and Care

OPA's OHIP+ Children and Youth Program FAQs

(Updated March 29, 2019 – changes as of this date marked in red font)

(Updated April 2, 2019 – changes as of this date marked in green font)

(Updated April 9, 2019 – changes as of this date marked in purple font)

1. **What changes are coming to the OHIP+ Children and Youth program?**

   - Effective April 1, 2019, the OHIP+ Children and Youth program will change to provide drug coverage for individuals 24 years of age and under who **do not** have a private plan.
   - For those who are covered under a private plan, they will receive coverage through that private plan and are ineligible for coverage under OHIP+ so long as the private plan remains in place.
   - It is important to note that ineligibility for OHIP+ will be irrespective of whether the drug prescribed is covered by the private plan. As such, there will be **no coordination of benefits**.

2. **What constitutes a private plan?**

   - A private plan is defined as an employer, group or individual plan, program or account that could be used for drug coverage.
   - It includes any funding that could be used to pay for drug products, such as Health Spending Accounts.
   - This is regardless of whether:
     - the drug requested is covered by the private plan;
     - there is a co-payment, deductible, or premium; or
     - the annual maximum has been reached for the plan and the patient has no further coverage.

3. **If the patient has a brand name drug card or is part of a patient support program, is that considered private coverage?**

    - Brand name drug cards and patient support programs are not considered private plans. If the child or youth has a brand name drug card and no other private plan coverage, they will be eligible for coverage under OHIP+.

4. **What if the patient has excessive out-of-pocket expenses despite having a private plan? Can this be covered by OHIP+?**

    - A child or youth who is 24 years of age or under with a private plan will NOT be eligible for OHIP+ regardless of whether:
        - the drug requested is covered by the private plan;
        - there is a co-payment, deductible, or premium; or
        - the annual maximum has been reached for the plan and the patient has no further coverage.
    - For individuals or families who have significant out-of-pocket private plan prescription expenses, they can apply for the Trillium Drug Program (TDP). The TDP is designed to assist Ontarians who have high out-of-pocket drug costs relative to their household income. Once the TDP deductible threshold is met, public drug coverage will be provided with a $2 co-payment. Please consult the Ministry's webpage for more information on TDP.

5. **If the child or youth is not covered under his/her parents' plans, do they qualify for OHIP+?**

    - If the child or youth 24 years of age and under is not covered by any other private plan (e.g., the parents have opted out of coverage for their dependents), then the child or youth would qualify for coverage under OHIP+.

6. **If the patient is part of another publicly funded, ODB-administered program (e.g. Ontario Works (OW), Ontario Disability Support Program (ODSP) or TDP, and others), do they qualify for OHIP+?**

    - If an individual 24 years of age and under qualifies for another ODB-administered publicly funded program, including OW, ODSP, Home Care Program, Long-Term Care Program, or Homes for Special Care or Community Homes for Opportunity, with the exception of TDP, the child or youth will continue to receive drug coverage under the alternative program with a $0 co-payment or deductible (regardless of insurance status).
    - If, however, they are part of TDP and have no other private insurance, the patient would qualify for coverage under OHIP+. If the patient is enrolled under TDP and has private coverage, the patient does not qualify for OHIP+. In this case, once the TDP deductible threshold is met, public drug coverage will be provided with a $2 co-payment.

7. **What if the patient/caregiver does not know if he/she has private coverage?**

- Based on the new changes, if a patient/caregiver is unaware of whether he/she is covered under a private plan, the pharmacist must not bill OHIP+ until that information is known.
- If the patient requires the prescription to be filled immediately, the patient/caregiver can pay out-of-pocket first, and after if it is confirmed that the patient does qualify for OHIP+, the prescription can be either rebilled within seven days of the transaction or the receipt can be submitted to the ODB program for reimbursement.

8. **How often do I have to ask whether a patient has private coverage? (Updated March 29/19)**

- Pharmacy team members are required to ask the patient/caregiver of all children and youth 24 years of age and under whether the patient is covered under a private plan **prior to filling any prescription**.
- OPA has raised the issue with the Ministry on how pharmacy professionals are to deal with situations where the patient or caregiver may not be available to ask about private coverage, e.g., IVR-generated or app-transmitted refill requests submitted several days ahead of a prescription pick-up. The Ministry has said that regardless of the situation, the pharmacy team must ask the patient/caregiver **every time a prescription is to be filled** for an individual 24 years of age and under whether the patient is covered under a private plan prior to adjudication. OPA recognizes the workflow inefficiencies and patient inconveniences this requirement will cause, and the Association will continue to work with the Ministry on a solution. Members will be provided with this response when it is received.

9. **Will OHIP+ cover drugs and products that are not reimbursed by private plans, such as valve-holding chambers (e.g., Aerochamber®)?**

- No. If a person has a private plan, he/she does not qualify for OHIP+ coverage.
- Eligibility for OHIP+ is irrespective of whether the prescribed drug or device is covered by a private plan. Although some drugs and products, such as valve-holding chambers, may not be covered by a private plan, these will not be covered by OHIP+ for patients requiring their use.

10. **Will children and youth 24 years of age and under who have private insurance be ineligible for pharmacy professional services, such as the Smoking Cessation Program?**

- Starting April 1, 2019, children and youth 24 years of age and under who have private insurance will no longer be eligible for coverage under OHIP+ and thus, will not be eligible for ODB-specific programs such as the Pharmaceutical Opinion and Smoking Cessation Programs (unless they qualify through another ODB eligibility stream).
- Non-ODB specific programs, including flu shots and MedsChecks, will still be available to all Ontarians.

11. Where can we find out more information? (Updated March 29/19)

- For more information regarding the changes to the OHIP+ Children and Youth program, please refer to the Executive Officer Notice. In addition, as OPA receives more information from the Ministry, we will continue to update these questions and answers and develop additional resources to assist our members and their patients in transitioning to the new program.
- OPA's OHIP+ web pages for patients for pharmacy professionals have also been updated to include communications from the Ministry as well as resources developed by OPA.
- For any questions you might have about the OHIP+ Children and Youth program that are not addressed either by this OPA document or any of the above resources, please email us at communications@opatoday.com or through the Practice Support Network (OPA members only) and one of our professional staff members will get back to you.

12. Will there be a bridging or transition period to the revised OHIP+ program?

- No. Effective April 1, 2019, children and youth 24 years of age and under who have private insurance will no longer be eligible for coverage under OHIP+.
- Refer to Question 13 for information to assist with transitioning patients who are receiving Exceptional Access Program (EAP) drugs under OHIP+ back to private plans.

13. Some of my patients are currently on drugs with EAP approvals. Will they automatically be covered for those drugs under their private plans? If not, is there any way to streamline the process?

- The Ministry has indicated that there will be no bridging or transition period, i.e., as of April 1, 2019, children and youth 24 years of age and under who have private insurance will no longer be eligible for coverage under OHIP+. OPA has been working closely with the Canadian Life and Health Insurance Association (CLHIA) on a process to facilitate timely access, post-April 1, 2019, to drugs which had an EAP approval and now require a Prior Authorization for coverage from the private plan. The Pharmacy Confirmation – OHIP+ Transition of Claims Requiring Prior Authorization Form can be completed for those patients who require it to expedite the approval process. The pharmacist must complete the first section. The second section can be completed by the patient, but we suggest that as a courtesy to your patient, you may wish to complete the entire form on their behalf to help them in this new process.
- After April 1, 2019, if Prior Authorization is required for coverage of a drug previously approved by EAP, the plan member is required to submit the following documents to the private plan:
    - the fully completed Pharmacy Confirmation – OHIP+ Transition of Claims Requiring Prior Authorization Form
    - the most recent ODB-adjudicated EAP receipt filled prior to April 1, 2019

- Since there will be a processing time associated with these requests, there may be delays for a Prior Authorization approval from private payors. If the patient requires the medication immediately, he/she can pay for the claim in question at the time of dispensing and the cash receipt for the post-April 1, 2019 claim can be submitted to the insurer for reimbursement if Prior Authorization for coverage is approved.
- Please note that post-April 1, 2019, EAP approvals will not be grandfathered. In order to ensure continuity of care, OPA recommends that prior to the implementation of the program changes, pharmacy team members remind patients who are on EAP drugs of the upcoming changes and to verify with their private plans whether Prior Authorization is required. Effective immediately, patients can start submitting the Pharmacy Confirmation – OHIP+ Transition of Claims Requiring Prior Authorization Form to their insurer to prevent delays in coverage.

14. If a patient is part of the Non-Insured Health Benefits Program (NIHB), is that considered a private plan? (Updated March 29/19)

- No. NIHB coverage is not considered a private plan under the OHIP+ regulation. Eligible children and youth 24 years of age and under can continue to receive benefits through NIHB, or they can access OHIP+ benefits if they do not have any other private plan.
- Simply put, drug benefits can be accessed through either the NIHB or OHIP+ program and the choice of plans is up to the pharmacy professional to select, but please note that the claims cannot be coordinated.

15. How can the pharmacy team verify whether the patient has private coverage?

- There is currently no mechanism to allow pharmacy staff to verify a patient's insurance coverage. As part of the new regulation, pharmacists are obligated to inquire of patients/caregivers on the presence of private drug coverage for individuals 24 years of age and under.
    - If the patient/caregiver indicates that they do not have private drug coverage, the special service code (SSC) "U – No-Private-Insurance Attestation" will need to be entered in order to process the claim through OHIP+.

16. What happens if the patient tells the pharmacist they have no private plan so the pharmacist bills OHIP+, but it is later discovered that the patient has a private plan? (Updated April 9/19)

- The new regulation requires the pharmacy team to ask the patient/caregiver **every time a prescription is to be filled** for an individual 24 years of age and under whether the patient is covered under a private plan.
- If the answer is *"No, I have no private coverage at all",* the SSC "U" is to be used to submit the claim to OHIP+.
- The Ministry has informed OPA that use of the SSC "U" will be deemed to be sufficient documentation to support an audit of claims and that a pharmacy team member has asked about the patient's private plan coverage and was informed there was none. OPA will notify our members should this change in the future.

- Although not mandatory as part of the Ministry protocols, many pharmacists are wanting some additional documentation to support the OHIP+ claim submission. Therefore, OPA has created an "OHIP+ Patient Insurance Declaration Stub" template (with four stubs per page) that can be used to document the patient's or caregiver's declaration at the time of claims processing that the patient has no private plan coverage and is eligible for OHIP+.
    - **Important Note:**
        - In no way does the use of this Insurance Declaration stub replace the need to ask the patient/caregiver of a child or youth 24 years of age and under at the time of claims processing whether there is private plan coverage.
        - The question **must** still be asked **prior to adjudication with the SSC "U"**. This stub document only serves as supplemental attestation by the patient/caregiver that there is no private insurance coverage in place at the time of filling a particular prescription. Its provision is only to provide you with an additional level of comfort should you feel the need to have it.
        - **Refusal of a patient/caregiver to sign this stub is not grounds for the pharmacy to refuse to fill an OHIP+ eligible prescription**. Patients and caregivers **are not required** to sign this stub in order to receive coverage under OHIP+. Regardless of whether this stub is signed, pharmacy team members **should not** refuse to process claims through OHIP+ for eligible patients who have been asked the question regarding private coverage and have confirmed, through use of the SSC, that the individual 24 years of age and under is not covered under any private plan.
        - The OHIP+ Patient Insurance Declaration Stub has not been reviewed or formally approved by the Ministry. As such, **it does not hold any legal bearing** in the case of a claims audit.

17. If I tried to submit a claim through OHIP+ but the patient has private coverage, will the claim be rejected?

- The Health Network System (HNS) can only check private insurance coverage data available on the TDP database.
- All other claims submitted to OHIP+ with the SSC will be accepted; hence the Ministry requires that pharmacy team members ask the question regarding private coverage each time a prescription is filled for a child or youth 24 years of age and under.

18. **A patient has Prior Authorization for coverage of Drug X through the private plan, but there are still significant out-of-pocket expenses. The patient is also eligible for TDP; however, this drug is only funded under EAP. Do they have to apply for EAP?**

    - Yes. Prior Authorization for coverage under a private plan is separate from EAP approval for TDP. In order to be eligible for funding under TDP, if the drug is not on the Formulary, a request will have to be submitted to EAP for approval.

19. **I am trying to submit a claim through OHIP+ but it is being rejected with the response code "PM – No-Private-Insurance-Attestation Missing", what does this mean?**

    - If a claim is being submitted to OHIP+ but the SSC "U" is missing, the claim will be rejected with the response code "PM – No-Private-Insurance-Attestation Missing**".**
    - If they have not done so already, the pharmacy team member should verify with the patient/caregiver of the child or youth 24 years of age and under whether there is private coverage. If there is no private insurance, then the claim should be resubmitted using the SSC "U".

20. **When does a claim get rejected with the new response code "ZR – Submit Receipt to TDP or Attest to No PI"?**

    - The claim will only be rejected with the "ZR" response code if the patient is enrolled in TDP only and has no private coverage, but the claim was submitted to ODB without the SSC "U".
    - In this case, the pharmacy team member should reconfirm whether the patient has private insurance coverage and if there is:
        - private insurance, the claim should be billed to the private insurance and private insurance information as well as the receipts should be submitted to TDP
        - no private insurance, the claim should be resubmitted using the SSC "U" to bill OHIP+

21. **Do I have to use the SSC "U" when submitting claims for pharmacy professional services?**

    - ODB eligibility is required for ODB-specific professional services, such as the Pharmaceutical Opinion Program and Smoking Cessation Program. Therefore, only children and youth 24 years of age and under who do not have a private plan will be eligible through the OHIP+ program (unless they are eligible through another ODB eligibility stream). In order to process the claim under OHIP+, the SSC "U" is required. If the SSC "U" is not submitted, the claim will be rejected with the response code "PM – No-Private-Insurance-Attestation Missing**".**
    - Non-ODB specific programs, including flu shots and MedsChecks, are available to all Ontarians. Submission of the SSC "U" is optional in these cases.

22. What type of communication is the Ministry sending out to inform the public about the changes to OHIP+? (Updated March 29/19)

- The Ministry has already sent out communications to prescribers and patients who currently are taking medications that have required an approval under EAP.
    - These prescriber and patient communications were sent to inform them of the upcoming changes to the OHIP+ program and the possible need to apply for Prior Authorization from the private insurers in order to ensure continuity of care.
- OPA recommends that prior to the implementation of the program changes, pharmacy team members remind patients who are on EAP drugs of the upcoming changes and to verify with their private plans whether Prior Authorization is required in order to assist with a smooth transition (please refer to Question 13 for more information).
- The Ministry has also updated its website to include an FAQ for patients and is using social media to inform patients of these upcoming changes. Webinars have been conducted to target specific groups including pharmacists, nurses, physicians, hospitals, and patient groups. Direct messaging has also been sent to TDP households.
- On March 28, 2019, the Ministry of Health and Long-Term Care also issued a News Bulletin on OHIP+ from the Government of Ontario's Newsroom.
- As there may still be some confusion among patients and families regarding the revised program, OPA recommends that pharmacy teams begin to communicate these upcoming changes with all patients/caregivers of children and youth 24 years of age and under.

Additional Questions (Updated March 29, 2019):

23. If a patient has no private plan and only TDP, how should the claim be processed?

- A patient enrolled in TDP who has no private plan would be eligible for OHIP+ coverage. In this situation, the claim should be processed through OHIP+ with the SSC "U".
- If the claim was accidentally processed without the SSC "U", the claim will be rejected with the response code "ZR – Submit Receipt to TDP or Attest to No PI". In this case, the pharmacy team member should reconfirm whether the patient has private insurance coverage and if there is:
    - private insurance, the claim should be billed to the private insurance and private insurance information as well as the receipts should be submitted to TDP
    - no private insurance, the claim should be resubmitted using the SSC "U" to bill OHIP+

24. If the question was asked about the presence of an existing private plan prior to using the SSC "U", is there any situation which would result in a need to reverse the claim?

- Yes, this situation may occur if an error was made regarding the patient's private plan attestation. For example, if the patient or caregiver of a child or youth 24 years of age and under had informed the pharmacy that the patient had no private plan coverage and the pharmacy team submits the claim through OHIP+ with the SSC "U", but the patient or caregiver notifies the pharmacy team at pick-up that an error was made and there is, in fact, private plan coverage in place, then the claim will need to be reversed.
- If it is within 7 days of the initial billing date, then the claim can be reversed electronically.
- If it has been more than 7 days since the initial billing date, the claim must be submitted for manual reversal. **Note: Although the patient is no longer eligible for OHIP+, because the original claim was processed under OHIP+ with the SSC "U", the SSC "U" must nonetheless be included on the form for manual reversal of this claim.**
- OPA is aware that the current 7-day window for electronic reversal of claims is problematic and may create undue hardship for some pharmacies due to cumbersome manual reversals. OPA is advocating with the Ministry to have this extended and will notify members should there be any changes.

25. If a patient only has private plan coverage for parts of the year (e.g., a seasonal worker who only has coverage for the months that he/she is working), would they be eligible for OHIP+?

- A child or youth 24 years of age and under who has no private plan will be eligible for OHIP+.
- The new regulation requires the pharmacy team to ask the patient/caregiver **every time a prescription is to be filled** for an individual 24 years of age and under whether the patient is covered under a private plan. Therefore, **at the time of the transaction**, if the patient has no private plan coverage then he/she would be eligible for OHIP+.

26. If a patient loses his/her job and consequently the private plan coverage, what is the process for getting OHIP+ coverage?

- There is no formal enrollment process in OHIP+.
- OHIP+ coverage is provided to children and youth 24 years of age and under with a valid OHIP number who have no private plan coverage.
- The new regulation requires the pharmacy team to ask the patient/caregiver **every time a prescription is to be filled** for an individual 24 years of age and under whether the patient is covered under a private plan. Therefore, **at the time of the transaction**, if the patient has no private plan coverage then he/she would be eligible for OHIP+.

27. A patient has a private plan, but the drug is not covered. It is covered under EAP, can the patient apply for EAP coverage?

- No, EAP coverage is only available to patients eligible for ODB coverage. A child or youth 24 years of age and under who has private plan coverage would not be eligible for OHIP+ even if the drug is not covered by the private plan (please refer to Question 2). As a result, the patient would not be eligible for EAP unless they are eligible through another ODB eligibility stream.

28. My patient is on a nutritional supplement drink which is currently covered by OHIP+ but will not be covered by the private plan post-April 1, 2019. Will OHIP+ make an exception for these patients?

- No, if the child or youth 24 years of age and under has a private plan, regardless of whether the drug product is covered by the private plan, he/she will not be eligible for OHIP+ (please refer to Question 2).
- The patient may be eligible for other programs such as the Assistance for Children with Severe Disabilities (ACSD) program or TDP.
- In order to avoid interruptions in therapy due to unforeseen expenses, pharmacy team members should attempt to contact patients/caregivers who may be in this situation and inform them of the changes to the OHIP+ program and discuss eligibility for alternative reimbursement mechanisms.

29. All these changes sound very confusing. Is there anything to help pharmacists navigate the process?

- Yes. In addition to this FAQs document, OPA has developed an OHIP+ Redesign Process Flow Chart to assist pharmacy professionals with navigating the new changes.
- OPA will continue to monitor the program post-implementation and provide our members with additional tools as needed.

Additional Question (Updated April 2, 2019):

30. **A claim for a patient on Drug Y that was previously covered under OHIP+ but not through EAP, is being rejected when I submit to the private plan now and it says that Prior Authorization is required for coverage. What should be done in this situation?**

- Although rare, there may be situations in which a non-EAP drug (perhaps a Limited Use product or other General Benefit product) that was covered under OHIP+ previously now requires a Prior Authorization from the private plan before coverage will be provided. In these situations, the Pharmacy Confirmation – OHIP + Transition of Claims Requiring Prior Authorization Form developed by CLHIA in collaboration with OPA and other stakeholders can be completed for those patients who require it to expedite the approval process. The pharmacist must complete the first section. The second section can be completed by the patient, but we suggest that as a courtesy to your patient, you may wish to complete the entire form on their behalf to help them in this new process.
- The completed form along with the most recent ODB-adjudicated receipt filled prior to April 1, 2019 should be submitted by the plan member to his/her private plan for review to determine if coverage will be provided for eligible drugs for a period of time. Plan members are encouraged to contact their private plan for more information. Processing time may vary depending on the private plan, but the purpose of this form is to help streamline the Prior Authorization process to help transition patients from the OHIP+ program back to their private plans with little to no disruption in therapy.
- Please note that after this initial approval period, patients may be asked to see their prescriber for additional information which must be submitted for coverage to continue.