NWT Disabilities Council

Denise McKee
Executive Director
ed@nwtdc.net

To: Government of the Northwest Territories
Health and Social Services

Feedback Regarding: Public Engagement on Changes to Extended Health Benefits Program

Summary of proposed changes

The GNWT operates three Extended Health Benefits Programs:

a) Specified Disease Conditions ("SPC")
b) Metis Health Benefits
c) Seniors Health Benefits (60+ years)

The proposed changes will only impact SPC.

At present, SPC provides eligible residents (those with conditions on the list or who receive special approval) 100% coverage for the following covered benefits:

a) Prescription drugs;
b) Medical supplies and equipment; and
c) Medical travel (when approved).

The proposed changes seek to replace SPD with two new programs:

a) Supplementary Health Benefits
b) Drug Benefit Program

Supplementary Health Benefit

The Supplementary Health Benefit provides 100% coverage with no cost-sharing for dental, eyewear, and medical supplies and equipment. Families who are under the established threshold will receive full coverage. Given the information available in the discussion paper, it is unclear whether families under the threshold with third-party coverage will be expected to exhaust that coverage before they become eligible for coverage under the Supplementary Health Benefit.

Drug Benefit

The Drug Benefit is a cost-sharing program. For those under the established income threshold set in Supplementary Health Benefits Program, 100% of drugs will be covered with no co-pay or deductible, although it is again unclear what role third-party will pay. For those above the threshold, a third-party insurance must be exhausted first. Once third-party insurance is exhausted, the family must pay a deductible amount (proportionate to income); after the third-party insurance is exhausted, the family is responsible for covering 30% of the cost of the drug up to a family maximum. After the family maximum is reached, the program covers 100% of drug costs.

The NWT Disabilities presented a concern regarding the current "Specified Disease Conditions" Program under Extended Health Care Benefits and the need to reform this program, as it is

discriminatory, to better meet the needs of all people with disabilities based on their medical needs. However, in review of the Supplementary Health Benefit Policy Framework we see a proposed policy that embeds discrimination, in a less overt manner, and has created an oppressive replacement that is not based on the needs and life experiences of people with disabilities but is solely income- based. The discussion paper does not seem to present a reasonable understanding of the impacts and variables, in the proposed plan, that will create inequity and have adverse implications to individuals, families and the health care system. We even question is there an understanding of the actual numbers of people the proposed changes will impact? Do these numbers exist?

In addition, the discussion paper is extremely limited in the information and definitions it provides (as presented in this paper) to allow for informed public feedback. We strongly urge the government provide a more comprehensive paper which clearly defines, provides more information and explains its positioning and then present for informed public feedback. We also encourage the government to invite the NWT Disabilities Council to participate in the process to allow disability informed expertise to help inform the development of the program.

Priority areas of concern in proposed changes –

Third-Party Insurance

Two concerns arise from the decision paper: (1) the role of third-party insurance for low-income families; and (2) the requirement that third-party insurance be exhausted for moderate-high income families.

From the discussion paper, it is not clear what role third-party insurance will play for families under the income threshold established by the Supplementary Health Benefit. The decision paper repeatedly states that it is a "payor of last resort", and that other insurance must be exhausted first. Depending on how the GNWT treats "exhausted", this could result in low-income families being expected to pay deductibles and co-pays out-of-pocket to exhaust their third-party insurance prior to receiving benefits from the government programs.

Example

A single mother with a total income of $30,000 has children who are covered from their father's third-party insurance (separated, no longer in the household). When she uses that insurance for her children, she will be subject to a co-payment and deductible (e.g., a $100 deductible and paying 30% of the drug cost or 30% of dental procedures) for the private plan. If the GNWT expects her to exhaust this plan prior to accessing the Drug Benefit or Supplementary Health Benefit, she could incur hundreds of dollars of co-payment and deductible on the private plan before she gets coverage.

The example above illustrates that reliance on exhausting third-party insurance may create barriers for low-income earners. To address this issue, we would propose the following.

1. Low-income families with third-party insurance are automatically covered under the Drug Benefit and Supplementary Health Benefit.
2. The Drug/Supplementary Health Benefit becomes a secondary insurer (like for a spouse) with direct billing that will cover the remaining outstanding costs of insured drugs and supplementary benefits after third-party insurance is applied. The Drug/Supplementary

> Health Benefit will also indemnify the family for any deductible incurred under the third-party insurance.[1]

This will prevent low-income families with third-party insurance from incurring greater costs than those without third-party insurance.

The second concern with third-party insurance is the lack of clarity on what role it is expected to play for moderate-high income earners without employee-sponsored plans. On page 13 of the discussion paper, the following is stated.

> "Residents who do not meet low-income threshold (established by income thresholds) and without third party employer-sponsored insurance will be encouraged to purchase personal health insurance from a provider with a drug benefit plan of $3000 annually. **Residents will not be eligible for the Drug Benefit Program unless an insurance plan has been exhausted**". (emphasis added)

The discussion paper provides no indication the GNWT has reasonably contemplated the serious impacts of requiring residents to purchase third-party insurance. The following issues are identified on even a preliminary contemplation of this approach.

1. Unlike employer-sponsored insurance programs, insurance providers for private plans can subject applicants to medical examinations and do not guarantee coverage. Residents with pre-existing medical conditions, particularly those with high medical costs (e.g., diabetes, multiple sclerosis, cystic fibrosis etc.), may not be able to secure third-party insurance coverage. If the Drug Benefits does not offer coverage unless a third-party insurance plan has been exhausted, an adverse distinction is created between people with and without pre-existing medical conditions, and people with pre-existing medical conditions are prevented from accessing the public benefit as a result of their disability (i.e., protected ground under the *Charter*).

2. Even where insurance is approved, residents with pre-existing medical conditions may be subject to higher premiums and deficient coverage vis-à-vis residents without pre-existing conditions (e.g., no coverage for the previous condition etc.). This can have multiple negative consequences.
    a. Firstly, this may result in a resident with a pre-existing condition having third-party coverage that is technically not "exhausted" but is not actually covering the cost of the specific drugs they need for their pre-existing condition. For example, a resident with multiple sclerosis may be obtain third-party coverage with an annual maximum of $3000 for drugs generally, but $0 in coverage for drugs specific to their multiple sclerosis. From the discussion paper, it is unclear whether the Drug Benefit would step in to provide coverage for specific drugs not covered by third-party insurance when the annual maximum for drug coverage under the plan is not met.
    b. Secondly, where residents with pre-existing medical conditions must incur higher premium costs than those without pre-existing medical conditions, they to pay more money out of pocket before they can access the government Drug Benefit. This would

[1] We would also urge that a procedure be developed such that families are not required to pay the deductible for third-party insurance up-front and then seek reimbursement from the GNWT. This could be prohibitive for many families and may result in families not accessing necessary medical services, contrary to policy objectives.

be an adverse effect specific for people with pre-existing medical conditions (i.e., disability, protected ground).

c. Thirdly, the same argument in (b) also applies with age, given that premiums can also increase with age. Where older adults must pay more in premiums for coverage than younger adults before they can access the government Drug Benefit, you are again creating an adverse effect specific to people on the basis of a protected ground.

The discussion paper also fails to account for the wide diversity of employer-sponsored benefit plans that exist. Employer plans can have varying levels of deductibles, co-payments, and annual maximums. The discussion paper provides no indication that the GNWT has reasonably contemplated the diversity of employer-sponsored plans in ensuring fairness for beneficiaries. If the goal of the plan is to ensure equitable access to drug benefits and the GNWT proposes that third-party insurance be exhausted, the quality of third-party plans reasonably needs to be considered.

Example

The discussion paper reiterates that residents do not become eligible for coverage until third-party insurance is exhausted.

If Resident A has a plan that covers 70% of drugs up to an annual maximum of $10,000, she will need to pay $4,285.00 to exhaust her coverage.

If Resident B has a plan that covers 80% of drugs up to an annual maximum of $5,000, he will need to pay $1,250.00 to exhaust his coverage.

Given these concerns, we recommend the following:

1. If the GNWT requires moderate-high income residents to purchase third-party insurance, the GNWT coordinate a plan with an insurance provider that will provide universal standard coverage and premiums that do not discriminate on the basis of age, disability, or other protected ground (see, e.g., https://www.alberta.ca/non-group-coverage.aspx).
2. To account for the varying quality of employer-sponsored insurance, the Drug Benefit enrollment be automatic and treated as a secondary insurer (e.g., like a spouse). The Drug Benefit will then automatically kick-in after the family has paid a certain amount of money out-of-pocket (i.e., the deductible). Once the deductible level is reached, the Drug Benefit will start providing coverage at 70% until the family maximum for out-of-pocket expenses is reached and then the Drug Benefit covers 100% of outstanding drug costs.

Lack of coverage for medical supplies and equipment

The proposed changes eliminate all coverage of medical supplies and equipment for families above the low-income threshold. There is no indication that the GNWT has reasonably contemplated the grave consequences of this drastic change to coverage for persons with disabilities who are non-low-income earners.

People with disabilities rely on medical supplies and equipment to meet their basic health needs and for community and labor force participation. Removal of coverage for medical supplies and

equipment will further entrench people with disability in poverty. The cost of prosthetics, mobility aids, and medical supplies (e.g., incontinence supplies, oxygen tanks etc.) is significant and for many people with disabilities, far exceeds costs associated with prescription drugs. Removing coverage for medical supplies and equipment will impose financial costs to families that many families will not be able to absorb. Where families are unable to cover the costs of medical supplies and equipment, further disablement and poorer physical and health outcomes are almost certain, which will only increase reliance on acute care services in the health care system, contrary to the stated purpose of the proposed changes (p.8). Further disablement and poorer health outcomes also increase the likelihood of persons exiting the labor force, becoming dependent on state-sponsored benefit programs, and living in poverty. In addition to this, the proposed scheme also has the perverse consequence of incentivizing poverty for people with disabilities. Earning a higher income that would bring a family outside the low-income threshold would not make financial sense if that family would suddenly be responsible for paying 100% of all their costly medical supplies and equipment. We would expect that some families would be forced to remain in a lower income bracket to ensure they receive the medical supplies and equipment they need.

The main purpose of the proposed changes is to align the provision of extended health benefits to the values of equity and fairness and to prevent families from incurring exorbitant medical costs. Providing no cap to out-of-pocket expenses for medical supplies and equipment required for the maintenance of one's medical condition or disability is antithetical to this purpose. Furthermore, it creates a real risk of poorer health outcomes, decreased labor force participation, increased social isolation, and increased reliance of state-sponsored supports.

We urge the GNWT to incorporate a scheme of coverage for medical supplies and equipment mirrors for non-low-income earners.

> Example
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> Alberta Aids to Independent Living covers 75% of the cost of medical supplies and equipment for families to family contribution maximum of $500 per annum, after which the program covers 100% of costs.
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> (https://www.alberta.ca/alberta-aids-to-daily-living.aspx)

Additional Points of Concern

Additional points of feedback are as follows.

Definition of family/household

The discussion paper provides no clear definition of what individuals will be included in the measurement of a "family/household" income. Given the territory's high rate of overcrowded housing and intergenerational living arrangements, there is a risk that the raw sum of relatives in a home could result in many families being disqualified from the low-income threshold even if all of them have very modest income sources like income assistance.

Given that the definition of family/household is foundational to defining who will receive benefits, we would urge the GNWT to release a proposed definition for public feedback.

In addition, we would urge the GNWT to treat adult children living in a household as independent adults. If the GNWT does not do this, it could have the consequence of disincentivizing parents housing adult children with disabilities at home.

> Example
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> If two parents have a combined income of $32,000 and their adult child with a disability receives $17,000 per year in income support, including the adult child would make the parents and the adult child all lose out on the low-income Supplementary Health Benefits and automatic 100% coverage under the Drug Benefit. The added cost of paying for these medical supplies and drug benefits for the adult child could motivate the family to move the child out of their home and into a congregate care setting.

Threshold Income

Of the options provided, it is our recommendation that the GNWT utilize $36,925 as the base income (i.e., the MBM-N for the most expensive region). Using the median measurement will result in disproportionate impact on families residing in more remote communities, who already face the greatest barriers to meeting their medical needs. We also recommend that the GNWT utilize the MBM-N option for the dependent adjustment as this better reflects the added cost of living in the north better than the flat rates set by the Government of Alberta (per p. 15 of the discussion paper). Furthermore, we would urge the GNWT to include in its policy that the income thresholds for all aspects of the proposed benefits will automatically increase by the rate of inflation each year.

That being said, we would note that the MBM-N sets the annual income needed to meet as basic standard of living across the NWT. This amount, however, does not account for increased costs associated with disability. The cost to maintain a basic standard of living is higher for families supporting a family member with a disability than those who do not. Not all disability-related expenses are tied to access to prescription drugs and medical supplies and equipment (which are, to some extent, attenuated by this extended health benefits). Non-exhaustively costs include expenses for: premiums for childcare and services for children with disabilities requiring additional supervision, reliance on taxis and private transportation due to lack of accessible public transportation, electronic devices for communication, over the counter medications for pain management, or adaptive equipment for household appliances. The discussion paper provides no indication that the GNWT has reasonably accounted for the additional costs that families supporting a family member with a disability face in attainting a basic standard of living. We would urge the GNWT to provide modified thresholds to account for the added global costs facing families with disabilities.

Medical Travel

In line with the argument made under medical supplies and equipment, no explanation is provided for the removal of coverage for medical travel completely, including for low-income residents.

We would urge the GNWT to provide full coverage for low-income earners and scaled co-payment for moderate-high income earners.