Alternatives North Submission concerning the Expansion of Extended Health Benefits

October 2022

This submission provides feedback on the proposed changes to the GNWT Extended Health Benefits program.

As noted in the GNWT's discussion paper, the "estimated 2,200 NWT residents [without] access to any benefits like the ones available to most residents through employer or government insurance plans" shows there is a clear need for improvements. We also acknowledge the concern in the discussion paper that "The EHB Policy has seen little change in the last 34 years and no longer meets the objectives of a publicly funded benefit program." In fact, Alternatives North holds that the harms that arise when residents cannot practice the health and medical advice they are given demands remediation.

A fair health care system will provide essential services to all who need them regardless of ability to pay. Alternatives North knows that the only way health programs will be accessible, equitable and easy to understand is if they are universal and funded through a progressive tax system. Access to health programs should never be income tested or fettered with user fees or other barriers to free access. Clear evidence shows that such barriers inevitably result in those with lower incomes, with unstable housing situations, with lower literacy levels, etc., falling through the cracks and suffering.

Comments on the proposed policy:

The proposed policy requires that applications must be completed annually to maintain eligibility. This is a bureaucratic barrier that will surely mean some northerners fall through the cracks. Failure to apply could be for a variety of reasons: oversight or inadvertence, lack of awareness of the requirement, literacy and language issues, etc. Regardless, annual application is a clear barrier to access. What will happen to people whose circumstances change during the year? Will there be mechanisms for reassessment? Will there be an appeal mechanism?

The proposed income testing procedure requires that the incomes of all members of a household be included. There is no guarantee that all members of a household would be willing, or could be coerced, into contributing to family health costs.

The paperwork involved in showing that other insurances aren't paying is guaranteed to be complicated and onerous, resulting in some people failing to get coverage to which they would otherwise be entitled because they give up chasing what they are owed due to confusing, onerous and wearying compliance requirements. The proposal also assumes that needed health and drug insurances are freely available everywhere in the Territories at an affordable price. As well, throwing citizens on the tender mercies of private insurers who can unilaterally stop coverage, increase their prices or otherwise restrict access or coverage leaves residents at serious risk.

Many NWT residents, particularly elders in smaller communities, don't file tax returns. The proposed plan, which intends to rely on CRA data to determine family income, doesn't appear to address this issue.

It's noted that a good part of the funding required for a universal program could be acquired from those companies that now provide insurance. They can legitimately be expected to contribute to the public

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plan an amount equal to their savings. A single, universal plan avoids the costs of duplication and complexity of figuring out the "payor of last resort."

A universal plan avoids the need to hire staff to police the many eligibility demands that are being suggested. (There may be a need to increase staff to handle new beneficiaries that would come with universal coverage but the point here is that there are offsets.)

Should the GNWT insist on moving forward with a patently inadequate plan to expand the EHB program in the manner described in the discussion paper, Alternatives North has further specific comments to offer. As mentioned, the goal of Alternatives North is to make sure that any program expansion covers those who are in need (without reducing any essential benefits now provided.) Health care programs must be accessible, equitable and easy to understand.

The Discussion paper notes that, "Cost sharing and coverage levels will be determined by how much income they earn." This premise has merit as long as the cost sharing burden on individual northerners is not so high that it stops low income earners from accessing needed drug or other health coverage.

It appears to Alternatives North that drug coverage is given a greater priority than other potential treatments. This is a narrow understanding of what contributes to a healthier lifestyle for NWT residents. For example, the DHSS has recently stopped offering footcare for elderly clients, apparently due to a staffing shortage. This is clearly counter-productive. It would be silly to fund orthopedic footcare and orthotics but not basic footcare that prevents the need for more elaborate care. The point we are making here is that the related health services such as homecare services, physiotherapy, occupational therapy, speech and language pathology and audiology need to be supported and funded so that the services continue.

We do not support the creation of separate Supplementary Health Benefit and Drug Benefit Programs. Both should be unified; both are essential contributors to a person's health status. The proposed Drug Benefit program creates another program for families to deal with and more forms and paperwork to complete.

The Discussion paper points out the low income measure to be used: "… the distinct Northern Market Basket Measure (MBM) which recognizes the high cost of living and other factors in the NWT. • $32,601 represents the annual income needed to meet a basic standard of living averaged across all NWT regions; or • $36,925 represents the annual income needed to meet a basic standard of living in the most expensive region to live in the NWT (Sahtu). • $9,451 per dependent (a child under 19) is added to the base low-income threshold."

We agree with the use of the MBM low income marker but we would add that the $9,451 should also be used as an indicator for changes to how much the "family" should be required to contribute. We support a phased-in approach to cost sharing. For example, if a "family" earns $9,451 more than the prior year, they could be asked to contribute more funding. Obviously, the new income change marker is much greater than the one used on the chart in the Discussion paper which shows increases in payment for each additional $2300-$2400 amount earned. We recommend a graduated approach of 75% for the government to pay and 25% for the family to pay for the first $9,451 in increased income. Then move to 50/50 shared costs when there is another $9,451 increase in earned income and a third range of 25% government paid and 75% family paid at the next income jump. A more gradual process would be

better for families that are improving their income levels earned with the use of $9,451 as a marker for measuring increasing income. A graduated approach would also help avoid situations where people are simply cut off from benefits. We recognize that a graduated approach may be more difficult to administer but this needs to be balanced with a more equitable implementation of benefits.

We understand that the expansion will not affect the Extended Health Benefits program for Seniors or those who are Indigenous or Métis. We do note with grave concern that the Discussion paper says that it is "at this time" that it doesn't apply to Seniors. Reducing current coverages provided to seniors would be truly regressive. We understand that the national formulary related to NIHB is used to gauge what is acceptable for coverage. This often leaves health care practitioners with difficult situations to meet the needs of their clients. For example, scooters are not a funded item but would be an excellent way for some clients with mobility challenges to get around a community with lots of snow and only gravel roads. There are also very strict criteria for determining who qualifies for motorized means of mobility and this, as well, does not work for clients with mobility problems in the NWT.

In the Discussion paper, "Cost sharing models are defined as a: ♣ Deductible (out of pocket payment amount before being eligible for the drug plan), ♣ Co-payment (fixed fee per prescription, ex. $5), ♣ Co-insurance amount (percentage of prescription cost ex. 30%), or ♣ Premium (upfront, monthly, or quarterly fees to access the drug plan)." Although none of the models is without fault, Alternatives North believes that premium fees would be the least likely to work for low income earners who would inevitably prioritize current expenses over coverage for "in case" or unforeseen health related problems.

Recommendation for a better solution:

The stated aim of the proposed change in policy is to make it fairer. There is a worthy desire to make extended health benefits accessible, equitable and easy to understand. The way this should be done is to expand the population covered by the current EHB plan to the entire population. Making our health care system truly universal could be phased in starting the enhanced coverage for those earning less than $30,000 per year immediately and raising that cut-off $10,000 per year until the entire population is eligible. As mentioned above, extra costs could be paid for by the establishment of a meaningfully progressive tax system in the NWT.

Thank you for the opportunity to provide our comments. We look forward to reading the What We Heard document produced as a result of the consultation.

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