POLICY STATEMENT

1. The Department of Health provides assistance to eligible persons who require health care products and services and medical travel support beyond the coverage conferred by the Nunavut Health Care Plan and one's third-party plan.

PRINCIPLES

2. This policy and its application are guided by the following principles:
    a. Health programs should be understandable and easy to access for eligible persons;
    b. The cost of health care products and services as well as medical travel should not be a barrier to care;
    c. The Extended Health Benefits Program is a payer of last resort;
    d. The Extended Health Benefits Program is divided in the following three streams:
        i. Stream 1-Medical Travel Support;
        ii. Stream 2-Specified Conditions; and
        iii. Stream 3-Seniors;
    e. The amounts covered by the Extended Health Benefits Program are in line with those conferred by Health Canada's Non-Insured Health Benefits Program; and
    f. Decisions under this policy are to be rendered in a timely manner.

APPLICATION OR SCOPE

3. This Policy applies to individuals who meet the eligibility criteria specified in the provisions of this Policy.

DEFINITIONS

4. In this Policy,
    a. "Aboriginal" means:
        i. A registered Indian according to the *Indian Act*;
        ii. An Inuk recognized by one of the Inuit Land Claim organizations; or
        iii. An infant less than one year of age whose parent is a registered Indian according to the *Indian Act* or an Inuk recognized by one of the Inuit Land Claim organizations.
    b. "Client escort" means a client escort as defined under the Government of Nunavut's Medical Travel Policy;

c. “Commercial accommodation” excludes private accommodation and includes a motel, a hotel, a lodge, an apartment, a serviced suite and a place rented through an offline or online rental agency;
d. “Director of Medical Insurance” means the Director of Medical Insurance appointed under subsection 23(1) of the *Medical Care Act*;
e. “Exception Prescription Drug” means a prescription drug that is not listed on the formulary;
f. “Formulary” means Health Canada’s Non-Insured Health Benefits Drug Benefit List, Chronic Renal Failure Formulary and Palliative Care Formulary, as amended;
g. “Medical practitioner” means a person licensed to practice medicine in a province or territory of Canada;
h. “Medical trip” means a medical travel approved under the Government of Nunavut’s Medical Travel Policy;
i. “Northern area” means a location designated and published as such by the Director of Medical Insurance pursuant to section 5(e);
j. “Nurse Practitioner” means a nurse practitioner as defined in the *Nursing Act* of Nunavut, or a person who is not licensed, registered or entitled to practice in Nunavut, but is entitled to practice the profession of nurse practitioner in another Canadian jurisdiction;
k. “Private accommodation” means any accommodation that:
    i. is owned or rented on a usual basis by a client’s relative or friend; and
    ii. is not co-rented or co-owned by the client or the client’s spouse or common-law partner;
l. “Third-party plan” includes
    i. Health Canada’s Non-Insured Health Benefits (NIHB); and
    ii. group health insurance and health benefits
        1. provided against a premium or not;
        2. accessible through the current or former employer of the person, a relative of the person or a member of the person’s household; and
        3. that covers one or more of:
            a. dental care;
            b. audiology services and products;
            c. vision care;
            d. medical supplies and appliances;
            e. prescription drugs; and
            f. medical travel support that covers flight co-payments, meals or accommodation while on a medical trip.

ROLES AND RESPONSIBILITIES

Director of Medical Insurance

5. In accordance with this Policy and its guidelines, the Director of Medical Insurance
    a. shall assess the eligibility of persons applying for registration pursuant to sections 25 and 32 and register eligible persons;

b. shall de-register persons who no longer meet the eligibility criteria specified in this Policy;
c. shall, following a consultation with a pharmacist, approve or refuse exception coverage for a version of a drug other than the least expensive one when an application under section 10 is made;
d. shall assess the eligibility of claims received under this Policy as well as authorize or refuse their payment;
e. shall designate locations to be considered northern areas under this Policy and publish them on a publicly available web page of the Department of Health;
f. shall provide justification for the decisions made under this Policy and its guidelines to persons who are subject to the decision;
g. shall assess and render decisions on applications for special coverage of a condition pursuant to section 27 and publish approvals according to section 29;
h. shall decline or confirm pre-approval as required by the guidelines; and
i. may, as appropriate, delegate the tasks in section 5.a. to 5.h. to staff in his or her division.

Deputy Minister of Health

6. In accordance with this Policy and its guidelines, the Deputy Minister of Health shall assess appeals and render decisions on them according to sections 34 to 37.

PROVISIONS

Third-Party Coverage

Categories of benefits

7. For the purposes of this Policy, the categories of benefits are dental care, audiology services and products, vision care, medical supplies and appliances, prescription drugs and medical travel support or their equivalent as they may be named by a third-party plan.

Participation in Third-Party Plan

8. A person is not eligible for a category of benefits under this Policy if the person is eligible for a third-party plan that covers that category of benefits and the person
    a. chooses not to participate in the third-party plan as a whole; or
    b. chooses not to participate in that category of benefits under the third-party plan.

Payer of Last Resort

9. The amounts to which a client is entitled under this Policy are reduced by the amounts paid by the client's third-party plan.

Prescription drugs

Generic and brand-name drugs

10. When both generic and brand-name versions of a prescription drug that is a benefit under section 26.a or 33.a exist, this Policy only covers the cost of the least expensive drug except if
    a. a medical practitioner or nurse practitioner applies for an exception on behalf of the client and documents the adverse reaction that occurred with the least expensive drug;
    b. the Director of Medical Insurance approves the exception for a different version to be covered following a consultation with a pharmacist; and
    c. the prescribing medical practitioner or nurse practitioner writes “no substitution” on the prescription.

Client choice

11. When this Policy only covers the least expensive version of a drug pursuant to section 10, the client may choose to obtain a more expensive version of that drug and pay for the difference in price.

Stream 1-Medical Travel Support

Eligibility

12. A client is only eligible for the benefits specified in sections 14 to 21 for the day(s) of a medical trip on which he or she
    a. does not have a third-party plan that covers flight co-payments, ground transportation, meals or accommodation for the medical trip;
    b. has exhausted the flight co-payments, ground transportation, meals or accommodation benefits provided by his or her third-party plan for the medical trip; or
    c. has a third-party plan that covers flight co-payments, ground transportation, meals or accommodation for the medical trip at lesser rates than the ones established in sections 14 to 21.

All-Inclusive Option From Third-Party Plan

13. Notwithstanding section 14.c., a client is not eligible for the benefits specified in sections 14.b to 21 on the day(s) of a medical trip for which
    a. the client’s third-party plan offered the client the option to stay, at no expense to the client, in an all-inclusive housing facility that covers;
        i. accommodation;
        ii. meals; and
        iii. ground transportation in the city where the client is sent for care for journeys between the health facility, the airport and the housing facility; and
    b. the client chose not to avail that option.

Transportation expenses

14. The following client and client escort expenses incurred while on a medical trip are benefits under this Policy
    a. the flight co-payment specified under the Medical Travel Policy;
    b. taxi fare between the person's home or the local health centre and the airport in Coral Harbour, Whale Cove, Resolute Bay and Arctic Bay;
    c. ground transportation in the city of the point of referral if the journey is between two of the following locations: health facility, airport and accommodation; and
    d. ambulance charges to transfer the client from one health facility to another.

Stay in private accommodation

15. A client is entitled to a $50 nightly accommodation allowance for a stay in a private accommodation if
    a. the stay is documented in a billet form by one regular occupant of the private accommodation; and
    b. the private accommodation is used to accommodate
        i. the client in cases when the client is not admitted in a health facility and no client escort is providing assistance;
        ii. the client as well as the client escort(s) in cases when the client is not admitted in a health facility and assistance is provided by client escort(s); or
        iii. the client escort(s) in cases when the client is admitted in a health facility and assistance is provided by client escort(s).

Meals for stay in private accommodation in northern area

16. When an accommodation that is located in a northern area and meets the criteria in section 15 is used during a client's medical trip, the client is entitled to
    a. a $50 meal allowance per day when the client is not admitted in a health facility; and
    b. a supplementary $50 meal allowance per day, per client escort assisting the client.

Short-term stay in hotel, motel or lodge in northern area

17. Subject to sections 20 and 21, a client is entitled to the reimbursement of expenses incurred to rent one hotel, motel or lodge room while on a medical trip if
    a. the hotel, motel or lodge room rented is in a northern area where the client is sent for care; and
    b. the hotel, motel or lodge room is rented to accommodate
        i. the client in cases when the client is not admitted in a health facility and no client escort is providing assistance;
        ii. the client as well as the client escort(s) in cases when the client is not admitted in a health facility and assistance is provided by client escort(s); or
        iii. the client escort(s) in cases when the client is admitted in a health facility and assistance is provided by client escort(s).

Short-term stay in commercial accommodation outside northern area

18. Subject to section 20 and 21, a client is entitled to the reimbursement of commercial accommodation rental expenses incurred up to a nightly maximum of $125 while on a medical trip if
    a. the commercial accommodation is located outside a northern area and is where the client is sent for care; and
    b. the commercial accommodation is rented primarily to accommodate
        i. the client in cases when the client is not admitted in a health facility and no client escort is providing assistance;
        ii. the client as well as the client escort(s) in cases when the client is not admitted in a health facility and assistance is provided by client escort(s); or
        iii. the client escort(s) in cases when the client is admitted in a health facility and assistance is provided by client escort(s).

Meals during stay in a hotel, motel or lodge in northern area or a commercial accommodation outside of a northern area

19. Subject to sections 20 and 21, when an accommodation that meets the criteria specified in sections 17 or 18 is rented during the client's medical trip, the client is entitled to
    a. a $50 meal allowance per day when the client is not admitted in a health facility; and
    b. a supplementary $50 meal allowance per day, per client escort assisting the client.

Long-term care plan - before start of medical trip

20. If prior to the commencement of a client's medical trip the client's nurse practitioner, medical practitioner or case manager, on the advice of the client's nurse practitioner or medical practitioner, indicates in writing that the client's medical trip is likely to last more than 90 days, the client is not entitled to the benefits specified in sections 17 to 19 but can avail the private accommodation benefits specified in sections 15 and 16 or
    a. an accommodation allowance of $60 per day that a private accommodation is not used;
    b. a meal allowance of $20 per day that a private accommodation is not used; and
    c. a supplementary meal allowance of $20 per client escort providing assistance to the client for each day that a private accommodation is not used.

Long-term care plan - after start of medical trip

21. If after the commencement of a client's medical trip the client's nurse practitioner, medical practitioner or case manager, on the advice of the client's nurse practitioner or medical practitioner, indicates in writing that the client's medical trip is likely to last more than 90 additional days from the date on which the notice is written, the client

a. ceases to be eligible for the benefits specified in sections 17 to 19 at the end of the 30th day after which the notice is written but remains eligible for the private accommodation benefits specified in sections 15 and 16; and
b. becomes is eligible for the following starting on the 31st day after which the notice is written:
    i. an accommodation allowance of $60 per day on which a private accommodation is not used;
    ii. a meal allowance of $20 per day on which a private accommodation is not used; and
    iii. a supplementary meal allowance of $20 per client escort providing assistance to the client for each day on which a private accommodation is not used.

Inquiry into projected length of medical trip

22. From time to time, the Director of Medical Insurance may require a client to provide documentation prepared by the client's nurse practitioner, medical practitioner or case manager, on the advice of the client's nurse practitioner or medical practitioner, estimating the duration of the client's medical trip.

Breastfed infants

23. The meal allowances specified in sections 16.a, 19.a, 20.b and 21.b.ii are not payable when the client is an infant who is still breastfed.

Stream 2-Specified Conditions

Eligibility

24. A person is eligible for registration under section 25 if the person
    a. is not aboriginal;
    b. is under the age of 65;
    c. is enrolled in the Nunavut Health Care Plan; and
    d. has a condition listed on schedule A or a condition accepted for special coverage under section 28 of this Policy.

Registration

25. A person who meets the eligibility criteria specified in section 24 can register for the Specified Conditions Stream of this Policy following the registration process set out in Guideline 1 (Registration).

Benefits

26. A person registered for the Specified Conditions Stream under section 25 is entitled to
    a. the full cost of prescription drugs listed on the formulary that are prescribed to the person for any condition listed on schedule A or for any condition accepted for special coverage under section 28 of this Policy for which the person is diagnosed and registered;

b. the full cost of exception prescription drugs that are
    i. prescribed to the person for any condition listed on schedule A or for any condition accepted for special coverage under section 28 of this Policy for which the person is diagnosed and registered; and
    ii. pre-approved for the client according to Guideline 2 (Claims and Pre-Approvals);
c. the full cost of medical supplies and appliances as well as their fitting and shipping cost if they
    i. are listed on Health Canada's Non-Insured Health Benefits' Medical Supplies and Equipment General Benefits list, as amended; and
    ii. are prescribed to the person for any condition listed on schedule A or for any condition accepted for special coverage under section 28 for which the person is diagnosed and registered; and
d. the following if they are rendered necessary to manage the side effects of a prescription drug described in section 26.a. or 26.b or of medical supplies and appliances described in section 26.c.:
    i. dental care as described in section 33.d
    ii. the full cost of prescription drugs listed on the formulary that are prescribed to the person;
    iii. audiology services and products as described in section 33.e.;
    iv. vision care as described in section 33.g.;
    v. the full cost of medical supplies and appliances as well as their fitting and shipping cost if they
        1. are listed on Health Canada's Non-Insured Health Benefits' Medical Supplies and Equipment General Benefits list, as amended; and
        2. are prescribed to the person.

Request for special coverage of condition

27. A person who meets the eligibility criteria specified in sections 24.a to 24.c and is diagnosed with a condition that is not listed in schedule A of this Policy and that has not been previously approved for special coverage under section 28 may request that the Director of Medical Insurance considers approving special coverage for that condition by submitting the appropriate form signed by the person's nurse practitioner or medical practitioner and bearing the following information:
    a. patient's name;
    b. patient's date of birth;
    c. patient's Nunavut Health Care Plan card number;
    d. patient's contact information
    e. the condition that is the subject of the request;
    f. evaluation of whether the condition is life threatening or will become life threatening if untreated;
    g. an assessment of the chronicity of the condition;
    h. the medical practitioner's name; and
    i. the medical practitioner's contact information.

Decision on special coverage for a condition

28. On receiving a duly filled form submitted pursuant to section 27, the Director of Medical Insurance shall, after having considered the chronicity of the condition, its life-threatening nature and any other relevant factor
    a. decide to approve or refuse special coverage; and
    b. communicate the decision to the patient and the medical practitioner or the nurse practitioner listed in the form.

Publication of special approval

29. On deciding to approve special coverage for a condition pursuant to section 28, the Director of Medical Insurance shall publish the name of the condition on a publicly available web page of the Department of Health and specify that the condition is now eligible for coverage under the Specified Conditions Stream.

Retroactive diagnosis

30. A person registered under section 25 who is retroactively diagnosed with a condition listed on schedule A or a condition accepted for special coverage under section 28 is eligible for the benefits specified in section 26 pertaining to that condition starting on whichever is the latest of
    a. the day that the person enrolled in the Nunavut Health Care Plan; and
    b. the onset date for the condition as established for the first time by a medical practitioner or nurse practitioner.

Stream 3-Seniors

Eligibility

31. A person is eligible for registration under section 32 if the person is:
    a. not aboriginal;
    b. 65 years of age or older; and
    c. is enrolled in the Nunavut Health Care Plan.

Registration

32. A person who meets the eligibility criteria specified in section 31 can register for the Seniors Stream of this Policy following the registration process set out in Guideline 1 (Registration).

Benefits

33. A person registered for the Seniors Stream under section 32 is entitled to
    a. the full cost of prescription drugs listed on the formulary that are prescribed to the person;
    b. the full cost of exception prescription drugs that are prescribed to pre-approved for the client according to Guideline 2 (Claims and Pre-Approvals);
    c. ambulance charges for transportation within Nunavut;
    d. a combined maximum of $1,000 per calendar year for dental care provided by dental professionals, such as the following:
        i. diagnostic services such as examinations and x-rays;

ii. preventive services such as cleanings;
iii. restorative services such as fillings;
iv. endodontics such as root canal treatments;
v. periodontics or the treatment of gums;
vi. prosthodontics other than removable dentures;
vii. oral surgery including the removal of teeth;
viii. orthodontics to correct irregularities in teeth and jaws when there is a severe and functionally handicapping malocclusion;
ix. adjunctive services, which include additional services such as sedation;
x. new dentures once in any 5 years; and
xi. repairs to dentures unless they are required as a result of misuse, carelessness or negligence;

e. the following medically required audiology services and products:
i. complete hearing assessment performed bilaterally once in any 5 years;
ii. partial hearing re-assessment performed bilaterally once in any 2 years;
iii. bone conduction, conventional analog, CROS/BiCROS, programmable analog or digital processing hearing aids and associated services prescribed to the person by an audiologist or medical practitioner once in any five years, unless earlier replacement approved is by the Director of Medical Insurance and necessary due to a change in audition;
iv. hearing aid batteries and tubes/domes;
v. replacement of ear mold and impression once in any two years;
vi. client-initiated hearing aid performance check and readjustment once per year; and
vii. repairs to hearing aids unless they are required as a result of misuse, carelessness or negligence;

f. the full cost of medical supplies and appliances as well as their fitting and shipping cost if they
i. are listed on Health Canada's Non-Insured Health Benefits' Medical Supplies and Equipment General Benefits list, as amended; and
ii. are prescribed to the person; and

g. the following vision care services and products at the rates established for Nunavut in the NU Eye Care & Vision Benefit Fee Grid of Non-Insured Health Benefits' Vision Care Benefit Policy Framework, as amended:
i. vision examination once in any year;
ii. a maximum of $100 for a frame for prescription eyeglasses once in any 2 years;
iii. the full cost of lenses for prescription eyeglasses once in any 2 years;
iv. the cost of special tinting and coating of lenses for eyeglasses once in any 2 years when an optometrist or an ophthalmologist has certified that such feature is medically required; and

v. the cost of disposable contact lenses when an optometrist or an ophthalmologist has certified that prescription eyeglasses are not suitable for the person given his or her condition.

Appeals

Filing an appeal

34. With the exception of a decision on an appeal rendered pursuant to section 36, a client may appeal any decision made under this Policy or its guidelines that affects him or her by submitting the appropriate appeal form to the Deputy Minister of Health, thereby providing
    a. the client's name;
    b. the client's Nunavut Health Care Plan number;
    c. the client's contact information;
    d. the decision being appealed;
    e. the reason(s) for the appeal; and
    f. any evidence that the client deems helpful to support the appeal.

Acknowledgement

35. On receiving an appeal form submitted pursuant to section 34, the Deputy Minister of Health shall acknowledge having received the appeal form.

Decision

36. Within 30 calendar days of receiving an appeal form pursuant to section 34, the Deputy Minister of Health shall gather any additional information deemed necessary for appropriate consideration of the appeal from employees of the Department of Health, the client and any other appropriate person and decide to
    a. maintain the decision subject to the appeal;
    b. annul the decision subject to the appeal;
    c. vary the decision subject to the appeal; or
    d. make any other decision that the Deputy Minister of Health deems necessary given the circumstances.

Communication of decision

37. On rendering a decision pursuant to section 36, the Deputy Minister of Health shall inform the client of the decision made on the appeal.

No Further Appeal

38. Decisions rendered by the Deputy Minister of Health pursuant to section 36 are final and binding.

NUNAVUT LAND CLAIMS AGREEMENT (NLCA) PARAMOUNT

39. Nothing in this Policy shall be construed as to limit the authority of the NLCA. The Agreement shall take precedence over this Policy.

FINANCIAL RESOURCES

40. Financial resources required under this Policy are conditional on approval by the Legislative Assembly, and on the availability of funds in the appropriate budget.

PREROGATIVE OF CABINET

41. Nothing in this directive shall in any way be construed to limit the prerogative of the Executive Council to make decisions or take actions respecting non-insured benefits outside the provisions of this Policy.

SUNSET CLAUSE

42. This Policy shall sunset on 31 March 2021 unless revised by Cabinet sooner.

Premier

Alcohol Dependency
Alzheimer's Disease
Asthma
Cancer
Celiac Disease
Cerebral Palsy
Certain Disorders of Blood & Immune System
Chronic Obstructive Lung Disease
Chronic Psychosis
Cleft Lip / Palate
Congenital Anomalies & Chronic Disease of the Urinary System
Congenital Cytomegalovirus Infection
Congenital Heart Disease
Crohn's Disease
Cystic Fibrosis
Dermatomyositis
Diabetes Insipidus
Diabetes Mellitus
Drug Dependency
Epilepsy
Head Injury
HIV Infection
All other HIV Related Diseases
Hypertension (Subject to certain BP levels)
Ischemic Heart Disease
Lupus Erythematosus
Multiple Sclerosis
Muscular Dystrophy
Osteoarthritis
Pernicious Anemia
Phenylketonuria
Psoriasis
Rheumatic Fever
Rheumatoid Arthritis
Rickets
Scleroderma
Scoliosis
Spina Bifida
Spinal Cord Injury
Tuberculosis
Ulcerative Colitis
Wegeners Granulomatosis

This guideline explains how to register for benefits.

Initial Registration for the Seniors Stream

1. A person eligible for the Seniors Stream may register for benefits by providing the Director of Medical Insurance with a duly filled application form that includes, if required, an employer-signed statement of third-party plan coverage.

Initial Registration for the Specified Conditions Stream

2. A person eligible for the Specified Conditions Stream may register for benefits by providing the Director of Medical Insurance with a duly filled application form that includes
    a. a statement by a nurse practitioner or medical practitioner specifying which condition(s) listed on schedule A or accepted for special coverage under section 28 of this Policy that the person is diagnosed with, as well as the drugs currently prescribed to the person for the condition(s); and,
    b. if required, an employer-signed statement of third-party plan coverage.

Registration for Additional Conditions

3. A person registered under the Specified Conditions Stream can register for coverage of an additional condition listed on schedule A or accepted for special coverage under section 28 of this Policy by providing the Director of Medical Insurance with a duly filled form, which includes
    a. a statement by a nurse practitioner or medical practitioner specifying which additional condition the person is diagnosed with and the drugs currently prescribed to the person for the condition.

Subsequent Registration

4. From time to time, the Director of Medical Insurance may require that clients registered for the Seniors and Specified Conditions Streams renew their registration for Extended Health Benefits.

Submitting Registration Documents on Behalf of Dependent

5. A person may submit registration documents on behalf of a dependent.

Confirmation or Refusal of Coverage

6. On receiving forms pursuant to paragraph 1 to 3, the Director of Medical Insurance will assess eligibility and confirm the benefits for which the client is eligible.

EXTENDED HEALTH BENEFITS – GUIDELINE 2 (CLAIMS AND PRE-APPROVALS)

This guideline explains how clients can claim their Extended Health Benefits and sets requirements for pre-approvals.

Key concepts:

1. Three key concepts apply to the claims process:
    a. "Direct billing" means that the vendor bills the Director of Medical Insurance for a covered product or service directly and on behalf of the client;
    b. "Deferred payment" means that the client pays the vendor directly for a covered product or service and then applies to the Director of Medical Insurance for reimbursement; and
    c. "Prior approval" means a written permission from the Director of Medical Insurance to purchase an item or service and have it covered under the Extended Health Benefits Policy.

Deadline to Submit Claim For Deferred Payment

2. With the exception of retroactive diagnosis claims pursuant to section 30 of the Policy, claims for deferred payment need to be submitted 90 calendar days after the service or product was provided.

Submission of a Claim

3. To claim a benefit through deferred payment, the client must provide the Director of Medical Insurance with a duly filled claim form and all the additional documentation required for that benefit as outlined in Table 1. Claim Methods, Additional Documents Required and Pre-Approvals.

Payment of Benefits

4. Based on the category of benefit being claimed through deferred payment, the client may elect to have the payment issued to him or herself, a client escort, or a host.

Claim on Behalf of a Dependent

5. When a client is a person's dependent, that person may claim payment of a benefit on behalf of the client if that person has paid for the service or product for the dependent.

Table 1. Claim Methods, Additional Documents Required and Pre-Approvals

Policy Section	Benefit	Claim Method	Additional Documents Required for Deferred Payment Claims	Note
Transportation				
14.a.	Flight co-payment	Deferred payment	Receipt*	
14.b.	Taxi fare in community	Deferred payment	Taxi receipt(s)*	
14.c.	Ground transportation at referral point	Deferred payment	Taxi, shuttle or transit receipt(s)*	Clients are to use transit when it is reasonable in the circumstances
14.d.	Interfacility ambulance transfer	Direct billing or deferred payment	Transfer receipt(s)*	
Meals & Accommodation				
15 and 16	Stay in private accommodation and associated meals	Deferred payment	-Billeting form -No meal receipts	
17 to 19	Meals and accommodation for a short-term stay in a hotel, motel or lodge in a Northern Area or a commercial accommodation outside a northern	Deferred payment	-Accommodation receipt(s) in client or client escort's name* -No meal receipts	
20.a., 20.b., 20.c., 21.b.i to 21.b.ii	Long-term care plan – stay outside of a private accommodation	Direct billing or deferred payment	-Accommodation receipt(s)* -No meal receipt(s)	
Prescription Drugs				
26.a, 33.a	Prescription drug – other than coverage of higher cost drug, retroactive diagnosis and exception prescription drugs	Direct billing if Nunavut pharmacy arranges it, deferred payment otherwise	-Receipt*	Prior approval according to paragraph 10 and 11 of this guideline is required for drugs listed as "limited use benefits" on the formulary.

Prescription Drugs (Continued)				
10	Prescription drug – coverage of higher cost drug under EHB	Deferred payment	-Receipt* -Copy of prescription with "no substitution mention"	Prior approval under section 10 of the Policy is required.
30	Prescription drug – retroactive diagnosis	Deferred payment	-Receipt* -Signed statement by medical practitioner or nurse practitioner including date established for the retroactive diagnosis	
26.b, 33.b	Exception prescription drugs	Direct billing if Nunavut pharmacy arranges it, deferred payment otherwise	-Receipt*	Prior approval according to paragraph 12 and 13 of this guideline is required for drugs listed as "limited use benefits" on the formulary.
Medical Supplies and Appliances				
26.c, 33.f	Medical Supply or Appliance – cost is less than $500 (excluding tax, shipping and fitting charges)	Direct billing if vendor arranges it, deferred payment otherwise	-Copy of prescription -Receipt*	
	Medical Supply or Appliance – cost is $500 or more (excluding tax, shipping and fitting charges)	Direct billing if vendor arranges it, deferred payment otherwise	-Receipt*	Prior approval under paragraphs 6 and 7 of this guideline is required.
Other Benefits				
33.c	In-community ambulance for seniors	Direct billing or deferred payment	-Receipt*	
33.d	Dental care	Deferred payment	-Receipt*	
33.e	Audiology services and products	Direct billing if vendor arranges it, deferred payment otherwise	-Receipt* -Copy of the prescription	
Other Benefits (Continued)				

33.g	Vision care	Deferred payment	-Receipt* -Certification by optometrist or ophthalmologist that tinting or coating of lenses is medically required (if applicable)	
26.d	Side effects coverage	Direct billing or deferred payment based on terms of pre-approval and vendor or Nunavut pharmacy's willingness to arrange direct billing	Listed in pre-approval terms and determined by the type of benefit being claimed	Prior approval under paragraphs 8 and 9 of this guideline is required.

* If a client does not have a third-party plan, original receipts need to be submitted.
If the client has a third-party plan, the client has to
(i) demonstrate or have demonstrated to the satisfaction of the Director of Medical Insurance that this amount is not eligible for coverage under the third-party plan, or
(ii) submit the slip issued by the third-party plan detailing the item or service, the total cost for it and the amount covered by the third-party plan instead of the original receipt. The Director of Medical Insurance may still request a copy of the original slip at a later time.

Pre-Approval for Medical Supplies and Appliances Benefit

6. When submitting a request for prior approval of a medical supply or appliance that costs $500 or more excluding taxes, fitting costs and shipping costs, the client must provide the Director of Medical Insurance with
    a. a filled-in request for prior approval form;
    b. a copy of the prescription; and
    c. quotes from three different vendors for the item.
7. Upon receiving a request for prior approval under paragraph 5 of this guideline, the Director of Medical Insurance will determine whether the medical supply or appliance meets the criteria specified under this Policy and issue a letter declining or confirming prior approval for one of the three quotes.

Pre-Approval for Side Effects Coverage

8. When submitting a request for prior approval of side effects coverage pursuant to section 26.d. of the Policy, the client must provide the Director of Medical Insurance with
    a. a statement signed by a medical practitioner, a nurse practitioner, a pharmacist, a physiotherapist or an occupational therapist documenting the side effects of the prescription drug described in section 26.a. or 26.b. or of

the medical supplies and appliances described in 26.c. that the client experiences; and,

b. as applicable,
    i. a letter from a dentist detailing the dental care needed to manage these side effects; or
    ii. a prescription for anything listed in sections 21.b.ii. to 21.b.v that is needed to manage these side effects.

9. Upon receiving a request for prior approval under paragraph 7 of this guideline, the Director of Medical Insurance will issue a letter
    a. declining prior approval; or
    b. confirming prior approval and the method and additional documents required to secure payment of the benefit.

Pre-Approval for a Prescription Drug listed as a Limited Use Benefit

10. Prior approval of a drug listed as a limited use benefit on the formulary requires that the client's prescribing medical practitioner or nurse practitioner submits the appropriate form to the Director of Medical Insurance.
11. Upon receiving a request for prior approval under paragraph 10 of this guideline, the Director of Medical Insurance will evaluate the request using the same criteria that Health Canada Non-Insured Health Benefits program uses to assess eligibility for coverage and
    a. request further information from the prescribing medical practitioner or nurse practitioner or the client to complete the eligibility assessment;
    b. issue a letter declining prior approval; or
    c. issue a letter confirming prior approval including any conditions that may be appropriate.

Pre-Approval for an Exception Prescription Drug

12. Prior approval of an exception prescription drug for a client requires that the client's prescribing medical practitioner or nurse practitioner submits the appropriate form to the Director of Medical Insurance.
13. Upon receiving a request for prior approval under paragraph 12 of this guideline, the Director of Medical Insurance will evaluate the request by taking into consideration the same criteria that Health Canada's Non-Insured Health Benefits program uses to assess eligibility for coverage and, on the recommendation of an advisory committee comprising at least one pharmacist and one medical practitioner,
    a. request further information from the prescribing medical practitioner or nurse practitioner or the client to complete the eligibility assessment;
    b. issue a letter declining prior approval for the client; or
    c. issue a letter confirming prior approval for the client including any appropriate conditions.

Return of Original Receipts

14. An original receipt that is submitted as part of a claim will be returned if the amount paid under this Policy does not cover the whole cost of the purchase shown on the receipt.

Nunavut Pharmacies – Prescription Drugs

1. Prescription drugs as limited use benefits on the formulary require prior approval through the process described in paragraphs 10 and 11 of guideline 2.
2. Exception prescription drugs require prior approval through the process described in paragraphs 12 and 13 of guideline 2.
3. To assist with direct billing, the Director of Medical Insurance will regularly provide Nunavut pharmacies with a list showing
    a. the names of clients eligible for drug benefits through the Seniors Stream;
    b. the name of clients eligible for drug benefits through the Specified Conditions Stream and the condition(s) for which each client is covered; and
    c. the coverage level provided under this Policy for the clients mentioned in paragraph 3. a. and 3. b. who participate in a third-party plan that covers prescription drugs;
    d. the limited use benefits drugs for which the clients mentioned in paragraph 3. a. and 3. b. have received prior approval;
    e. the exception prescription drugs for which the clients mentioned in paragraph 3.a. and 3. b. have received prior approval.
4. Nunavut pharmacies are to contact the Director of Medical Insurance's Office if they are uncertain about whether a client is eligible for coverage or if a drug is approved for a specific client.
5. Nunavut pharmacies assume responsibility for recovering the cost of prescription drugs dispensed to a client through direct billing if the client is ineligible for coverage or if a drug is not approved for a specific client.
6. Nunavut pharmacies have 30 calendar days from the day on which a drug is dispensed to a client under this Policy using the direct billing method to submit a claim to the Director of Medical Insurance that specifies
    a. the name, DIN, quantity and total cost of the drug dispensed;
    b. the share of the cost paid for by or billed to the client's third-party plan, if any;
    c. the share of the cost billed to the client for him or her to submit a claim to his or her third-party plan, if any;
    d. the client's name and Nunavut Health Care Plan number;
    e. the prescription number; and
    f. the prescriber's name and license number.

Vendors - Medical Supplies and Appliances & Audiology Services and Products

7. Vendors need to secure the approval of the Director of Medical Insurance to use direct billing before providing a service or product to a client and invoicing the Department of Health under this Policy for it.

8. If the Director of Medical Insurance has agreed to pay through direct billing for a product or service covered for a client under this Policy, the vendor can provide the said product or service to the client and then has 30 calendar days to submit a claim to the Director of Medical Insurance that specifies
    a. the particulars and total cost of the product or service;
    b. the share of the cost paid for by or billed to the client's third-party plan, if any;
    c. the share of the cost billed to the client for him or her to submit a claim to his or her third-party plan, if any;
    d. proof that the product or service was provided to the client;
    e. a copy of the prescription for the product or service; and
    f. the client's name and Nunavut Health Care Plan number.

DEPARTMENT OF HEALTH

Extended Health Benefits

User Consultation Report

February 26, 2016

Table of Contents

1. Introduction

The following report presents a summary of the Extended Health Benefits (EHB) consultations which took place between December 2015 and January 2016 as part of the Department's policy review process.

The consultations were conducted with current EHB clients through the medium of telephone interviews and the conduct of two focus groups, Iqaluit and Rankin Inlet, January 14 and January 25, 2016 respectively.

Results of both the consultations and phone interviews will serve to help shape the future direction of the EHB policy. Although a written report cannot convey participant energy, synergy, and their connection; the inclusion of direct quotes, should allow the reader to feel engaged and have a sense of the involvement that went into the consultations and subsequent report.

2. Background

The EHB policy last underwent a full policy review in 2008 and reached its sunset date on March 31, 2012. The Department of Health made a request to Cabinet for an extension and has since been provided four one-year extensions. The Department of Health placed the EHB policy as an urgent priority in its 2014/15 Business Plan and is ready for it to be submitted for Cabinet approval.

3. Information on the Extended Health Benefits Policy

The EHB program currently has 219 enrolees, who receive benefits under one of three streams.

The three EHB streams are as follows:

1) The Seniors Stream

Assists individuals aged 65 or more with:

- prescription drugs;
- dental and vision care;
- medical supplies and appliances (e.g. wheelchair, insulin pump);
- audiology services and products (e.g. hearing aids); and
- ambulance transportation.

2) The Specified Disease Conditions Stream

Currently assists individuals aged 65 or less and diagnosed with one of 42 conditions or a condition approved for special coverage. Clients receive benefits through payment of prescription drugs , medical supplies and appliances.

3) The Medical Travel Stream

Assists individuals who do not have third-party insurance or have exhausted the benefits provided by their third-party insurance (NIHB or private insurance through an employer, for example). Benefits include:

Benefit	Rate
Transportation	
Flight co-payment	$125 each way
Ground transportation at medical travel destination	Airport shuttle, taxi and bus at full fare
Ambulance transfer from health facility to another	Full cost
Accommodation and meals for short-term stays (90 days or less)	
Stay in commercial accommodation	1st night: Full cost of hotel room and $77.75 for meals Following nights: $20/night towards hotel and $20 for meals
Stay in private accommodation (with friends and family)	$50 per night for accommodation $20 per day for meals
Accommodation and meals for long-term stays (more than 90 days)	
Clients who will be on medical travel for an extended period of time – to receive cancer care, for example – are offered $70 per day to cover both meals and accommodation in a private or serviced apartment.	

Note: Someone who does not have an employer-sponsored plan may receive 100% of the benefits described above. Someone with an employer-sponsored plan receives the percentage amount not covered by their plan. For example, if a person's private plan covers 80% of an expense, EHB covers the remaining 20%.

The Seniors and Specified Disease Conditions Stream covers non-aboriginal clients only. Aboriginal clients receive benefits from Health Canada's Non-Insured Health Benefits program, which is completely distinct.

4. Consultation Process

4.1 Pre-Consultation

A consultation strategy was initially developed by the Department of Health's Policy Division and refined based on feedback from the Senior Executive Committee, Communications, as well as identified stakeholders within the Department of Health. Feedback and approval from these groups led to identifying the approach and format of both the telephone interview and focus groups.

4.2 Methodology

4.2.1 Audience

It was determined that the target audience for the EHB consultations would be current EHB clients. It was decided that this target group was the most informed and any changes made would have a direct impact on them. As enrolees of the EHB program comprise a small population, it was also determined that this group, as users of the policy, could provide accurate information, share their experience, and provide valuable insight to program strengths and weaknesses.

4.2.2 Consultation Type

Given the small number of EHB clients and the their location throughout the territory, is was determined that a combination of telephone interviews and two focus groups would be an effective and efficient method of obtaining feedback on the proposed changes to the EHB policy.

The communities of Iqaluit and Rankin Inlet were chosen for focus groups based on the number of EHB clients living in each community. The inclusion of telephone interviews provided the Department of Health with the opportunity to gain feedback and perspectives from across the territory and to reach a cross-section of communities and regions.

Focus groups took place on:

- January 14, 2016 – Iqaluit
- January 25, 2016 – Rankin Inlet

4.2.3 Sample

Three different sample lists of clients were used; one for the telephone interviews, one for the Iqaluit focus group, and one for the Rankin Inlet focus group. Any client contacted and who could not participate in the focus group in either Iqaluit or Rankin Inlet was provided an opportunity to participate in a phone interview.

The distribution which included contact information for EHB clients was obtained from the Health Insurance Office and kept in a password protected document.

Sample – Telephone Interviews

As the EHB program has three tiers the sample and sample size were selected accordingly:

- Seniors – 20 clients (10 clients who receive full EHB coverage and 10 clients who receive the balance not covered by their 3rd party insurance provider.

- Specified Disease Condition – 20 (10 clients who receive full EHB coverage and 10 clients who receive the balance not covered by their 3rd party insurance provider).
- Medical Travel – 10 clients

In total, the initial sample size included fifty clients; however, two clients who were originally contacted to participate in the focus group indicated that they could not meet in person and expressed interest in participating via telephone which increases the total to fifty-two participants.

Sample – Focus Groups

The distribution of EHB clients showed the highest number of clients to be located in Iqaluit and Rankin Inlet. In order to ensure the focus groups had enough participants it was decided to conduct the sessions in Iqaluit and Rankin Inlet.

An effort was made to include a balance of clients from the three EHB streams (seniors, specified disease condition, and medical travel) in each focus group.

4.2.4 Format

The telephone interviews and focus groups consulted on the same material however differed in terms of format:

Format – Telephone Interviews

To ensure that clients had the necessary information prior to providing their thoughts and opinions, an introduction to the EHB policy was provided which included an overview of the three EHB streams as well as providing the client an opportunity to ask any questions. Once the client indicated they were ready to continue on with the interview questions, the interviewer proceeded to introduce each topic one by one, first starting with information on the current policy, and then following with the proposed changes.

Format – Focus Groups

After a client confirmed their attendance to either focus group, an email was sent to the client detailing necessary information such as date of the group, time, and location. Also included in the email was an information sheet which provided an overview of the EHB program, and a link to the EHB page on the Department of Health website. Because clients are typically enrolled in one stream of the program, an information sheet was provided to inform them of the other streams, so as to offer some background information and also context.

At the beginning of the focus group, an introduction with an overview of the program was presented and clients had the opportunity to ask questions to ensure they had a good understanding.

The format and organization of the focus group was arranged as follows:

- The facilitator introduced each proposed change to the policy one by one, first starting with a general overview of how the program is currently administered and then moving into a discussion about the changes.
- Clients were provided with the opportunity to ask questions throughout the focus group if they did not understand a concept.
- Discussion was encouraged by asking open ended questions, such as:
    - What are your thoughts on this proposed change?
    - How would this change impact your life?
    - What are some things that you think should be considered?

Each focus group had a note taker who transcribed answers onto a laptop as clients were speaking.

At the beginning of the focus group, clients were provided with an anonymous feedback form where they could indicate any thoughts they had about EHB but were not comfortable to share with the group.

After the focus group, clients in attendance received an email which included another feedback form asking them for any insights or reflections after a few days had passed.

4.2.5 Data Collection

Data Collection – Telephone Interviews

Telephone interview responses were collected and entered into a password protected excel worksheet. Additionally, the responses to open-ended questions were transcribed into a word document. For privacy reasons, personal information pertaining to the client was not included in these documents.

Data Collection – Focus Groups

At both focus groups, a note taker was present and transcribed the discussions that took place into a word document. Client names were not included in these documents except for two instances where clients expressed that they would like their names on the record.

4.2.6 Question Design

Question Design for Telephone Interviews

The questions that were formulated for the telephone interviews were initially based on a Likert scale so as to code answers in an efficient and streamlined way. For example, a client would be asked to rate their approval or disapproval of a proposed change on a scale from 1 to 5 (1 meaning that they strongly disapproved/disagreed, 5 meaning that they strongly approved/agreed).

The use of a Likert scale was advantageous in the sense that it streamlined the answers that were provided and in theory was supposed to cut down on the interview's length which was a concern for some clients.

The drawback to the use of the Likert scale was that it was too complicated to understand for many clients. Interviewers found that clients would ask to have the question repeated several times, and there was some confusion over what the different values meant. Because clients found it easier to respond to open ended questions, the questions were changed to accommodate for that preference, a practice known as emergent design.

Before moving on to the next topic or question, the client was asked if they would like to share any comments or feedback. These comments were transcribed into a word document as the client spoke.

Question Design for Focus Groups

Questions asked of the focus group were kept as open as possible to allow for as many perspectives as possible to emerge. Please see the "Format – Focus Groups" section for further details.

4.2.7 Summary of Telephone Calls Made

Table 1: Summary of Calls Made for Telephone Interviews

Outcome	Total
Completed interviews	12
Not in service/wrong number	10
Answering Machine*	10
Declined the interview	7
Opted to participate in focus group	6***
No Answer**	5
Moved	2
Total Sample Size	**52**
Total EHB Clients	**219**
* Clients with answering machines were telephoned twice on different days. On the second telephone call, a message was left with information and a call back number.	
** Some clients did not have answering machines. These clients were called twice on different days, but no contact was unsuccessful.	
*** Six clients on the Telephone Interview Call List were also repeated on the Focus Group Call List and opted to attend one of the focus groups. Between Iqaluit and Rankin Inlet, sixteen clients confirmed attendance at one of the focus groups, in total 10 clients attended the focus groups (four in Iqaluit, six in Rankin Inlet).	

Table 2: Summary of Client's Locations for Telephone Interviews

Location	Total Telephone Interviews Conducted
Arviat	1
Baker Lake	1
Cambridge Bay	2
Igloolik	1
Iqaluit	5
Pangnirtung	1
Rankin Inlet	1
Total Telephone Interviews	**12**

Table 3: Summary of Focus Group Calls Made for Iqaluit and Rankin Inlet

	Iqaluit (January 14th, 2016)	Rankin (January 25th, 2016)
Total clients contacted*	22	29
Total Opted to participate in telephone interview instead of focus group	1	1
Total confirmed	9	7
Total calls made**	36	44
Total in attendance	**4**	**6**
*Clients were called at random.		
**Several attempts were made to initiate contact if the client could not be reached at the telephone number provided. If an answering machine was available, a message was left on the second or third attempt.		

5. Topics Consulted On

5.1 Side Effects Coverage

Current Policy

As of now, the EHB policy states that clients registered in the Specified Disease Condition Stream are covered only for the drugs associated with the specified disease condition for which they are registered. The policy is mute on what happens when a client needs a secondary medication that is not typically linked to the specified disease condition in order to manage the side effects of the covered drug initially prescribed. For example, cancer medication often causes nausea. To counter this, doctors often prescribe anti-nausea medication, which is not always linked to cancer specifically.

Proposed Change

Clients in the focus groups were asked about their thoughts on including side effects coverage in the new policy.

This topic was not discussed in the telephone interviews in order to shorten the length of the interview (in the interest of client engagement and interest). As well, the Department believes this is the least contentious issue and a decision was made to leave it out of the telephone interviews so that there would be enough time to discuss the more sensitive topics.

5.2 Top-Up Coverage

Current Policy

Currently, if a client has third-party insurance plan that covers a certain percentage of medical benefits, the client can bill the remainder of the cost to the Extended Health Benefits program. For example, the insurance plans provided by many employers – such as the GN and the federal government – cover 80% of the cost of prescription drugs. As of now, a person with this kind of coverage can bill the other 20% to the Extended Health Benefits program.

The average income for people who access top-up coverage is $107,000. The median income is $113,206.

Proposed Change

The proposed change is to remove top-up coverage and redistribute the budget to cover increases to medical travel benefits stream.

To provide support to clients with exorbitant costs, a catastrophic drug coverage clause would be added to the policy so that patients who have had to pay an out of pocket total of $3,000 or more for drugs would be covered once this amount was expended.

At the first focus group, catastrophic drug coverage had not been a proposed model that was consulted on. After expressed concern at the first focus group, the clause was added to the proposal and consultations on this topic ensued.

Clients in both the telephone interviews and the focus groups were asked for their opinions on the removal of top-up coverage and redistributing the budget towards medical travel benefits.

5.3 Medical Travel

To discuss Medical Travel benefits, current funding levels and proposed changes were explained to clients over the phone or shown in person at the focus groups. Clients were then asked to provide feedback on the proposed funding changes.

Definitions:

- **Commercial accommodation** – Hotel, motel, lodge, apartment, serviced suite, or a place rented through an offline or online rental agency. Excludes private accommodation.
- **Private accommodation** – means any accommodation that:
  - is owned or rented on a usual basis by a client's relative or friend; and
  - is not co-rented or co-owned by the client or the client's spouse or common-law partner.

Table 3: Current & Proposed Commercial Accommodation Benefits – South

	Current		Proposed
	Night #1	Subsequent Nights	No difference between 1st and subsequent days
Accommodation	Full cost	$20	$100
Meals	$77.75	$20	$50

Table 4: Current & Proposed Commercial Accommodation Benefits – North

	Current		Proposed
	Night #1	Subsequent Nights	No difference between 1st and subsequent days
Accommodation	Full cost	$20	Full cost
Meals	$77.75	$20	$50

* This topic was discussed in the focus groups only in an interest of keeping the telephone interviews short to keep client engagement and attention.

Table 4: Current & Proposed Long-Term Medical Travel Benefits

	Current	Proposed
Accommodation	$50	$60
Meals	$20	$20

Table 5: Current & Proposed Private Accommodation Benefits – South

	Current	Proposed
Accommodation	$50	$50
Meals	$20	$0

*This topic was discussed in the Rankin Inlet focus group only as the change was proposed after the first focus group was held in Iqaluit. The proposed change is so that the EHB policy is in line with Non-Insured Health Benefits (NIHB).

Private Accommodation – North

	Current	Proposed
Accommodation	$50	$50
Meals	$20	$50

*This topic was discussed in the focus groups only in an interest of keeping the telephone interviews short to keep client engagement and attention.

5.4 Communication

In addition to consulting on the proposed changes to the EHB policy, the Department of Health was also interested in obtaining feedback regarding the communication and dissemination of information to the public.

Communication Questions – Telephone Interviews

In the telephone Interviews, clients were asked three questions regarding communication:

- "Do you feel you have enough information about the health insurance benefits provided by the Department of Health?"
- "Do you feel that other people have enough information about the health insurance benefits provided by the Department of Health?"
- "In your view, what can the Department of Health do to help Nunavummiut better understand their benefits?"

Communication Questions – Focus Groups

In the focus groups, clients were asked for their feedback on several topics relating to communication such as:

- Information about the EHB program on the Department's website:
  - "Is the website easy to access?"
  - "Is the content informative?"
  - "What are your suggestions for improvement?"
- Best methods of sharing information:
  - "In your view, what can the Department of Health do to help Nunavummiut better understand their benefits?"
- Customer service:
  - "What have your interactions with the EHB program been like?"

6. Feedback

6.1 Feedback on Side Effects Coverage

Proposed Changes to Side Effects Coverage

Include Side Effects Coverage in the new EHB policy.

Responses from Focus Groups

Overwhelmingly, client responses indicated that side effects coverage should be included in the revised policy to not only ensure clarity to clients and healthcare service providers, but also to ensure clients receive all the drugs rendered necessary by their specified disease condition be it directly or indirectly.

In one client's view:

> ***"I think it should be covered. If a doctor has prescribed it, it should be covered period. It's not like Advil, it is a medication that can have an impact on your health and wellbeing."*** *– Focus Group Participant*

A client highlighted that in some cases, it is not drugs that are needed to manage side effects but other types of medical services:

"I lost most of my teeth on morphine because it dissolves teeth. I wanted to see if my teeth would be covered but I was told it would be faster to wait until I am 65 years old to qualify for dental coverage as a senior." *– Focus Group Participant*

6.2 Feedback on Top-Up Coverage

Proposed Changes to Top-Up Coverage

Remove Top-Up Coverage and redistribute budget to increase medical benefits. Note: after concerns were raised in the first focus group in Iqaluit, a catastrophic drug clause was added to the proposed changes and consulted on with clients at the second focus group in Rankin Inlet.

Responses from Telephone Interviews

- When asked about whether or not the client supports the removal of top-up coverage:
  - 5 out of 12 clients indicated that they disagree with the change;
  - 4 out of 12 clients indicated that they agree with the change; and
  - 3 out of 12 clients indicated that they do not know.
- Comments from the telephone interviews include:

"Because the process takes too long and it takes forever to get reimbursed, I don't even bother with billing you guys for 20%. It's a waste of my time." *– Telephone Interview Participant*

And:

"Top-up and medical travel are two different things. You can't take from one and give to the other so simply." *– Telephone Interview Participant*

Responses from Focus Groups

Feedback from clients in the focus groups on the removal of top-up coverage took on two different themes. Some clients did not have an issue with the removal, while others did.

Arguments in Support of the Removal of Top-Up Coverage:

One group did not want to pay more for their medications, but agreed that they would support the removal of top-up coverage if there were a financial need for redistribution:

"It's a tough question, who is going to benefit from this? A person may be better off getting top-up coverage if the cost of their medication is really high. But we are also independent people and have to take care of ourselves too." *– Focus Group Participant*

And:

"Top-Up doesn't affect me because I don't have any other form of insurance, so for me if it means I get better medical travel benefits then I would agree with removing it." *– Focus Group Participant*

Arguments Against the Removal of Top Up Coverage:

Cost of Medication

Some clients in the first focus group indicated that the cost of the medication will make a substantial difference in terms of affordability if top-up coverage was removed which prompted the Department to consult on catastrophic drug coverage at the second focus group:

> ***"My annual bill for medications is $32,000. Without top-up coverage I would not be able to afford my medications."*** *– Focus Group Participant*

And:

> ***"If medication costs are kept low people will take what they need instead of putting it off. If you put off taking your medication you will cost the health care system even more because you are more ill than before and need to go to the emergency room often."***
> *– Focus Group Participant*

Single Income Families

A few clients who attended the focus groups raised the point that there are some individuals who support their families on a single income. One client in particular commented:

> ***"It's true—I do earn approximately 100K a year, but I'm the sole provider for an entire family. It would be very hard to have to pay for my medications and support my family."***
> *– Focus Group Participant*

Fixed Incomes

A client was very worried that as they approached retirement they would not be able to afford their medications because they will soon be on a fixed income. They indicated that they had not planned for an increased contribution.

> ***"I have been paying for health care plans my whole life and now that I am about to retire you are saying that I might have to start paying a $3,000 deductible? I did not plan for this."*** *– Focus Group Participant*

"Is the program in jeopardy?"

One client asked if the program was in financial jeopardy during the discussion about redistributing the budget:

> ***"Is the program in jeopardy? If you want to remove top-up, is it because you don't have the funds to increase medical travel benefits. It's like taking from Pete's pocket and putting it in Tom's."*** *– Focus Group Participant*

6.3 Feedback on Medical Travel Benefits

Proposed Changes to Commercial Accommodation in the South

	Current		Proposed
	Night #1	Subsequent Nights	No difference between 1st and subsequent days
Accommodation	Full cost	$20	$100
Meals	$77.75	$20	$50

Responses from Telephone Interviews

- Clients were asked about whether they agreed with the proposed funding changes to commercial accommodation in the south:
  - 6 out of 12 clients indicated that they disagreed with the proposed changes;
  - 5 out of 12 clients indicated that they agreed with the proposed changes; and
  - 1 out of 12 clients indicated that they did not know.
- Many clients commented that $100.00 per night for accommodation down south would not be sufficient to cover the cost of a "safe" and "quality" hotel close to the hospital which in their view would cost more.

Responses from Focus Groups

Some concerns from the focus groups included:

> ***"Hotel rates fluctuate online and it makes you think about the uncertainty in price. Even time of season and time of year there are more people, which affects the rate you'll be able to get."*** *– Focus Group Participant*
>
> ***"The number should be more like $150 a night for accommodations. Southway costs $139 plus $15 taxes a night which is for a mid-range hotel, this is more reasonable."****—Focus Group Participant*
>
> ***"I would absolutely not want to see someone stay at an unsafe or unsanitary place because there is no hotel at $100 or less per night."****—Focus Group Participant*
>
> Contrary to the last point:
>
> ***"$100 might not cover everything but this is reasonable assistance and it is certainly way better than $20 per night."****—Focus Group Participant*

Proposed Changes to Commercial Accommodation in the North

	Current		Proposed
	Night #1	Subsequent Nights	No difference between 1st and subsequent days
Accommodation	Full cost	$20	Full cost
Meals	$77.75	$20	$50

* This topic was discussed in the focus groups only in an interest of keeping the telephone interviews short to keep client engagement and attention.

Responses from Focus Groups

Clients were glad to hear that the proposed changes would cover the cost of accommodation in the north at full cost, but there were some opinions on the proposed funding for meals:

"It's very expensive to eat in the North – I think $75 a day for meals is more reasonable."

Proposed Changes to Long-Term Medical Travel

	Current	Proposed
Accommodation	$50	$60
Meals	$20	$20

Responses from Telephone Interviews

- Clients were asked about whether they agreed with the proposed funding changes for long-term medical travel:
  - 1 out of 12 clients did not agree with the proposed changes; and
  - 8 out of 12 clients agreed with the proposed changes;
  - 3 out of 12 clients did not know.

Responses from Focus Groups

Discussion in the focus groups regarding long-term medical travel centered on the question of what is currently considered to be a fair market rate for a furnished apartment down south, and whether the proposed changes would be able to cover that cost including meals. Clients suggested that market research should be done to determine what the costs would be on average.

Some clients indicated that the proposed change would be sufficient, as renting an apartment would be cheaper than staying at a hotel long term.

Proposed Changes to Private Accommodation in the South

	Current	Proposed
Accommodation	$50	$50
Meals	$20	$0

Response from Focus Group

Clients at the focus group indicated that they would like to receive some benefit towards meals with the proposed change.

Proposed Changes to Private Accommodation in the North

	Current	Proposed
Accommodation	$50	$50
Meals	$20	$50

Response from Focus Groups

Clients indicated that they were content with the proposed change to private accommodation in the north.

6.4 Feedback on Communication

During the telephone interviews and focus groups, clients were asked about their experiences and interactions with the Department of Health regarding health insurance.

Responses from Telephone Interviews

Clients were asked, "Do you feel you have enough information about the health insurance benefits provided by the Department of Health?":

- 5 out of 12 clients indicated that they do have sufficient knowledge; and
- 7 out of 12 clients indicated that they do not have sufficient knowledge.

Clients were asked, "Do you feel that other people have enough information about the health insurance benefits provided by the Department of Health?":

- 2 out of 12 clients indicated that they thought others were knowledgeable;
- 8 out of 12 clients indicated that they do not think others are knowledgeable about health insurance benefits; and
- 2 out of 12 people did not know.

Clients were also asked "In your view, what can the Department of Health do to help Nunavummiut better understand their benefits?" Some responses included:

- ***"The department can give as much info as they want but if it's not in a format that is simple and easy to understand then no one is going to retain it or know what to do."***
- ***"There isn't enough information at the hospital."***
- ***"I was sent a pamphlet in the mail, it was helpful."***
- ***"Send a letter to clients providing a detailed explanation of their benefits. For the longest time I didn't even know that I was covered for prescription drugs."***
- ***"I had issues with getting in touch with someone in Rankin Inlet, a brochure with who is best to contact for specific issues would be helpful."***
- ***"There should be radio clips that people can listen to and get information on. Just something simple that will alert people to look into their benefits."***
- ***"I've only been told information through word of mouth and there is a lot of misinformation out there."***
- ***"Maybe provide a pamphlet when people get their health card renewed."***

Responses from Focus Groups

Clients were asked for their feedback on several topics relating to communication:

- Information about the EHB program on the Department's website;
- Best methods of sharing information; and
- Customer service.

Website

Clients were in agreement that the website is simple and accessible. However, some clients pointed out that they would like to see more in-depth information regarding different topics related to EHB, such as medical travel, what to do if something goes wrong, and a more detailed complaints process.

A comment to consider from a client regarding the website is:

> ***"This is the issue, this is the first time I have found the website and looked at it. I did not actually know there was a website to begin with. I had to call and email around until I got***

the information I needed and they asked me to fax my forms in. We are getting passed the time of fax machines. People can scan and email and it is much quicker."

Sharing Information

Each focus group unanimously agreed that more could be done to provide Nunavummiut with information about their health care benefits—utilizing a wider range of communication styles. Some ideas discussed included:

- Posters at pharmacies;
- Pamphlets mailed out when a person is about to become a senior;
- Pamphlets mailed out every two years when the Nunavut Health Care Card gets renewed;
- Pamphlets stocked at Health Centres in all official languages;
- A document that describes the policy in simple terms;
- Better trained employees at the Health Insurance Office (clients indicated that their phone calls and emails have been ignored);
- Clearer direction from the Department of Finance to GN employees regarding their employee benefits and how these benefits interact with third party insurance, and the health insurance benefits provided by the Department of Health;
- Training for doctors and Health Centre staff on health insurance programs and options; and
- Clear instructions on the application process for the program that details how to send receipts, what format, who to call, etc.

Customer Service

Regarding customer service, clients in the focus groups had to say the following things:

> ***"My husband had a surprise heart attack in the Spring and the health professionals were wonderful. The benefits all fell into place and I was quite impressed by how everyone rallied around to make things happen for us. Now the everyday stuff with receipts and forms and so on is such a pain the ass that I'd rather put the $500 on the table and get it done. I can't stand all of the paperwork and receipts and all. Before, I didn't have to fill out forms every single time – it was just once for the condition. Now it seems like I have to fill forms every time I go down."*** *– Focus Group Participant*

Additionally:

> ***"On record, Jacqueline Greene and some of the nurses here are phenomenal. The doctors are great, they go through the EHB form and I have nothing but wonderful comments for them."*** *– Focus Group Participant*

Regarding the coordination of different benefits one client mentioned:

> ***"Here is the reality: we are told there are different programs for different people – government employees, non-governmental employees, the spouses thereof, Inuit, non-Inuit. No wonder why we are all confused with what all our benefits are. You need someone who is properly trained, who knows what they are talking about, and can provide specific answers."*** *-- Focus Group Participant*

One client candidly shared:

> ***"I was treated like a beggar when I went into that health benefits office and I never want to go there again. I'd prefer to pay for my medical expenses myself to not have to go through that experience. I'm not trying to get money for beer and chips; it is for real medical expenses. It hurts a lot to be treated like that…I hate getting treated like I am trying to steal or squeeze money. They don't try to help you. I pay taxes, it's not like it's a free service…It's like they try to find any way to deny me of benefits I'm entitled to."***
> *– Focus Group Participant*

Another client had issues to share about the process for being approved:

> ***"For me to fill out the application properly, I needed three trips – I took it from the Regional Services Office, took it to the nurse on an appointment that I could only get two weeks down the road. The nurse said a doctor has to fill that out, and for that you need a nurse's referral so I had to wait another two weeks. This was all for a chronic condition that I was already approved for last year."*** *– Focus Group Participant*

One client wanted to share their experience with trying to obtain information:

> ***"Personally I need to talk to someone to get information. I don't want to look through fine print of an insurance certificate. I want to talk to someone knowledgeable. I've called them many times before and my phone calls and emails were ignored. Right now the more questions I ask the more I get pushed away. I need to talk to someone independent and impartial who isn't in charge of approving or denying my benefits, someone who is there to just provide me with the correct information."*** *— Focus Group Participant*

One client wanted to share their issues as a GN employee trying to obtain information regarding their employee benefits:

> ***"As a GN employee I've been given the wrong information about the health insurance I get through work and the employee benefits available through the GN. I've contacted my compensation and benefits officer three times to get information but I've been given different answers every single time. At this point I don't know what information is correct and who to even contact."*** *— Focus Group Participant*

7. Summary of Feedback

Between the telephone interviews and the focus groups several common themes emerged regarding how EHB clients felt about the program.

7.1 Including Side Effects Coverage

Clients unanimously agreed on the inclusion of side effects coverage in the new EHB policy.

7.2 Removal of Top-Up Coverage

A few clients approved of removing top-up coverage for the following reason:

- If the cost of the medication is not too high then clients need to take responsibility for the portion of the cost not covered by their third party insurance provider.

Many clients disapproved of removing top-up coverage for the following reasons:

- High medication costs;
- Single income families may not be in a position to afford their medications;
- Seniors on fixed incomes may have unpredictable medication costs; and
- If the program is not in jeopardy, there may not be a justification for removing top-up coverage.

7.3 Medical Travel

Commercial Accommodation in the South:

- Majority of clients indicated that they did not believe $100/night for accommodation was sufficient.
- Contrary to that position, some clients indicated that $100/night for accommodation is reasonable as it is an improvement from the current funding level.

Commercial Accommodation in the North:

- For the most part clients were in favor of the proposed change, but indicated that $50/day to cover meals in the north may not be enough.

Long-Term Medical Travel:

- Several clients indicated that they do not know if the proposed change is fair as they do not know on average how much the cost of living is down south.
- Some clients indicated that the change seems reasonable because renting an apartment would be cheaper than a hotel.

Private Accommodation in the South:

- Clients expressed that they would have liked the proposed change to include an allotment for meals.

Private Accommodation in the North:

- Clients indicated that they were content with the proposed change.

7.4 Communication

Website:

- Clients indicated that the EHB page on the Department of Health website is simple and easy to navigate.
- Clients expressed that they would like to see more in-depth information in specific topics pertaining to the EHB program and policy.

Sharing Information:

- Clients unanimously agreed that more could be done to provide Nunavummiut with information about their health care benefits—utilizing a wider range of communication styles. Some ideas discussed included:
    - Posters and pamphlets in all official languages at pharmacies and Health Centres;
    - A mail out of pamphlets when an individual renews their Nunavut Health Care Card or is about to become a senior;
    - Better direction from the Department of Finance to clients who are GN employees on how to coordinate the different types of health benefits they receive.

        - § For example, GN employees have third party insurance plans, could also be on NIHB and/or EHB, and have GN employee benefits as well.
    - o A pamphlet that describes the policy in simple terms;
    - o Better trained employees at the Health Insurance Office and Health Centres; and
    - o Clear instructions on the application process for the program that details how to send receipts, what format, who to call, etc.

Customer Service:

- A few clients expressed great satisfaction with the health care professionals they have encountered at the Health Centres.
- Other clients expressed dissatisfaction with the service they had received from the Health Insurance Office.

8. Conclusion

As the previous sections illustrate, clients reached consensus on some topics and disagreed on others. However, all could agree that each client interacts with the program differently depending on their unique circumstances.

One key finding from the consultations is that regardless of clients' different circumstances and needs, they voiced concerns that communication and customer service to clients and potential clients needs to be improved for all streams of the program. With improved communication and customer service, clients felt that they would feel more secure and less anxious about trying to access reliable information about their benefits.

Many clients who were interviewed over the phone or attended the focus groups were satisfied that the consultations on the proposed policy were meaningful and comprehensive. Most clients who participated felt they were heard. Many wanted similar engagement with the public to continue in the future.