Non-Insured Health Benefits Program

First Nations and Inuit Health Branch

Annual Report 2014/2015

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Introduction

SECTION 1

During 2014/15, the Non-Insured Health Benefits (NIHB) Program of the First Nations and Inuit Health Branch (FNIHB) at Health Canada provided 824,033 registered First Nations and Inuit clients with access to a limited range of medically necessary health-related goods and services not otherwise provided through private insurance plans, provincial/territorial health or social programs.

The NIHB Program is administered nationally and covers the following medically necessary benefits:

- Prescription and over-the-counter drugs;
- Medical supplies and equipment;
- Dental care;
- Vision care;
- Short-term crisis intervention mental health counselling; and
- Medical transportation to access medically required health services not available on reserve or in the community of residence.

Through the coverage of these benefits, Health Canada supports First Nations and Inuit in reaching an overall health status that is comparable with other Canadians.

The NIHB Program operates according to the following guiding principles:

- All registered First Nations and recognized Inuit normally resident of Canada, and not otherwise covered under a separate agreement with federal or provincial governments or through a separate self-government agreement, are eligible for non-insured health benefits, regardless of location in Canada or income level;
- Benefits will be provided based on professional, medical or dental judgment, consistent with the best practices of health services delivery and evidence-based standards of care;
- There will be national consistency with respect to mandatory benefits, equitable access and portability of benefits and services;
- The Program will be managed in a sustainable and cost-effective manner;
- Management processes will involve transparency and joint review structures, whenever jointly agreed to with First Nations and Inuit organizations; and
- When an NIHB-eligible client is also covered by another public or private health care plan, claims must be submitted to the client's other health care/benefits plan first. NIHB will then coordinate payment with the other payor on eligible benefits.

Now in its twenty-first edition, the 2014/15 NIHB Annual Report provides national and regional data on the NIHB Program client population, expenditures, benefit types and benefit utilization. This Report is published in accordance with the NIHB Program's performance management responsibilities and is intended for the following target audiences:

- First Nations and Inuit organizations and governments at community, regional and national levels;
- Regional and Headquarters managers and staff of Health Canada; and
- Others in government and in non-government organizations with an interest in the provision of health services to First Nations and Inuit communities.

British Columbia Tripartite Agreement

SECTION 1.1

The British Columbia Tripartite Framework Agreement on First Nation Health Governance was signed by Canada, the First Nations Health Council (FNHC) and the British Columbia Ministry of Health on October 13, 2011. A key commitment made in the *Framework Agreement* is the transfer of Federal Health Programs, including Non-Insured Health Benefits (NIHB), from Canada to the First Nations Health Authority (FNHA).

Between July 2nd, 2013 and October 1st, 2013, the FNHA assumed responsibility for the design, planning, management and delivery of the Non-Insured Health Benefits Program to First Nations clients residing in the British Columbia Region. As a transitional measure, Health Canada has continued to provide claims processing and certain adjudication services for the Pharmacy, Dental and MS&E benefits to First Nations clients in British Columbia on behalf of the FNHA. This arrangement will be in place for a term of up to four years.

It is important to both parties that service delivery to clients be seamless during this time of transition. To support that shared goal, Health Canada and the FNHA have been working to facilitate a smooth transfer of responsibilities between the parties and to continue preparing for the full transfer of the NIHB Program in British Columbia following the conclusion of this transition period.

Furthermore, over the course of 2014/15, the NIHB program and the FNHA continued to establish ways of working together into the future, in support of ongoing capacity building and as part of the new partnership.

Health Canada has established and implemented measures so that Inuit, and First Nations who are in British Columbia temporarily, will continue to have access to the whole suite of existing NIHB benefits.

Client Population

SECTION 2

Over the last ten years, the NIHB client population has grown at an average annual rate of 1.0%. As of March 31, 2015, there were 824,033 First Nations and Inuit clients registered in the Status Verification System (SVS) and were eligible to receive benefits under the NIHB Program. The NIHB client population decreased significantly in 2013/14 as a result of the creation of the First Nations Health Authority (FNHA). In a phased approach, between July and October 2013, the FNHA assumed the programs, services, and responsibilities formerly delivered by Health Canada's First Nations and Inuit Health Branch (FNIHB) to First Nation clients residing in British Columbia. Of the 824,033 total eligible clients at the end of the 2014/15 fiscal year, 779,300 (94.6%) were First Nations clients while 44,733 (5.4%) were Inuit clients.

Historically, the First Nations and Inuit population has a higher growth rate than the Canadian population as a whole. This is primarily because First Nations and Inuit have a higher birth rate compared to the overall Canadian population. In addition, amendments to the *Indian Act*, such as the passage of *An Act to amend the Indian Act* (Bill C-31), the *Gender Equity in Indian Registration Act* (Bill C-3), and the creation of the Qalipu Mi'kmaq Band, have and will continue to result in greater numbers of individuals being able to claim or restore their status as registered Indians.

To become eligible under the Program, an individual must be a resident of Canada and have the following status:

- A registered Indian according to the *Indian Act*; or
- An Inuk recognized by one of the Inuit Land Claim organizations; or
- An infant less than one year of age, whose parent is an eligible client; and
- Currently registered, or eligible for registration, under a provincial or territorial health insurance plan; and
- Is not otherwise covered under a separate agreement (e.g., a self-government agreement) with federal, provincial or territorial governments.

When clients are eligible for benefits under a private health care plan or a public health or social program, claims must be submitted to those plans and programs first before submitting them to the NIHB Program.

The passage of Bill C-3, the *Gender Equity in Indian Registration Act*, which came into force on January 31, 2011, has given eligible grandchildren of women who lost status as a result of marrying non-Indian men, entitlement to become registered as an Indian in accordance with the *Indian Act*. Once registered under the *Indian Act*, these individuals will be eligible to receive benefits through the NIHB Program. As of March 31, 2015, a total of 27,308 clients had become eligible to receive benefits through the NIHB Program as a result of this legislation.

The creation of the new Qalipu Mi'kmaq First Nations band was announced on September 26, 2011 as a result of a settlement agreement that was negotiated between the Government of Canada and the Federation of Newfoundland Indians (FNI). Through the formation of this band, members of the Qalipu Mi'kmaq became recognized under the *Indian Act* and eligible for registration. As of March 31, 2015, a total of 24,017 Qalipu clients were registered in the SVS and were eligible to receive benefits through the NIHB Program.

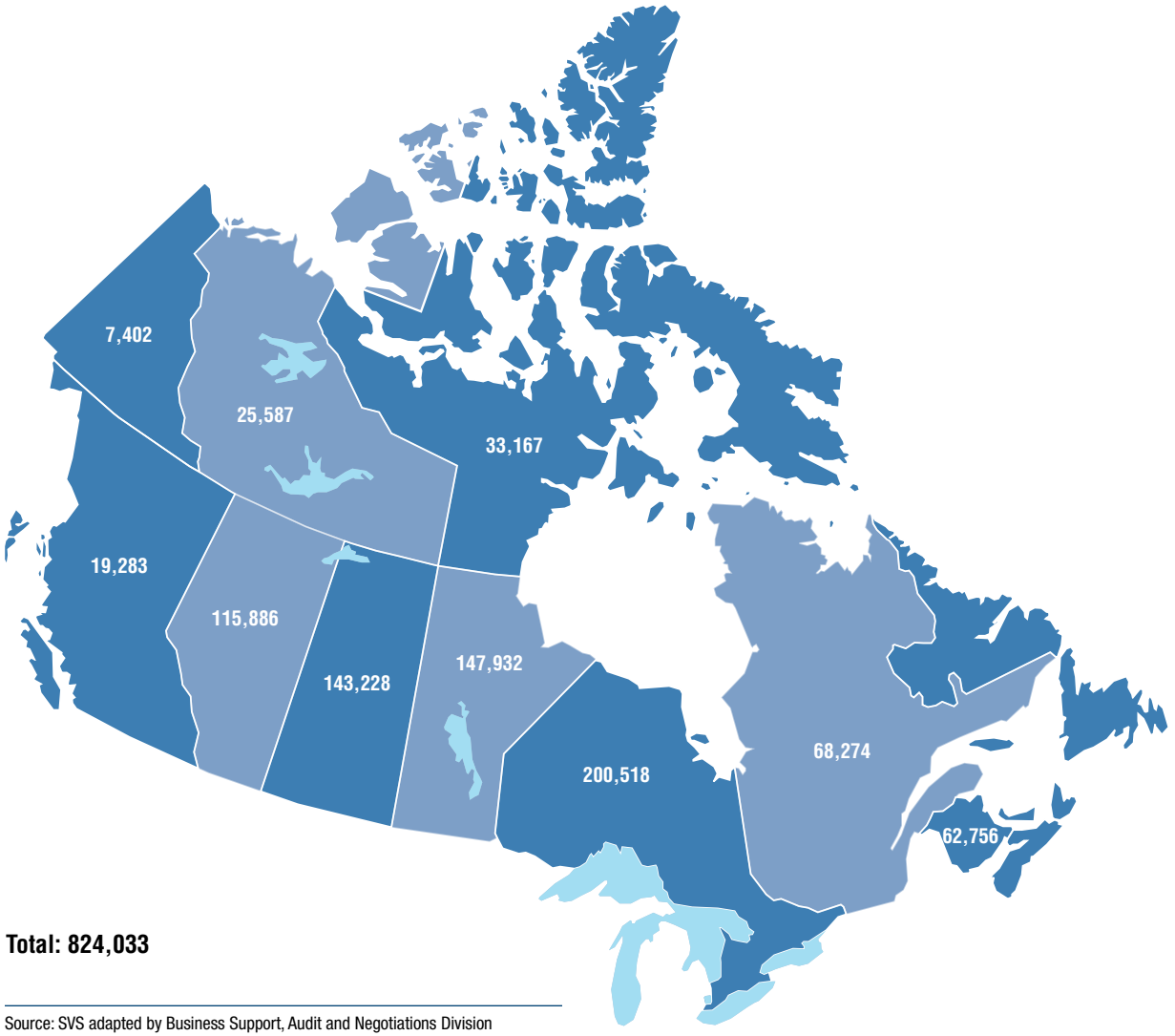
FIGURE 2.1

Eligible Client Population by Region
March 2015

NIHB Program client eligibility information is provided by the Status Verification System (SVS). The total number of eligible clients on the SVS at the end of March 2015 was 824,033, an increase of 1.9% from March 2014.

The Ontario Region had the largest proportion of eligible population, representing 24.3% of the national total, followed by the Manitoba Region at 18.0% and the Saskatchewan Region at 17.4%.

Note that Figure 2.1 lists population values based on region of band registration, which is not necessarily region of residence. The majority of B.C. clients previously covered by the NIHB Program are currently covered by the B.C. First Nation Health Authority (FNHA) and are not represented in this chart. The remaining B.C population are clients associated with B.C. bands, but residing in other provinces and territories of Canada.



Total: 824,033

Source: SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 2.2

Eligible Client Population by Type and Region
March 2014 and March 2015

Of the 824,033 total eligible clients at the end of the 2014/15 fiscal year, 779,300 (94.6%) were First Nations clients while 44,733 (5.4%) were Inuit clients. The number of First Nations clients increased by 1.9% and the number of Inuit clients increased by 2.4%

From March 2014 to March 2015, Yukon had the highest percentage change in total eligible clients with a 3.7% increase, followed by Manitoba and Nunavut each with an increase of 2.4%.

REGION	First Nations		Inuit		TOTAL		% Change
	March 2014	March 2015	March 2014	March 2015	March 2014	March 2015	2014 to 2015
Atlantic	61,694	62,418	321	338	62,015	62,756	1.2%
Quebec	65,583	66,965	1,236	1,309	66,819	68,274	2.2%
Ontario	196,444	199,837	648	681	197,092	200,518	1.7%
Manitoba	144,232	147,739	184	193	144,416	147,932	2.4%
Saskatchewan	140,103	143,163	61	65	140,164	143,228	2.2%
Alberta	113,046	115,299	544	587	113,590	115,886	2.0%
British Columbia	19,348	18,964	280	319	19,628	19,283	-1.8%
Yukon	7,042	7,303	96	99	7,138	7,402	3.7%
N.W.T.	17,517	17,612	7,917	7,975	25,434	25,587	0.6%
Nunavut	0	0	32,390	33,167	32,390	33,167	2.4%
National	**765,009**	**779,300**	**43,677**	**44,733**	**808,686**	**824,033**	**1.9%**

Source: SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 2.3

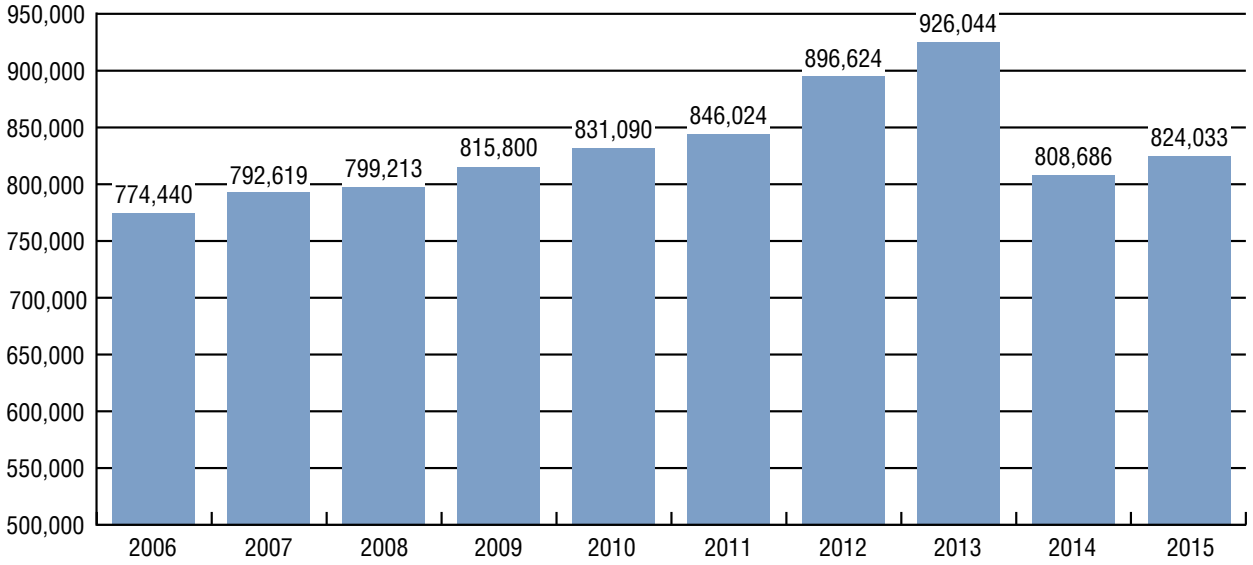
Eligible Client Population

Over the past 10 years, the total number of eligible clients in the SVS has increased by 6.4%, from 774,440 in March 2006 to 824,033 in March 2015.

The NIHB Program client population is constantly changing. It has been impacted by amendments to the *Indian Act*, such as the passage of Bill C-31, Bill C-3, and the creation of the new Qalipu Mi'kmaq Band, which have and will continue to result in significant increases in the NIHB client population. In contrast, the creation of the First Nations Health Authority (FNHA) in British Columbia and the settlement of First Nations and Inuit self-government agreements, such as those with the Nisga'a Lisims Government and the Nunatsiavut Government, have resulted in decreases in the total NIHB client population, as these individuals are no longer eligible to receive benefits through Health Canada's NIHB Program.

Over the past five years, the NIHB Program's total number of eligible clients decreased by 2.6% from 846,024 in March 2011 to 824,033 in March 2015. The Atlantic Region had the largest increase in eligible clients over this period, with a growth rate of 77.9%. This significant increase can be attributed to the registration of 24,017 new Qalipu Mi'kmaq First Nations clients during fiscal years 2011/12 to 2014/15. If these clients are excluded from the population in the Atlantic Region, population growth over the past five years in this region would have been 9.8%. The regions of Quebec, Nunavut, and Ontario followed with growth rates of 14.4%, 10.1% and 9.6% respectively.

Eligible Client Population, March 2006 to March 2015



Source: SVS adapted by Business Support, Audit and Negotiations Division

Eligible Client Population by Region, March 2011 to March 2015

REGION	March 2011	March 2012	March 2013	March 2014	March 2015
Atlantic	35,269	58,271	62,030	62,015	62,756
Quebec	59,659	63,209	65,944	66,819	68,274
Ontario	182,900	189,903	197,019	197,092	200,518
Manitoba	137,212	140,987	144,748	144,416	147,932
Saskatchewan	134,633	138,513	142,056	140,164	143,228
Alberta	107,839	112,264	115,867	113,590	115,886
British Columbia	124,988	128,597	131,782	19,628	19,283
Yukon	8,168	8,430	8,682	7,138	7,402
N.W.T.	25,236	25,412	26,125	25,434	25,587
Nunavut	30,120	31,038	31,791	32,390	33,167
Total	**846,024**	**896,624**	**926,044**	**808,686**	**824,033**
Annual % Change	**1.8%**	**6.0%**	**3.3%**	**-12.7%**	**1.9%**

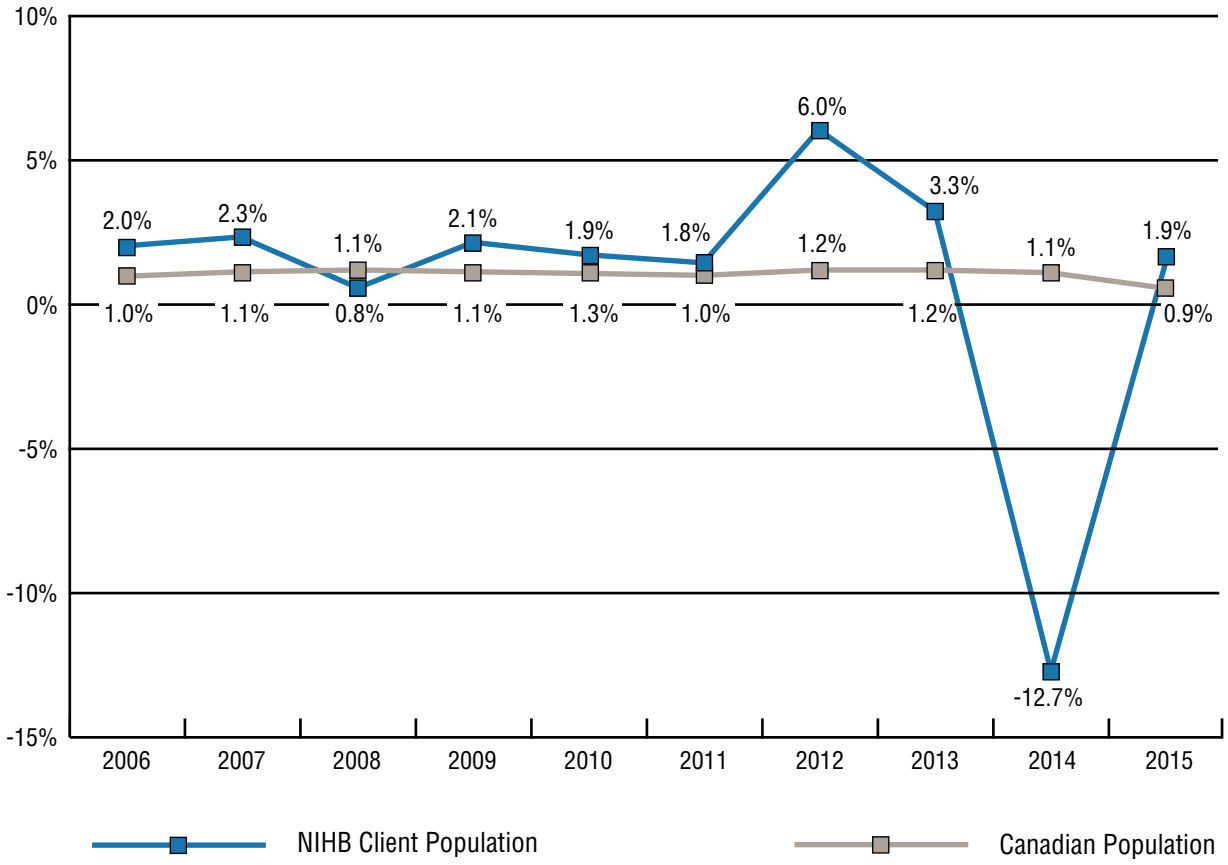
Source: SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 2.4

Annual Population Growth, Canadian Population and Eligible Client Population
2006 to 2015

From 2006 to 2015, the Canadian population increased by 10.3% while the NIHB eligible First Nations and Inuit client population increased by 6.4%. Prior to the removal of First Nations Health Authority (FNHA) clients, the NIHB ten year eligible population increase was 24.1%, with an average annual growth of 2.4%. Population growth is expected to return to historical rates in future fiscal years as the transition of residents of British Columbia to the FNHA is completed.

The higher than average NIHB Program client population growth rate of 6.0% in 2011/12 and 3.3% in 2012/13 can be attributed to the registration of new Bill C-3 clients as status Indians, and to new Qalipu Mi'kmaq First Nations clients in the Atlantic Region.



Source: SVS and Statistics Canada Catalogue No. 91-002-XWE, Quarterly Demographic Statistics, adapted by Business Support, Audit and Negotiations Division

FIGURE 2.5

Eligible Client Population by Age Group, Gender and Region
March 2015

Of the 824,033 NIHB eligible clients on the SVS as of March 31, 2015, 49.2% were male (405,395) and 50.8% were female (418,639).

The average age of the eligible client population was 32 years of age. By region, this average ranged from a low of 27 years of age in Nunavut to a high of 37 years of age in the Quebec Region.

The average age of the male and female eligible client population was 31 years and 33 years respectively. The average age for males ranged from a low of 26 years in Nunavut to a high of 35 years in the regions of Quebec, Ontario and the Yukon. The average age for females varied from a low of 27 years in Nunavut to a high of 38 years in the Yukon and Quebec Region.

The NIHB eligible First Nations and Inuit client population is relatively young with nearly two-thirds (65.7%) under the age of 40. Of the total population, over one-third (34.1%) are under the age of 20.

The senior population (clients 65 years of age and over) has been slowly increasing as a proportion of the total NIHB client population. In 2005/06, seniors represented 5.6% of the overall NIHB population. Most recently in 2014/15, seniors accounted for 7.2%. This demographic trend will contribute to cost pressures on the NIHB Program.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	1,286	1,312	2,598	1,698	1,647	3,345	4,944	4,820	9,764	6,224	5,962	12,186
5–9	2,525	2,343	4,868	2,641	2,434	5,075	7,410	7,127	14,537	8,374	8,284	16,658
10–14	2,547	2,509	5,056	2,513	2,352	4,865	7,561	7,257	14,818	7,507	7,105	14,612
15–19	2,767	2,706	5,473	2,640	2,574	5,214	8,398	7,955	16,353	7,444	7,102	14,546
20–24	2,888	2,806	5,694	2,974	2,832	5,806	8,884	8,653	17,537	7,609	7,419	15,028
25–29	2,520	2,469	4,989	2,533	2,607	5,140	8,047	7,837	15,884	6,269	6,119	12,388
30–34	2,278	2,320	4,598	2,291	2,273	4,564	7,028	7,226	14,254	5,251	5,017	10,268
35–39	2,138	2,135	4,273	2,170	2,132	4,302	6,705	6,757	13,462	4,554	4,504	9,058
40–44	2,201	2,155	4,356	2,174	2,293	4,467	6,690	6,843	13,533	4,500	4,613	9,113
45–49	2,225	2,324	4,549	2,293	2,510	4,803	6,921	7,125	14,046	4,334	4,448	8,782
50–54	2,032	2,257	4,289	2,393	2,581	4,974	6,813	7,445	14,258	3,759	4,079	7,838
55–59	1,701	1,995	3,696	2,013	2,504	4,517	5,679	6,640	12,319	2,766	3,050	5,816
60–64	1,276	1,644	2,920	1,558	1,822	3,380	4,035	5,178	9,213	1,876	2,239	4,115
65+	2,334	3,063	5,397	3,066	4,756	7,822	8,278	12,262	20,540	3,220	4,304	7,524
Total	**30,718**	**32,038**	**62,756**	**32,957**	**35,317**	**68,274**	**97,393**	**103,125**	**200,518**	**73,687**	**74,245**	**147,932**
Average Age	34	36	35	35	38	37	35	37	36	28	30	29

Source: SVS adapted by Business Support, Audit and Negotiations Division

REGION	Saskatchewan			Alberta			British Columbia			Yukon			N.W.T.			Nunavut			TOTAL		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	5,240	5,037	10,277	4,484	4,222	8,706	1,103	1,083	2,186	171	161	332	639	629	1,268	1,874	1,761	3,635	27,663	26,634	54,297
5–9	8,148	7,896	16,044	6,694	6,464	13,158	715	679	1,394	258	210	468	1,057	953	2,010	2,028	2,017	4,045	39,850	38,407	78,257
10–14	7,419	7,310	14,729	6,013	5,781	11,794	659	640	1,299	274	244	518	954	1,000	1,954	1,885	1,726	3,611	37,332	35,924	73,256
15–19	7,282	7,163	14,445	6,008	5,645	11,653	819	638	1,457	289	275	564	1,092	1,075	2,167	1,708	1,622	3,330	38,447	36,755	75,202
20–24	7,567	7,462	15,029	6,052	5,671	11,723	768	672	1,440	337	316	653	1,416	1,374	2,790	1,648	1,614	3,262	40,143	38,819	78,962
25–29	6,663	6,470	13,133	5,158	5,100	10,258	777	649	1,426	292	284	576	1,213	1,178	2,391	1,460	1,434	2,894	34,932	34,147	69,079
30–34	5,380	5,298	10,678	4,310	4,338	8,648	810	712	1,522	299	282	581	1,054	953	2,007	1,151	1,138	2,289	29,852	29,557	59,409
35–39	4,563	4,607	9,170	3,672	3,717	7,389	634	650	1,284	256	206	462	818	882	1,700	952	1,014	1,966	26,462	26,604	53,066
40–44	4,293	4,501	8,794	3,342	3,498	6,840	638	582	1,220	269	247	516	859	862	1,721	915	894	1,809	25,881	26,488	52,369
45–49	4,095	4,345	8,440	3,183	3,349	6,532	560	685	1,245	319	254	573	888	921	1,809	903	921	1,824	25,721	26,882	52,603
50–54	3,427	3,691	7,118	2,767	3,088	5,855	534	732	1,266	330	346	676	774	897	1,671	713	740	1,453	23,542	25,856	49,398
55–59	2,458	2,881	5,339	1,994	2,416	4,410	422	581	1,003	211	261	472	542	679	1,221	444	469	913	18,230	21,476	39,706
60–64	1,647	1,967	3,614	1,343	1,794	3,137	269	454	723	140	186	326	409	488	897	362	376	738	12,915	16,148	29,063
65+	2,684	3,734	6,418	2,370	3,413	5,783	661	1,157	1,818	268	417	685	876	1,105	1,981	668	730	1,398	24,425	34,941	59,366
Total	**70,866**	**72,362**	**143,228**	**57,390**	**58,497**	**115,886**	**9,369**	**9,914**	**19,283**	**3,713**	**3,689**	**7,402**	**12,591**	**12,996**	**25,587**	**16,711**	**16,456**	**33,167**	**405,395**	**418,639**	**824,033**
Average Age	28	29	29	28	30	29	31	35	33	35	38	36	33	34	33	26	27	27	31	33	32

FIGURE 2.6

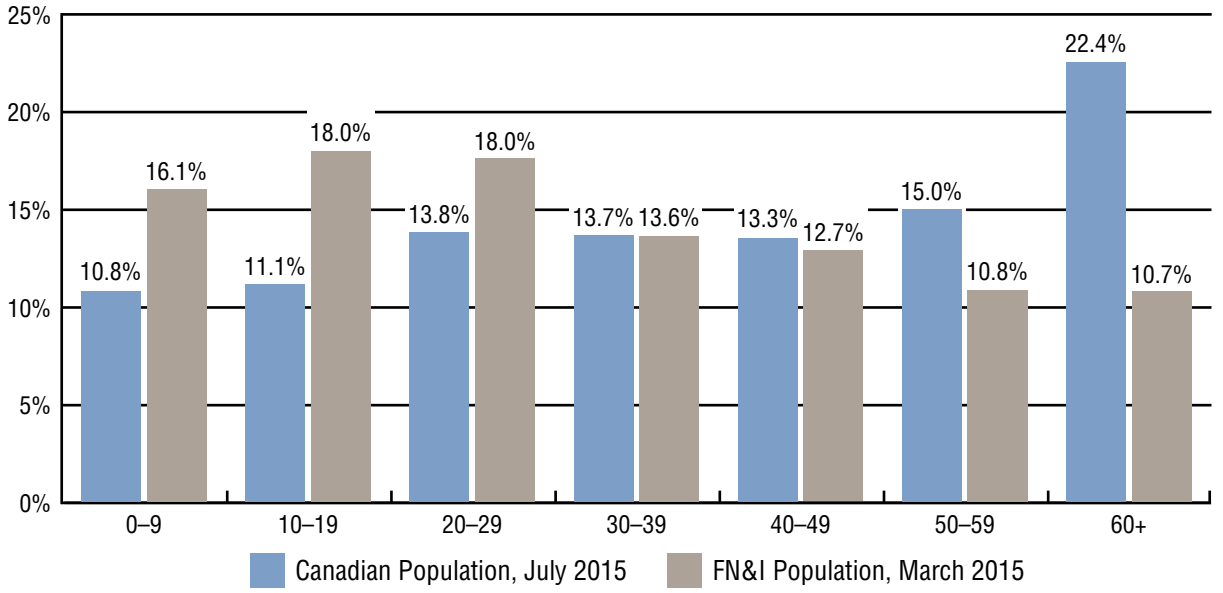
Population Analysis by Age Group

The overall First Nations and Inuit client population is relatively young compared to the general Canadian population. The share of the NIHB client population under 20 years of age was 34.1% compared to 21.9% of the same age group in the Canadian population. The average age of First Nations and Inuit clients is 32 compared to 41 years of age for the Canadian population.

A comparison of March 2011 to March 2015 eligible client population shows an aging population. The client population 40 and above, as a proportional share of the overall client population, increased from 33.2% in 2011 to 34.3% in 2015.

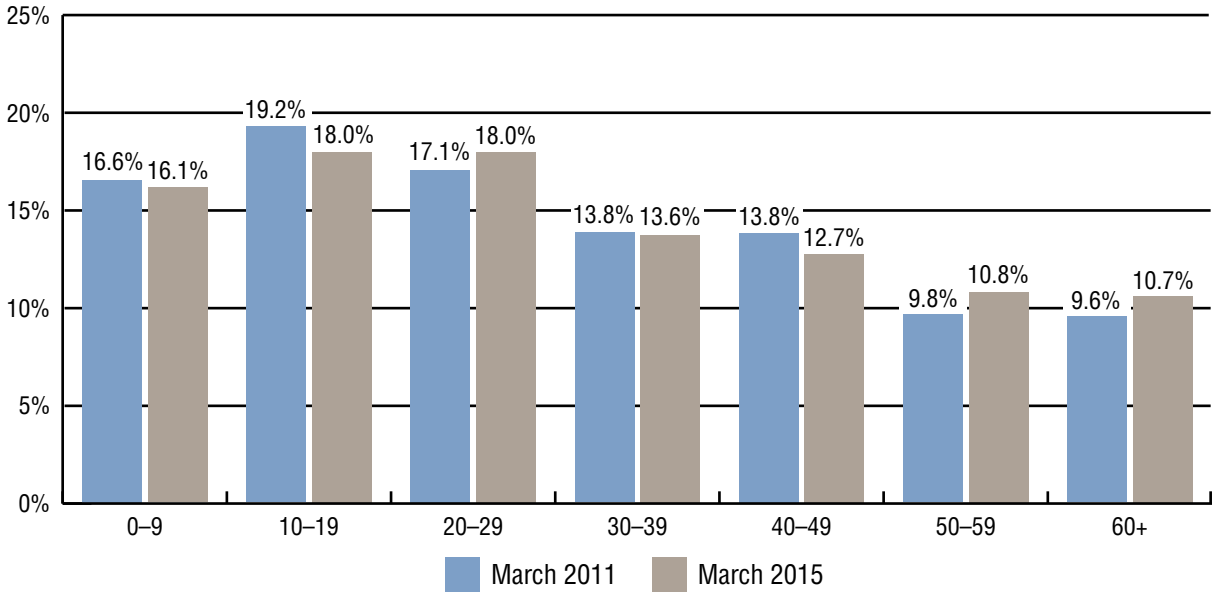
As the First Nations and Inuit client population ages, the costs associated with delivering Non-Insured Health Benefits, particularly pharmacy benefits, to this client population are expected to increase significantly.

Proportion of Canadian Population and of the First Nations and Inuit (FN&I) Client Population, by Age Group



Source: SVS and Statistics Canada CANSIM table 051-0001, Population by Age and Sex Group, adapted by Business Support, Audit and Negotiations Division

Proportion of Eligible First Nations and Inuit Client Population by Age Group



Source: SVS adapted by Business Support, Audit and Negotiations Division

NIHB Program Expenditures

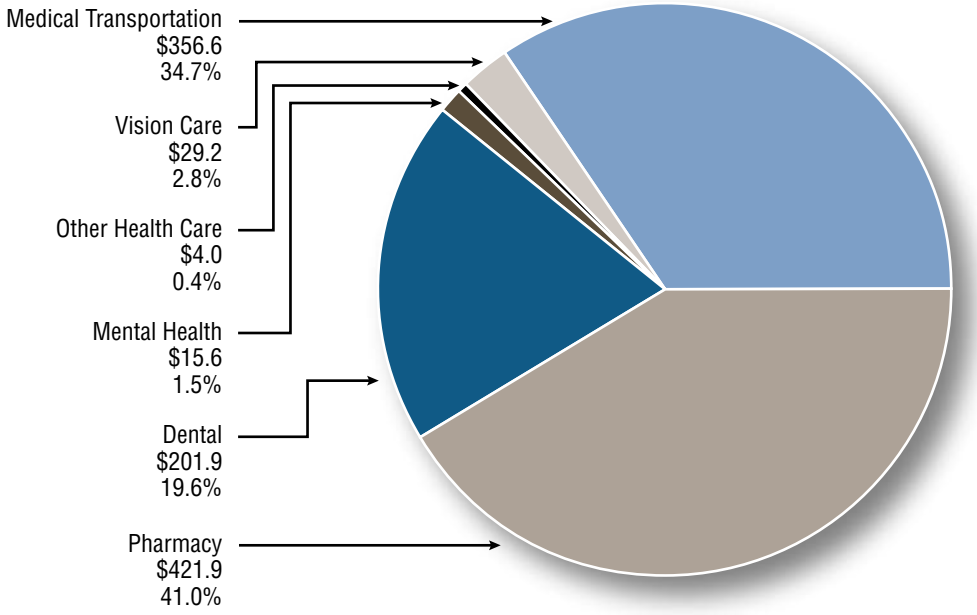
FIGURE 3.1

NIHB Expenditures by Benefit ($ Millions)
2014/15

In 2014/15, total NIHB expenditures were $1,029.1 million. This represents a marginal increase of 0.3% over total NIHB expenditures of $1,026.4 million in 2013/14. This minor increase can be attributed to the transfer of responsibility for First Nations individuals residing in British Columbia to the First Nations Health Authority (FNHA) in 2013/14. If FNHA eligible client expenditures are excluded for both fiscal years, total 2014/15 expenditures ($1,029.1 million) represent an increase of 5.1% compared to total 2013/14 expenditures of $979.6 million.

Of the 2014/15 total, Pharmacy costs (including medical supplies and equipment) represented the largest proportion at $421.9 million (41.0%), followed by Medical Transportation costs at $356.6 million (34.7%) and Dental costs at $201.9 million (19.6%).

NIHB Pharmacy, Dental and Medical Transportation benefit expenditures accounted for 95.3% of total NIHB expenditures in 2014/15.



Total NIHB Expenditures: $1,029.1M*

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

* Not reflected in the $1,029.1 million in NIHB expenditures is approximately $34.4 million in administration costs including Program staff and other headquarters and regional costs. More detail is provided in Figure 11.1.

FIGURE 3.2

NIHB Expenditures and Growth by Benefit
2014/15

Overall NIHB Program expenditures increased by 0.3%, or $2.7 million, from 2013/14. This minimal increase in overall expenditures can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA). If the expenditures for these FNHA eligible clients are excluded from 2013/14 and 2014/15 total NIHB expenditures, then the total NIHB expenditure growth rate would have been 5.1%.

Excluding FNHA eligible expenditures for both years, all NIHB benefit areas, with the exception of NIHB Vision Care had an increase in expenditures over the previous fiscal year. The highest net increase in expenditures over fiscal year 2013/14 was in the NIHB Medical Transportation benefit at $20.0 million, followed by NIHB Pharmacy benefits with an increase of $19.2 million and NIHB Dental benefits which increased by $5.1 million.

BENEFIT	Total Expenditures ($ 000's) 2013/14	Total Expenditures ($ 000's) 2014/15	% Change From 2013/14
Medical Transportation	$ 352,036	$ 356,610	1.3%
Pharmacy	416,165	421,895	1.4%
Dental	207,179	201,886	-2.6%
Mental Health	14,152	15,581	10.1%
Other (Including Premiums)	5,406	4,005	-25.9%
Vision Care	31,459	29,151	-7.3%
Total Expenditures	$ 1,026,397	$ 1,029,127	0.3%

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 3.3

NIHB Expenditures by Benefit and Region ($ 000's)
2014/15

The Manitoba Region accounted for the highest proportion of total expenditures at $239.2 million, or 23.2% of the national total, followed by the Ontario Region at $203.0 million (19.7%), and the Saskatchewan Region at $180.0 million (17.5%). In comparison, the lowest expenditure was in the Atlantic Region at $46.9 million (4.6%).

Headquarters expenditures represent costs paid for claims processing services, as well as various contribution agreements including funding arrangements with the FNHA for Bill C-3 and Qalipu clients and for payment of Inuit premiums in British Columbia. Other expenditures in this category include partner contribution agreements related to Program oversight. Total Headquarters expenditures account for 2.3% ($23.6 million) of NIHB expenditures. This figure does not include the $14.4 million in Headquarters administrative costs outlined in Figure 11.1

REGION	Medical Transportation	Pharmacy	Dental	Vision Care	Mental Health	Other Health Care	TOTAL
Atlantic	$ 7,419	$ 28,398	$ 8,238	$ 2,666	$ 169	$ 21	**$ 46,912**
Quebec	23,506	42,581	15,799	1,622	1,148	10	**84,666**
Ontario	65,781	81,982	46,759	5,717	2,803	2	**203,043**
Manitoba	115,705	81,059	33,527	4,800	4,099	0	**239,190**
Saskatchewan	51,543	83,361	37,679	6,066	1,351	0	**180,000**
Alberta	44,403	63,632	35,974	6,531	6,010	0	**156,550**
North	48,246	23,941	20,413	1,743	0	1	**94,343**
Headquarters	0	16,678	2,943	0	0	3,971	**23,592**
Total	**$ 356,610**	**$ 421,895**	**$ 201,886**	**$ 29,151**	**$ 15,581**	**$ 4,005**	**$ 1,029,127**

Source: FIRMS adapted by by Business Support, Audit and Negotiations Division

FIGURE 3.4

Proportion of NIHB Expenditures by Region
2014/15

In 2014/15, the Manitoba Region had the highest proportion of total NIHB expenditures (23.2%) and accounted for 32.4% of total NIHB Medical Transportation expenditures. This can be attributed to the large number of First Nations clients living in remote or fly-in only northern communities in the Manitoba Region.

The Saskatchewan Region accounted for the highest proportion of NIHB Pharmacy expenditures at 19.8%, followed closely by both Ontario and Manitoba at 19.4% and 19.2% respectively.

The Ontario Region, which accounted for 19.7% of total NIHB expenditures in 2014/15, recorded the highest proportion of total NIHB Dental expenditures at 23.2%. This region also accounted for the highest proportion of the total NIHB population at 24.3%.

The proportion of NIHB Vision Care expenditures ranged from a high of 22.4% in the Alberta Region and 20.8% in the Saskatchewan Region to a low of 5.6% in Quebec.

The Alberta Region (38.6%) and the Manitoba Region (26.3%) combined accounted for over one half of total NIHB Mental Health expenditures in 2014/15.

REGION	Medical Transportation	Pharmacy	Dental	Vision Care	Mental Health	Othe Health Care	Proportion of NIHB Expenditure	Proportion of NIHB Population
Atlantic	2.1%	6.7%	4.1%	9.1%	1.1%	0.5%	**4.6%**	**7.6%**
Quebec	6.6%	10.1%	7.8%	5.6%	7.4%	0.3%	**8.2%**	**8.3%**
Ontario	18.4%	19.4%	23.2%	19.6%	18.0%	0.0%	**19.7%**	**24.3%**
Manitoba	32.4%	19.2%	16.6%	16.5%	26.3%	0.0%	**23.2%**	**18.0%**
Saskatchewan	14.5%	19.8%	18.7%	20.8%	8.7%	0.0%	**17.5%**	**17.4%**
Alberta	12.5%	15.1%	17.8%	22.4%	38.6%	0.0%	**15.2%**	**14.1%**
North	13.5%	5.7%	10.1%	6.0%	0.0%	0.0%	**9.2%**	**8.0%**
Headquarters	0.0%	4.0%	1.5%	0.0%	0.0%	99.2%	**2.3%**	**0.0%**
Total	100%	100%	100%	100%	100%	100%	100%	100%

Source: FIRMS and SVS adapted by by Business Support, Audit and Negotiations Division

FIGURE 3.5

Proportion of NIHB Regional Expenditures by Benefit
2014/15

At the national level, approximately three-quarters (75.6%) of total Program expenditures occurred in two benefit areas: pharmacy (41.0%) and medical transportation (34.7%). Dental expenditures accounted for one-fifth (19.6%) of total NIHB expenditures.

NIHB Medical Transportation expenditures accounted for over half (51.1%) of total expenditures in the Northern Region. In the Atlantic Region, 60.5% of total expenditures were spent on pharmacy benefits.

The proportion of dental expenditures ranged from 14% in the Manitoba Region to 23% in both Ontario and Alberta.

Pharmacy costs represented the highest percentage of total expenditures in all regions except in the Northern Region and in Manitoba, where transportation accounted for the largest share of costs.

REGION	Medical Transportation	Pharmacy	Dental	Vision Care	Mental Health	Other Health Care	TOTAL
Atlantic	15.8%	60.5%	17.6%	5.7%	0.4%	0.0%	**100%**
Quebec	27.8%	50.3%	18.7%	1.9%	1.4%	0.0%	**100%**
Ontario	32.4%	40.4%	23.0%	2.8%	1.4%	0.0%	**100%**
Manitoba	48.4%	33.9%	14.0%	2.0%	1.7%	0.0%	**100%**
Saskatchewan	28.6%	46.3%	20.9%	3.4%	0.8%	0.0%	**100%**
Alberta	28.4%	40.6%	23.0%	4.2%	3.8%	0.0%	**100%**
North	51.1%	25.4%	21.6%	1.8%	0.0%	0.0%	**100%**
Headquarters	0.0%	70.7%	12.5%	0.0%	0.0%	16.8%	**100%**
National	**34.7%**	**41.0%**	**19.6%**	**2.8%**	**1.5%**	**0.4%**	100%

Source: FIRMS and SVS adapted by by Business Support, Audit and Negotiations Division

FIGURE 3.6

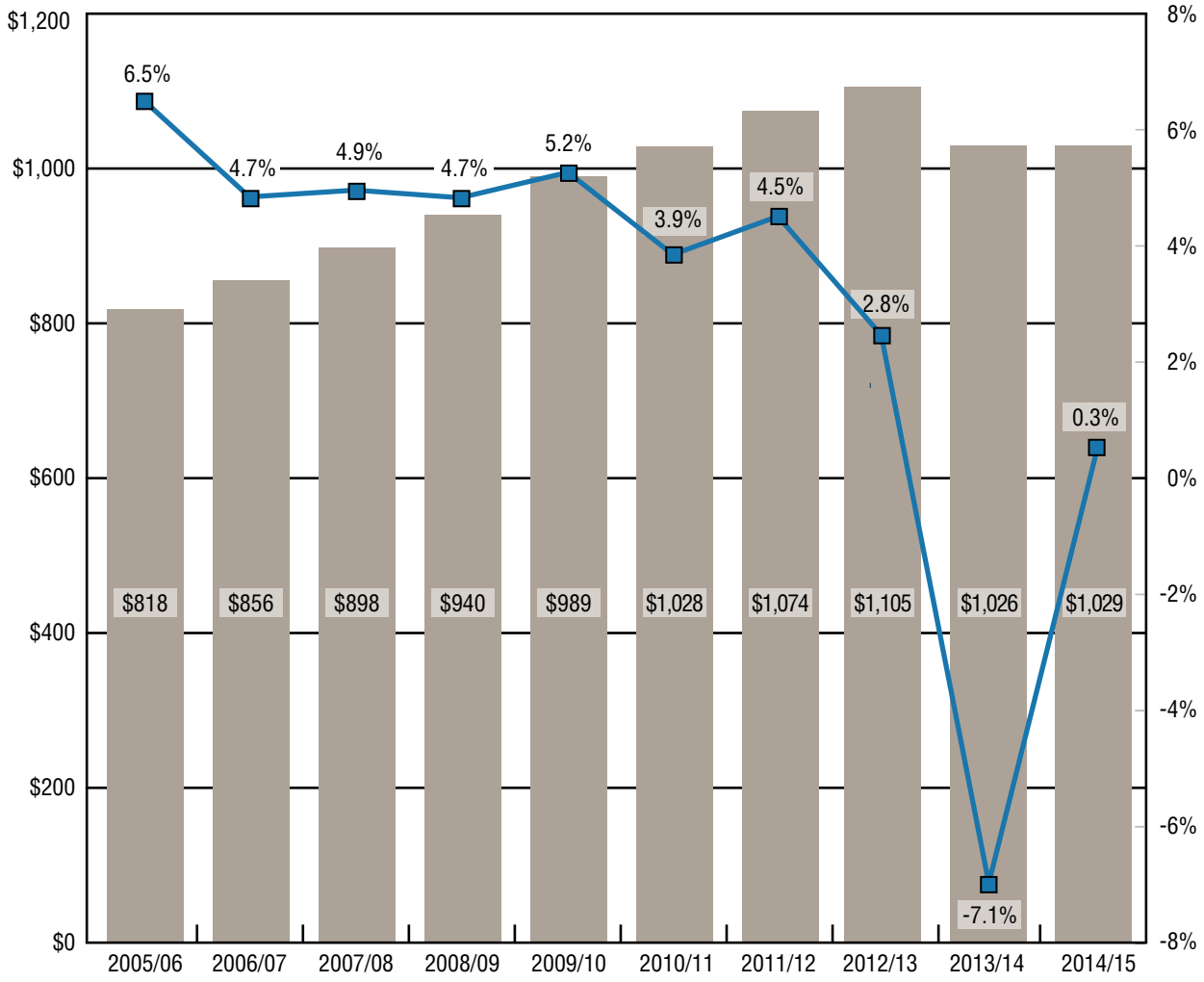
NIHB Annual Expenditures ($ Millions) and Percentage Change
2005/06 to 2014/15

In 2014/15, NIHB Program expenditures totalled $1,029.1 million, a marginal increase of 0.3% from $1,026.4 million in 2013/14. This nominal increase in expenditure growth can be attributed to the transfer of responsibility to the First Nations Health Authority (FNHA) for the management and delivery of non-insured health benefits to First Nation clients in the province of British Columbia. If the expenditures for these FNHA eligible clients are excluded from the 2013/14 and 2014/15 total NIHB expenditures, then the growth rate would have been 5.1%.

Since 2005/06, total expenditures have grown by 34.0%. The annualized rate of growth over this period was 3.0%. There has been wide variation in growth rates between 2005/06 and 2014/15, with a low of -7.1% in 2013/14 to a high of 6.5% in 2005/06.

Fluctuations in NIHB expenditure growth rates are impacted by a number of factors. Policy changes designed to improve access to the Program and those intended to promote Program sustainability affect NIHB expenditure growth rates. For example, the introduction of new therapies and generic drugs to the market, changes to provincial pricing policies, and economic inflationary pressures have impacted NIHB expenditure growth rates.

Other factors which affect growth include Program changes such as the centralization of dental benefits in 2012/13, the transfer of responsibility for First Nations clients residing in BC to the FNHA in 2013/14, and court decisions resulting in new eligible client populations such as the creation of the Qalipu Mi'kmaq Band. In addition, variations in the rates of growth are also a result of self-government initiatives and changes in service delivery models within the Program, between the federal government, and between the provinces and territories.



Source: FIRMS and SVS adapted by by Business Support, Audit and Negotiations Division

FIGURE 3.7

NIHB Annual Expenditures by Benefit ($ 000's)
2005/06 to 2014/15

In the period from 2005/06 to 2014/15, the expenditures for NIHB Medical Transportation and Dental benefits have grown more than other benefit areas. NIHB Medical Transportation expenditures grew by 58.2% from $225.4 million in 2005/06 to $356.6 million in 2014/15. NIHB Dental expenditures rose by 31.2% from $153.9 million in 2005/06 to $201.9 million in 2014/15.

Over the same period, NIHB Pharmacy expenditures increased by 14.5% and NIHB Vision expenditures had an increase of 16.8%.

NIHB Mental Health expenditures decreased by 9.0% over this same time period from $17.1 million in 2005/06 to $15.6 million in 2014/15. The decrease in growth over this period can be partly attributed to clients accessing mental health services through other service points such as counselling and mental health services through the Indian Residential Schools Resolution Health Support Program.

The decrease in NIHB Premiums expenditures can be attributed to the Government of Alberta eliminating Alberta health care insurance premiums for all Alberta residents on January 1, 2009 and to the transfer of responsibility for health care insurance premiums for First Nations clients residing in British Columbia to the First Nations Health Authority (FNHA). Other expenditures in 2014/15 include various contribution agreements including funding arrangements with the FNHA for Bill C-3 and Qalipu clients and for payment of Inuit premiums in British Columbia. Additional expenditures in this category include partner contribution agreements related to Program oversight.

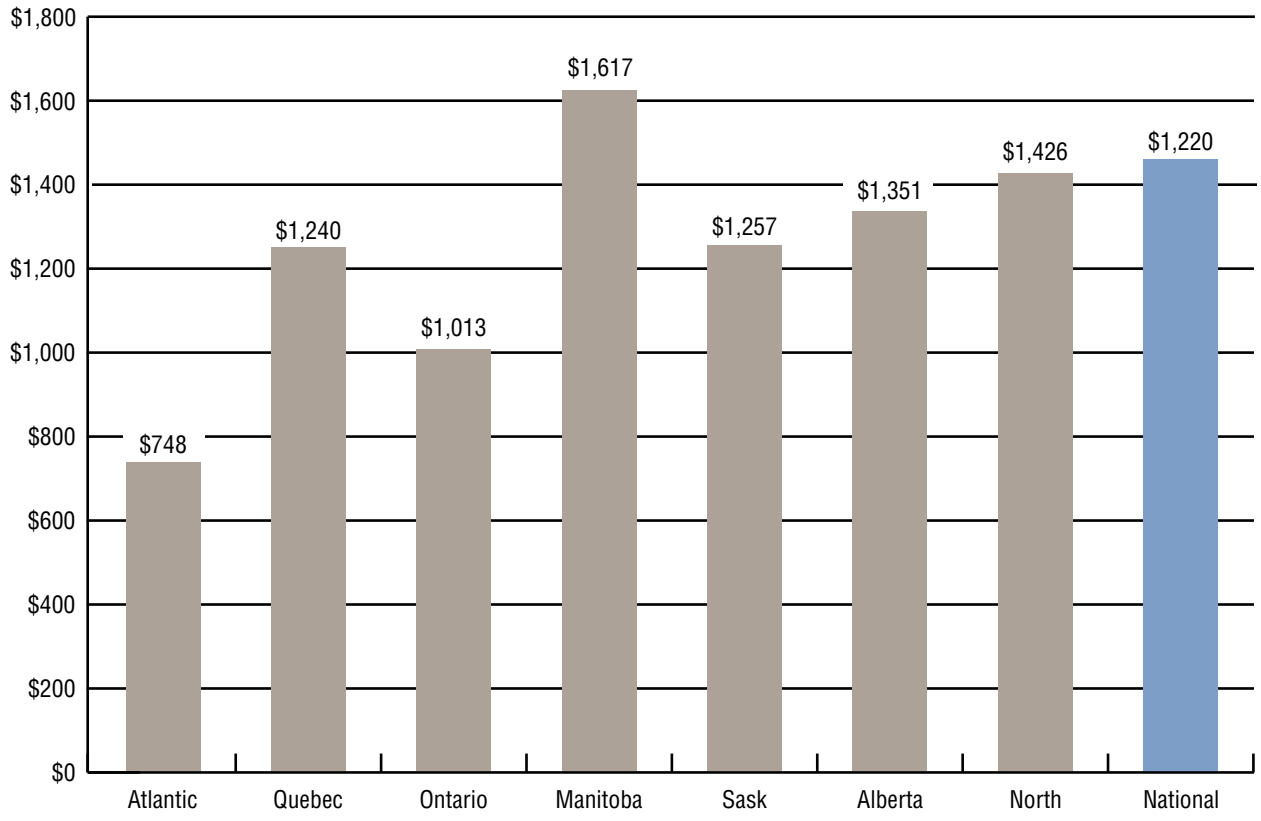
BENEFIT	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Medical Transportation	$ 225,379	$ 241,602	$ 262,294	$ 280,446	$ 301,673	$ 311,760	$ 333,304	$ 351,424	$ 352,036	$ 356,610
Pharmacy	368,398	386,190	403,248	418,968	435,097	440,768	459,359	462,699	416,165	421,895
Dental	153,900	158,584	165,576	176,382	194,918	215,796	219,057	222,706	207,179	201,886
Mental Health	17,115	16,271	12,289	11,380	12,516	12,083	12,936	14,337	14,152	15,581
Premiums/Other	27,987	28,659	29,211	26,430	17,110	18,428	19,868	21,257	5,406	4,005
Vision Care	24,968	24,894	25,621	26,577	27,779	29,219	29,780	32,167	21,459	29,151
Total	**$ 817,748**	**$ 856,201**	**$ 898,239**	**$ 940,182**	**$ 989,094**	**$ 1,028,053**	**$ 1,074,304**	**$ 1,104,591**	**$ 1,026,397**	**$ 1,029,127**
Annual % Change	6.5%	4.7%	4.9%	4.7%	5.2%	3.9%	4.5%	2.8%	-7.1%	0.3%

Source: FIRMS adapted by by Business Support, Audit and Negotiations Division

FIGURE 3.8

Per Capita NIHB Expenditures by Region (Excluding Premiums)
2014/15

The national per capita expenditure for all benefits in 2014/15 was $1,220. Manitoba had the highest per capita cost in 2014/15 at $1,617. The Northern Region followed with a per capita cost of $1,426. The higher than average per capita cost for these regions is partly attributable to high medical transportation costs due to the large number of First Nations clients living in remote or fly-in only northern communities. In contrast, the Atlantic Region had the lowest per capita cost of $748, due to the comparatively low medical transportation expenditures in the region.



Source: FIRMS and SVS adapted by by Business Support, Audit and Negotiations Division

NIHB Pharmacy Expenditure and Utilization Data

SECTION 4

The NIHB Program provides eligible clients with coverage for pharmacy benefits not insured by private, public or provincial/territorial health care plans. The NIHB Program covers a range of prescription drugs and over-the-counter medications listed on the NIHB Drug Benefit List (DBL). In addition, a limited but comprehensive range of medical supplies and equipment (MS&E) items are also covered by the Program. This is intended to contribute to better health outcomes in a fair, equitable and cost-effective manner, while recognizing the unique health needs of First Nations and Inuit clients. Policies to achieve this objective have and will continue to be adopted by the NIHB Program.

Another objective of the Program is to provide pharmacy benefits and services based on professional judgment, consistent with the current best practices of health services delivery and evidence-based standards of care. To achieve this objective, the addition and removal of pharmacy benefits covered by the NIHB Program follows an evidence-based standard of care approach with a particular emphasis on client safety.

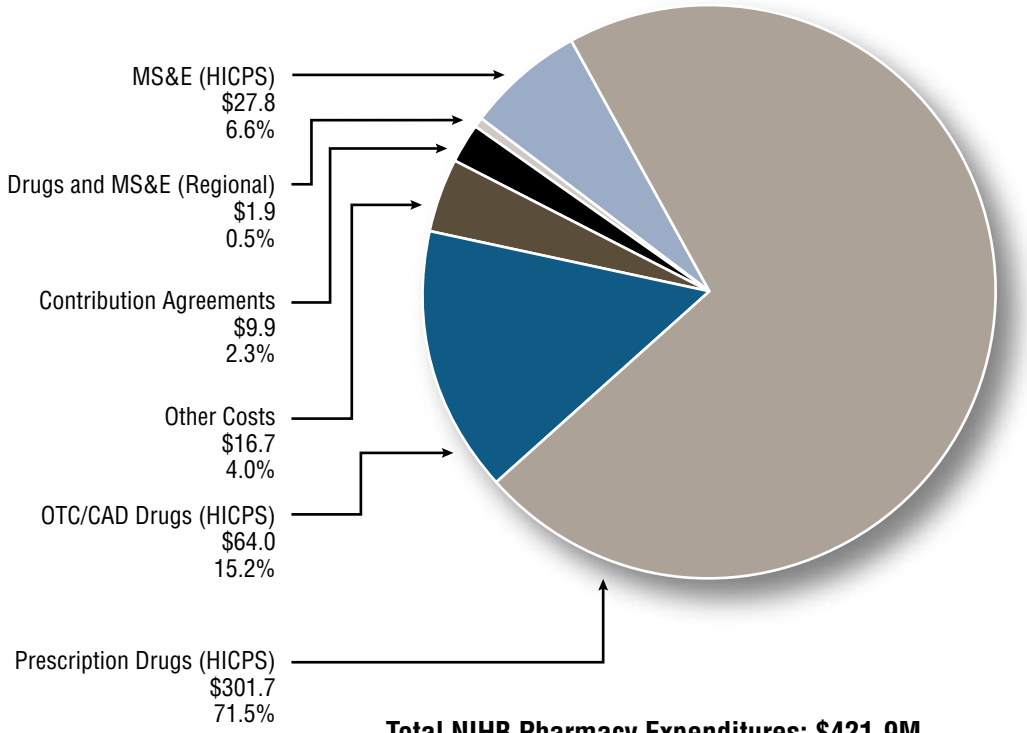
Like prescription and over-the-counter medications, MS&E benefits are covered in accordance with Program policies. Clients must obtain a prescription from a prescriber that is recognized by the NIHB Program for MS&E items, and have the prescription filled at an approved provider. Items covered under the MS&E benefit include:

- Audiology benefits, such as hearing aids and repairs;
- Medical equipment, such as wheelchairs and walkers;
- Medical supplies, such as bandages and dressings;
- Orthotics and custom footwear;
- Pressure garments;
- Prosthetics;
- Oxygen supplies and equipment; and
- Respiratory supplies and equipment.

In 2014/15, the NIHB Program paid for pharmacy claims made by a total of 504,032 First Nations and Inuit clients. The total expenditures for these claims was $421.9 million or 41.0% of total NIHB expenditures. Of all the NIHB Program benefits, the pharmacy benefit accounts for the largest share of expenditures and is the benefit most utilized by clients.

FIGURE 4.1

Distribution of NIHB Pharmacy Expenditures ($ Millions)
2014/15



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

In 2014/15, NIHB Pharmacy benefits totalled $421.9 million or 41.0% of total NIHB expenditures.

Figure 4.1 illustrates the components of pharmacy expenditures under the NIHB Program. The cost of prescription drugs paid through the Health Information and Claims Processing Services (HICPS) system was the largest component, accounting for $301.7 million or 71.5% of all NIHB Pharmacy expenditures, followed by over-the-counter (OTC) drugs and controlled access drugs (CAD) which totalled $64.0 million or 15.2%. Medical supplies and equipment (MS&E) items paid through HICPS was the third largest component in the pharmacy benefit at $27.8 million or 6.6%.

Drugs and MS&E (Regional), at $1.9 million or 0.5%, refers to regionally managed prescription drugs and OTC medications. This category also includes MS&E items paid through Health Canada regional offices.

Contribution agreements, which accounted for $9.9 million or 2.3% of total pharmacy benefit costs, are used to fund the provision of pharmacy benefits through agreements such as those with the Mohawk Council of Akwesasne in Ontario and the Bigstone Cree Nation in Alberta.

Other costs totalled $16.7 million or 4.0% in 2014/15. Included in this total are Headquarters contract and claims processing expenditures related to the HICPS system.

FIGURE 4.2

Total NIHB Pharmacy Expenditures by Type and Region ($ 000's)
2014/15

Prescription drug costs paid through the Health Information and Claims Processing Services (HICPS) system represented the largest component of total costs accounting for $301.7 million or 71.5% of all NIHB Pharmacy costs. The Saskatchewan Region had the largest proportion of these costs at 21.0%, followed by Manitoba at 20.8% and the Ontario Region at 20.0%.

The next highest component was over-the-counter (OTC) and controlled access drug (CAD) costs at $64.0 million or 15.2%. The regions of Ontario (22.4%), Manitoba (20.8%) and Saskatchewan (19.7%) had the largest proportions of these costs in 2014/15.

The third highest component was the combined medical supplies and equipment (MS&E) category at $27.8 million (6.6%). The Saskatchewan Region (22.4%) had the highest proportion of MS&E costs in 2014/15. This was followed by the Alberta Region (21.6%), the Manitoba Region (18.2%), and the Ontario Region (14.0%).

REGION	OPERATING						Total Operating Costs	Total Contribution Costs	TOTAL COSTS
	Prescription Drugs	OTC/CAD Drugs	Drugs/ MS&E Regional	Medical Supplies	Medical Equipment	Other Costs			
Atlantic	$ 21,136	$ 4,973	$ 4	$ 660	$ 1,458	$ -	$ 28,231	$ 167	**$ 28,398**
Quebec	32,956	7,923	18	660	1,024	-	42,581	0	**42,581**
Ontario	60,211	14,355	18	1,112	2,783	-	78,478	3,505	**81,982**
Manitoba	62,697	13,316	0	1,643	3,402	-	81,059	0	**81,059**
Saskatchewan	63,211	12,597	1,287	2,084	4,131	-	83,310	52	**83,361**
Alberta	43,915	7,848	18	1,928	4,063	-	57,772	5,859	**63,632**
North	17,339	2,913	592	920	1,909		23,673	267	**23,941**
Headquarters	-	-	-	-	-	16,678	16,678	0	**16,678**
Total	**$ 301,664**	**$ 63,990**	**$ 1,937**	**$ 9,007**	**$ 18,769**	**$ 16,678**	**$ 412,044**	**$ 9,850**	**$ 421,895**

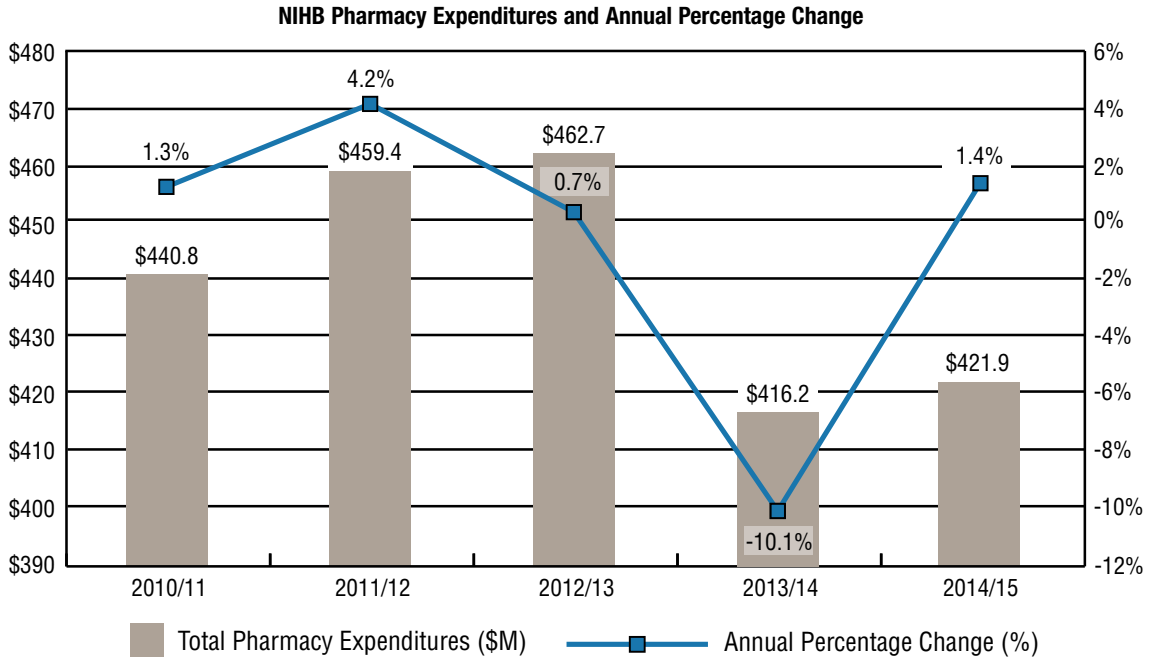
Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.3

Annual NIHB Pharmacy Expenditures
2010/11 to 2014/15

NIHB Pharmacy expenditures increased by 1.4% during fiscal year 2014/15. Over the past five years, growth in pharmacy expenditures has ranged from a high of 4.2% in 2011/12 to a low of -10.1% in 2013/14. The annualized growth rate over these five years is -0.6%, which was strongly impacted by the transfer of eligible First Nations clients living in British Columbia to the responsibility of the First Nations Health Authority in 2014.

Pharmacy expenditure growth has been low and steady over the past five years. Reasons for this stability include the introduction of lower cost generic drugs as they become available on the market, optimizing drug utilization, policy changes designed to promote NIHB Program sustainability, such as the implementation of the NIHB Short-Term Dispensing Policy in 2008/09, and changes in generic pricing policies in key provinces (Quebec, Ontario, Saskatchewan and British Columbia).



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

NIHB Pharmacy Expenditures ($ 000's)					
REGION	2010/11	2011/12	2012/13	2013/14	2014/15
Atlantic	$ 23,689	$ 27,571	$ 29,979	$ 27,517	$ 28,398
Quebec	38,234	38,827	40,393	40,825	42,581
Ontario	73,887	76,430	77,131	78,510	81,982
Manitoba	76,496	80,639	80,676	77,034	81,059
Saskatchewan	70,625	73,293	74,646	78,546	83,361
Alberta	59,738	61,621	60,584	58,777	63,632
North	23,190	23,863	23,682	23,144	23,941
Headquarters	14,814	16,227	15,749	16,874	16,678
Total	$ 440,768	$ 459,359	$ 462,699	$ 416,165	$ 421,895

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

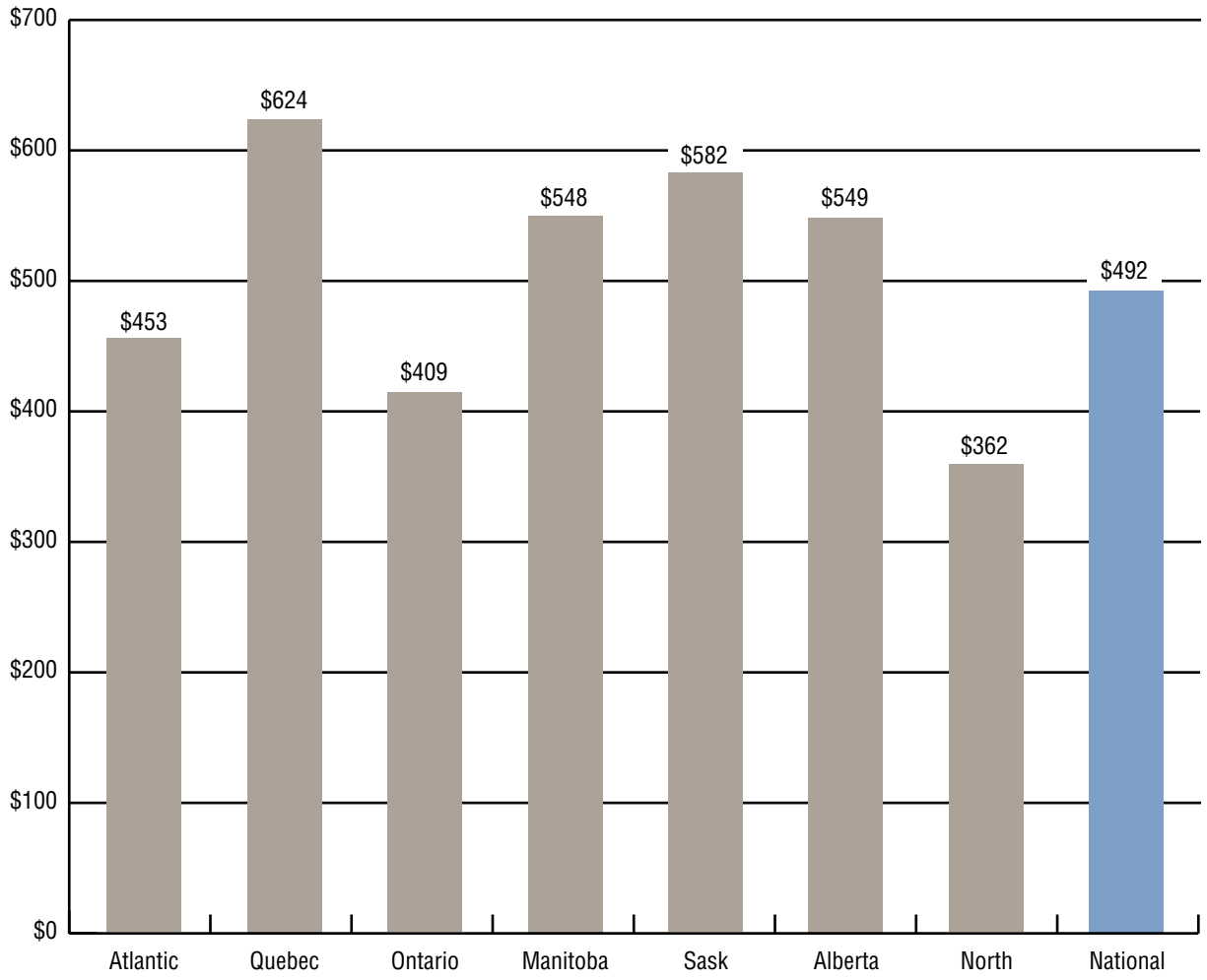
FIGURE 4.4

Per Capita NIHB Pharmacy Expenditures by Region
2014/15

In 2014/15, the national per capita expenditure for NIHB Pharmacy benefits was $492. This was a decrease of 0.4% from the $494 recorded in 2013/14.

The Quebec Region had the highest per capita NIHB Pharmacy expenditure at $624, followed by the Saskatchewan Region at $582.

The Northern Region had the lowest per capita expenditure followed by the Ontario Region at $409. A relatively low per capita expenditure in the North is attributed to lower than average utilization rates and also a younger population utilizing lower cost medications. (Refer to Figure 4.6)



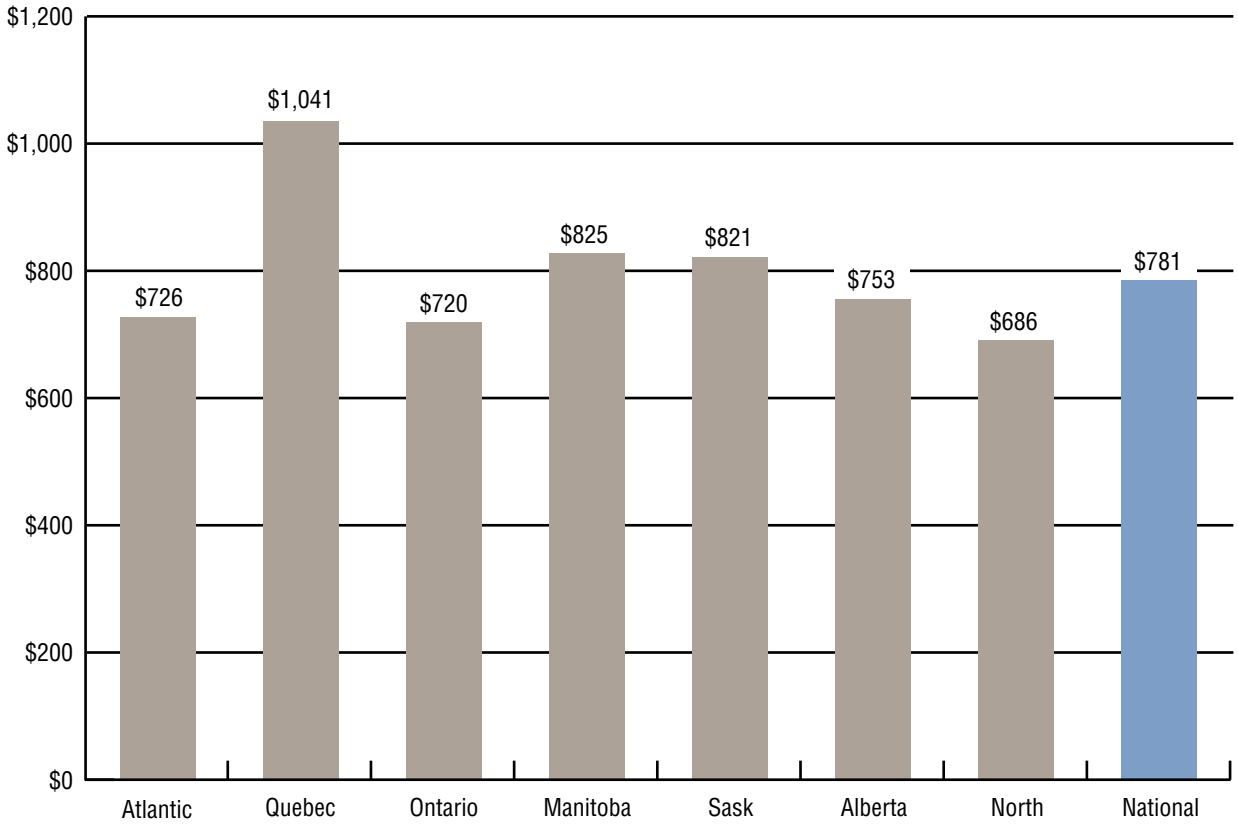
Source: FIRMS and SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.5

NIHB Pharmacy Operating Expenditures per Claimant by Region
2014/15

In 2014/15, the national average expenditure per eligible client receiving at least one pharmacy benefit (claimant) was $781, an increase of 1.8% over 2013/14.

The Quebec Region had the highest average NIHB Pharmacy operating expenditure per claimant at $1,041, followed by Manitoba at $825.



Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.6

NIHB Pharmacy Utilization Rates by Region
2010/11 to 2014/15

Utilization rates represent those clients who received at least one pharmacy benefit paid through the Health Information and Claims Processing Services (HICPS) system in the fiscal year as a proportion of the total number of clients eligible to receive benefits as registered on the Status Verification System (SVS) in that year.

In 2014/15, the national utilization rate was 61% for NIHB Pharmacy benefits paid through the HICPS system. The slightly lower utilization over the last four fiscal years is a result of new C-3 and Qalipu Mi'kmaq First Nations being registered with the NIHB Program throughout the fiscal year but not immediately making claims.

The rates understate the actual level of service as the data do not include pharmacy services provided through contribution agreements and benefits provided through community health facilities or provided completely via alternate health coverage. For example, if the Bigstone Cree Nation client population were removed from the Alberta Region's population because the HICPS system does not capture any data on services used by this population, the utilization rate for pharmacy benefits in Alberta would have been 71% in 2014/15. Similarly for the Ontario Region, if the Akwesasne client population were removed from the Ontario Region's population, the utilization rate for pharmacy benefits would have been 58%. If both the Bigstone and Akwesasne client populations were removed from the overall NIHB population, the national utilization rate for pharmacy benefits would have been 63%.

	Pharmacy Utilization				
REGION	2010/11	2011/12	2012/13	2013/14	2014/15
Atlantic	66%	55%	61%	62%	62%
Quebec	59%	59%	59%	59%	60%
Ontario	55%	55%	55%	54%	54%
Manitoba	67%	67%	67%	66%	66%
Saskatchewan	72%	71%	70%	70%	70%
Alberta	67%	66%	66%	66%	66%
Yukon	61%	61%	60%	59%	60%
N.W.T.	53%	53%	53%	53%	54%
Nunavut	44%	45%	46%	46%	47%
National	**64%**	**62%**	**62%**	**61%**	**61%**

Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.7

NIHB Pharmacy Claimants by Age Group, Gender and Region
2014/15

Of the 824,033 clients eligible to receive benefits under the NIHB Program, a total of 504,032 claimants, representing 61% of the NIHB client population, received at least one pharmacy item paid through the Health Information and Claims Processing Services (HICPS) system in 2014/15. Of this total, 285,167 were female (57%) and 218,865 were male (43%). This compares to the total eligible population where 51% were female and 49% were male.

The average age of pharmacy claimants was 34 years. The average age for female and male claimants was 35 and 33 years of age, respectively.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	763	802	1,565	977	944	1,921	2,316	2,189	4,505	3,480	3,346	6,826
5–9	1,353	1,305	2,658	1,324	1,328	2,652	3,095	3,059	6,154	4,539	4,663	9,202
10–14	1,183	1,232	2,415	1,072	1,110	2,182	2,853	2,834	5,687	3,603	3,723	7,326
15–19	1,239	1,884	3,123	1,071	1,796	2,867	3,149	4,621	7,770	3,446	4,884	8,330
20–24	1,283	2,151	3,434	1,183	2,063	3,246	3,470	5,761	9,231	3,619	5,841	9,460
25–29	1,169	1,806	2,975	1,089	1,902	2,991	3,456	5,341	8,797	3,429	5,099	8,528
30–34	1,068	1,622	2,690	1,020	1,637	2,657	3,290	4,889	8,179	3,190	4,252	7,442
35–39	1,130	1,479	2,609	1,111	1,529	2,640	3,327	4,456	7,783	2,891	3,790	6,681
40–44	1,226	1,564	2,790	1,202	1,598	2,800	3,466	4,561	8,027	3,063	3,827	6,890
45–49	1,352	1,629	2,981	1,302	1,780	3,082	3,837	4,755	8,592	3,056	3,731	6,787
50–54	1,252	1,601	2,853	1,425	1,791	3,216	3,889	5,026	8,915	2,911	3,547	6,458
55–59	1,158	1,473	2,631	1,292	1,804	3,096	3,464	4,410	7,874	2,244	2,666	4,910
60–64	967	1,302	2,269	1,059	1,334	2,393	2,561	3,432	5,993	1,559	1,985	3,544
65+	1,696	2,199	3,895	2,031	3,132	5,163	4,542	6,923	11,465	2,458	3,409	5,867
Total	**16,839**	**22,049**	**38,888**	**17,158**	**23,748**	**40,906**	**46,715**	**62,257**	**108,972**	**43,488**	**54,763**	**98,251**
Average Age	37	37	37	38	39	39	37	39	38	31	33	32

Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

REGION	Saskatchewan			Alberta			North			TOTAL		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	3,323	3,248	6,571	2,897	2,647	5,544	1,150	1,041	2,191	15,539	14,829	30,368
5–9	4,979	5,200	10,179	3,906	3,865	7,771	1,138	1,047	2,185	20,573	20,665	41,238
10–14	4,082	4,404	8,486	3,076	3,120	6,196	838	931	1,769	16,880	17,531	34,411
15–19	3,621	5,297	8,918	2,962	3,904	6,866	888	1,672	2,560	16,596	24,371	40,967
20–24	3,828	6,131	9,959	3,106	4,347	7,453	1,080	2,184	3,264	17,788	28,851	46,639
25–29	3,709	5,552	9,261	2,787	4,008	6,795	1,014	2,017	3,031	16,866	26,067	42,933
30–34	3,309	4,525	7,834	2,614	3,468	6,082	902	1,689	2,591	15,611	22,391	38,002
35–39	2,984	3,855	6,839	2,377	2,959	5,336	820	1,468	2,288	14,830	19,808	34,638
40–44	2,922	3,772	6,694	2,200	2,780	4,980	991	1,417	2,408	15,257	19,768	35,025
45–49	2,890	3,659	6,549	2,232	2,592	4,824	1,048	1,432	2,480	15,887	19,860	35,747
50–54	2,535	3,189	5,724	1,977	2,486	4,463	1,057	1,469	2,526	15,195	19,368	34,563
55–59	1,937	2,527	4,464	1,518	1,991	3,509	723	1,087	1,810	12,438	16,136	28,574
60–64	1,364	1,726	3,090	1,053	1,475	2,528	637	797	1,434	9,254	12,192	21,446
65+	2,217	3,124	5,341	1,786	2,577	4,363	1,327	1,777	3,104	16,151	23,330	39,481
Total	43,700	56,209	99,909	34,491	42,219	76,710	13,613	20,028	33,641	218,865	285,167	504,032
Average Age	30	31	31	30	32	31	35	36	35	33	35	34

Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

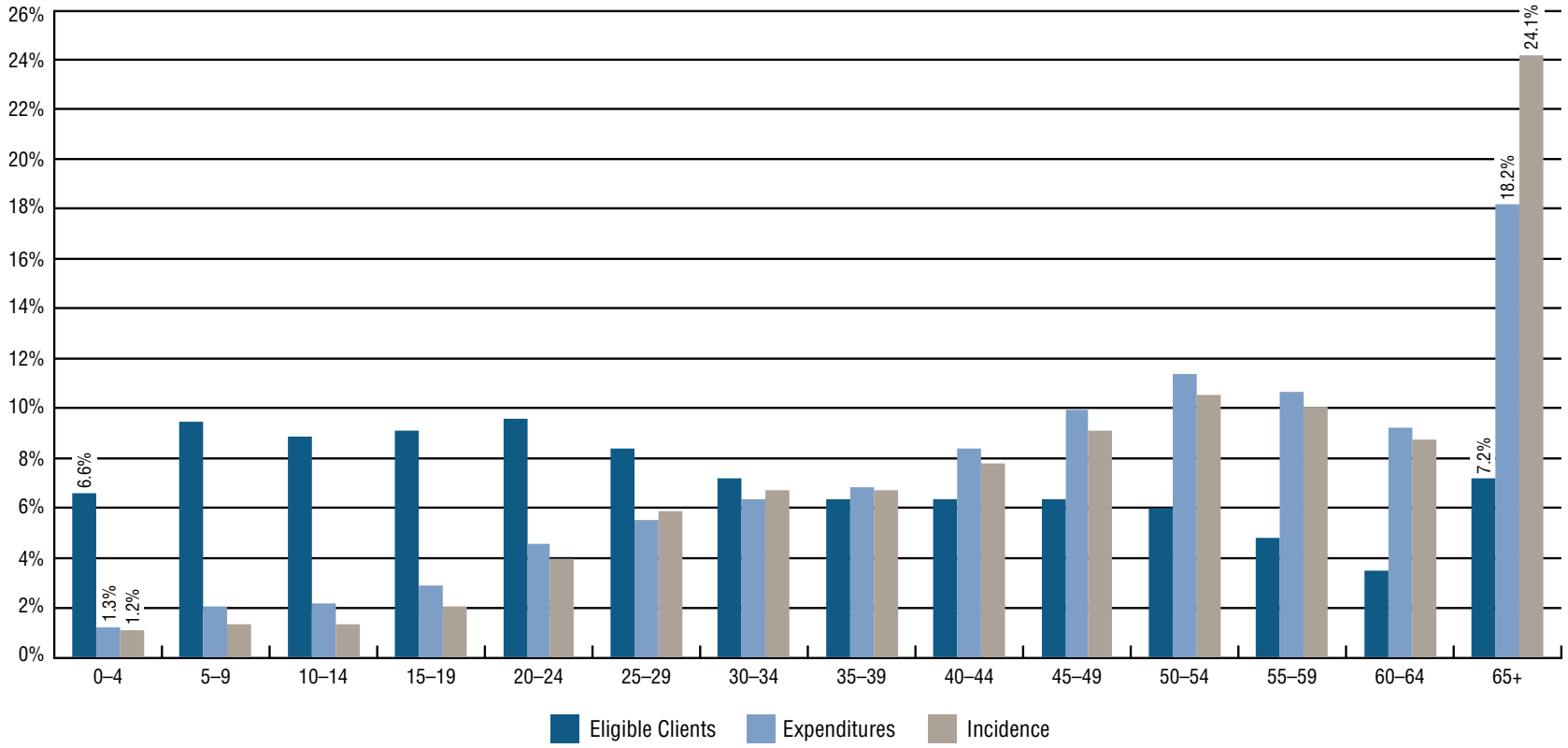
FIGURE 4.8

Distribution of Eligible NIHB Population, Pharmacy Expenditures and Pharmacy Incidence by Age Group
2014/15

The main drivers of NIHB Pharmacy expenditures are the cost of medications, the volume of claims submitted and the professional fees associated with filling these claims. In 2014/15, 6.6% of all clients were in the 0 to 4 age group, but this group accounted for only 1.2% of all pharmacy claims made and only 1.3% of total pharmacy expenditures. In contrast, 7.2% of all eligible clients were in the 65+ age group, but accounted for 24.1% of all pharmacy claims submitted and 18.2% of total pharmacy expenditures.

During 2014/15, the average claimant aged 65 or more submitted 93 claims compared to 62 claims for their counterpart in the 60 to 64 age group and 6 claims for the average claimant in the 0 to 4 age group.

An examination of pharmacy benefit cost per NIHB claimant indicates that these expenditures vary according to age. For example, in 2014/15 the average cost per child aged 0 to 4 years was $168. The cost increased steadily for every age group, with claimants aged 35–39 having an average cost of $778, comparable to the total average claimant cost of $781. Claimants over 65 years of age had the highest cost per claimant with an average of $1,816 for all pharmaceutical services received throughout the fiscal year.



Source : Données du STRDPSS et du SVS adaptées par la Division des solutions d'affaires, de la vérification et des négociations

* Claims are not equal to prescriptions as a prescription can comprise a number of claim lines. For further clarification see Section 9.1.1.

FIGURE 4.9

NIHB Top Ten Therapeutic Classes by Number of Claimants
2014/15

Figure 4.9 ranks the top ten therapeutic classes according to number of claimants. In 2014/15, Non-Steroidal Anti-Inflammatory Drugs (NSAID) had the highest number of distinct claimants at 194 thousand, an increase of 1.4% over 2013/14. Penicillins such as Amoxil (Amoxicillin) ranked second in number of claimants with 159 thousand followed by Opioid Agonists with 118 thousand claimants.

Cephalosporins, a class of antibiotic agents, had the largest decline in claimants over the previous fiscal year, decreasing by 1.4% from 74 thousand claimants in 2013/14.

Therapeutic Classification	Claimants	% Change from 2013/14	Examples of Product in the Therapeutic Class
Non-Steroidal Anti-Inflammatory Drugs (NSAID)	194,486	1.4%	Voltaren (Diclofenac)
Penicillins	159,186	3.3%	Amoxil (Amoxicillin)
Opioid Agonists	117,646	2.8%	Statex (Morphine Sulphate)
Miscellaneous Analgesics and Antipyretics	112,709	2.2%	Tylenol (Acetaminophen)
Beta-Adrenergic Agonists	84,361	7.2%	Ventolin (Salbutamol)
Proton-Pump Inhibitors	80,854	6.3%	Losec (Omeprazole)
Antidepressants	79,228	5.0%	Effexor (Venlafaxine)
SMMA—Anti-inflammatory Agents	75,165	2.3%	Cortate Cream (Hydrocortisone)
Cephalosporins	72,412	-1.4%	Keflex (Cephalexin)
Adrenals	69,016	6.2%	Flovent (Fluticasone Propionate)

Source: HICPS adapted by Business Support, Audit and Negotiations Division

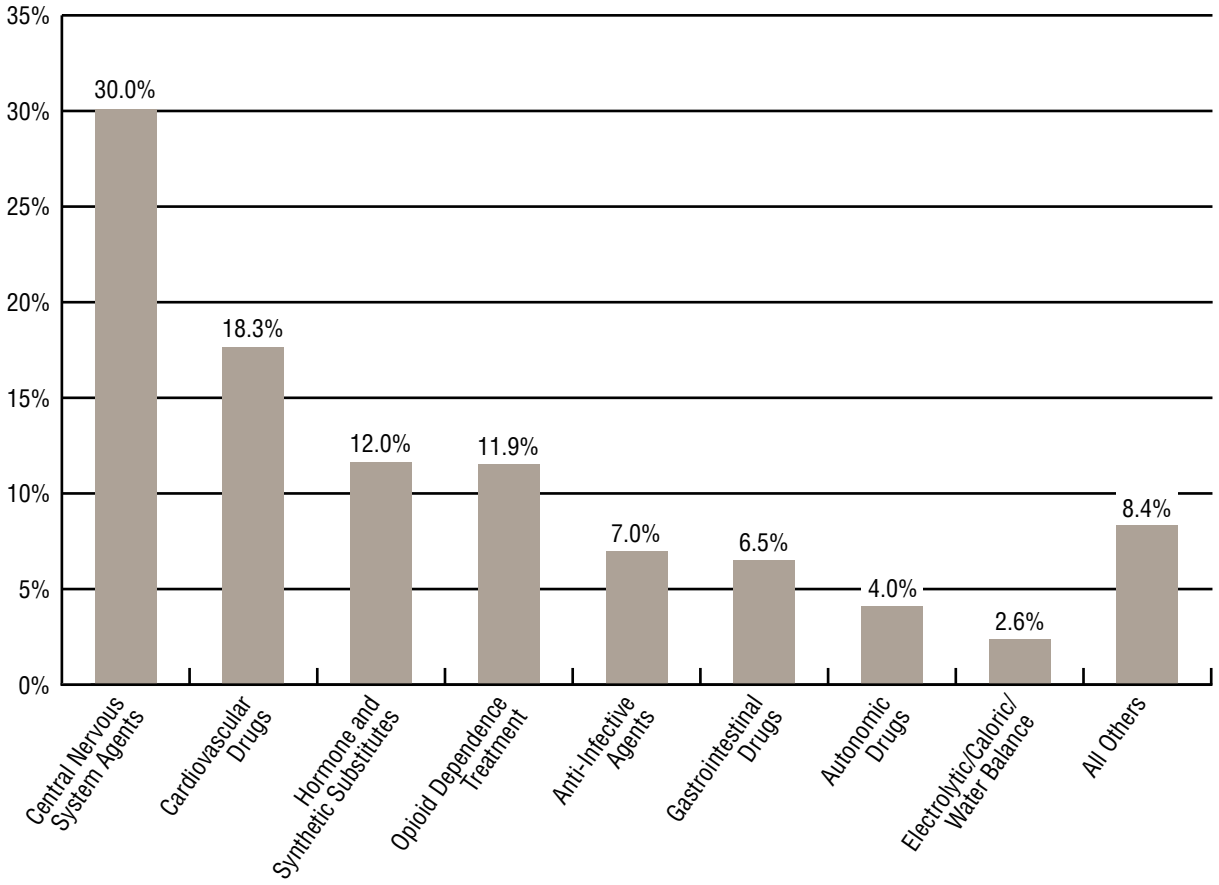
FIGURE 4.10

NIHB Prescription Drug Claims Incidence by Pharmacologic Therapeutic Class
2014/15

Figure 4.10 demonstrates variation in claims incidence by therapeutic classification for prescription drugs.

Central nervous system agents, which include drug classes such as analgesics and sedatives, accounted for 30.0% of all prescription drug claims in 2014/15. Central nervous systems agents are used in the treatment of conditions such as arthritis, depression or epilepsy.

Cardiovascular drugs had the next highest share of prescription drug claims at 18.3% followed by hormones and synthetic substitutes, which consist primarily of oral contraceptives and insulin, at 12.0%. Cardiovascular drugs are used to treat clients with arrhythmias, hypercholesterolemia or ischemic heart disease. Hormones and synthetic substitutes are given to clients to treat conditions such as diabetes or hypothyroidism.



Source: HICPS adapted by Business Support, Audit and Negotiations Division

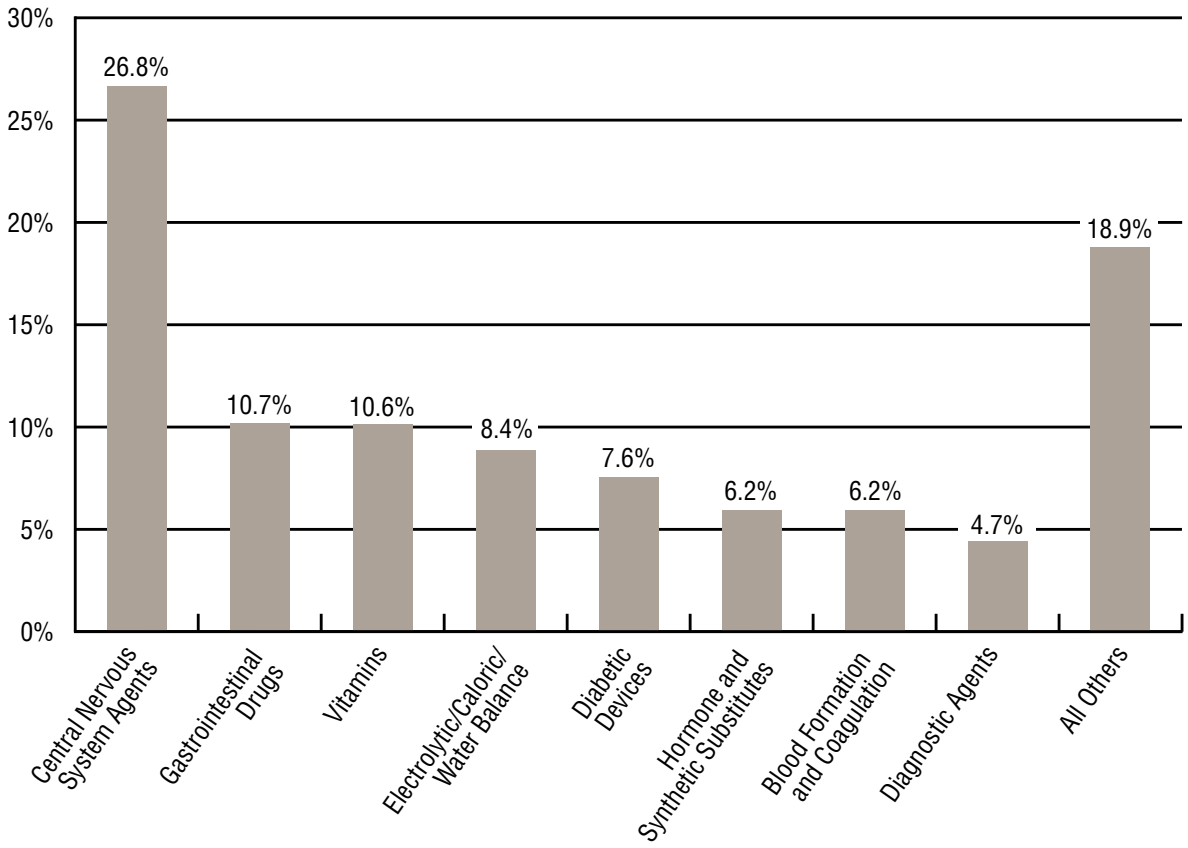
FIGURE 4.11

NIHB Over-the-Counter Drugs (Including Controlled Access Drugs—CAD) Claims Incidence by Pharmacologic Therapeutic Class
2014/15

Figure 4.11 demonstrates variation in claims incidence by therapeutic classification for over-the-counter (OTC) drugs. The NIHB Program covers the cost of some OTC drugs. To be reimbursed by the NIHB Program, all OTC drugs require a prescription from a recognized health professional who has the authority to prescribe in their province or territory of practice.

OTC central nervous system agents, which are drugs used to manage pain such as headaches (e.g. acetaminophen), accounted for 26.8% of all OTC drug claims.

Gastrointestinal products such as antacids and laxatives, which are used to treat heartburn and constipation, are the next highest category of OTC medication at 10.7%, followed by vitamins at 10.6%. The electrolytic/caloric/water balance class such as calcium, which is used in the prevention and treatment of conditions such as osteoporosis, followed at 8.4%.



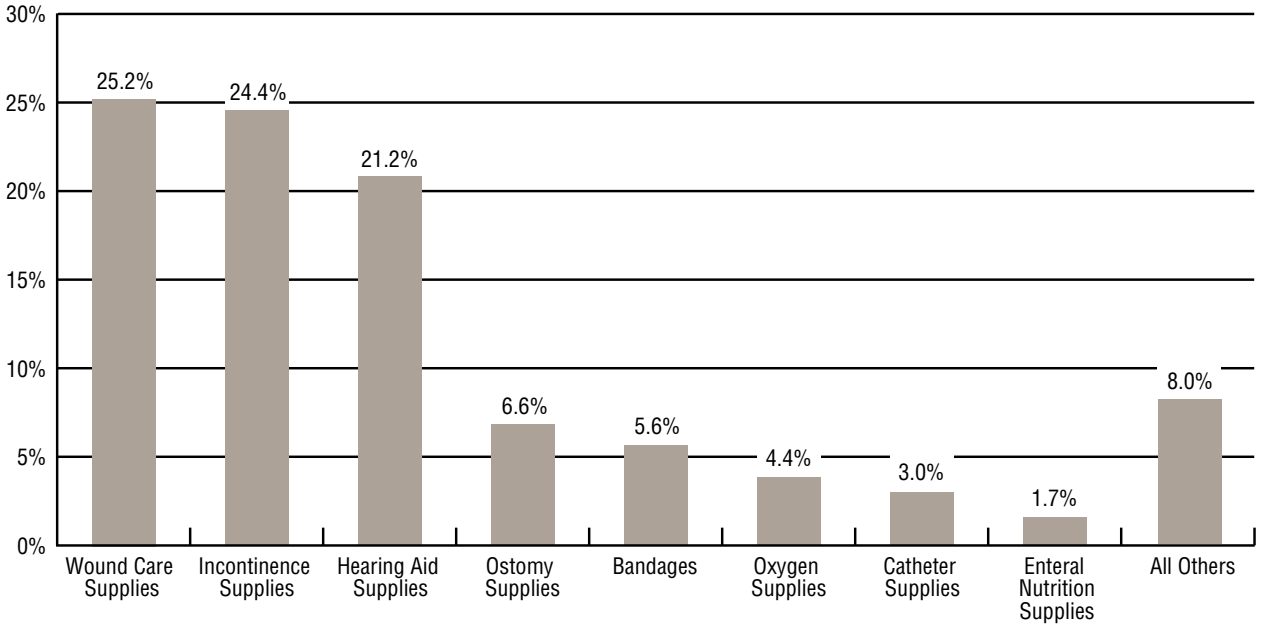
Source: HICPS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.12

NIHB Medical Supplies by Category and Claims Incidence
2014/15

Figure 4.12 demonstrates variation in medical supply claims by specific category.

In 2014/15, wound care supplies such as silver dressings, sterile dressings and iodine dressings accounted for 25.2% of all medical supply claims. Incontinence supplies such as liners and pads, represented the second highest category of medical supplies at 24.4%, followed by hearing aid supplies at 21.2%.



Source: HICPS adapted by Business Support, Audit and Negotiations Division

FIGURE 4.13

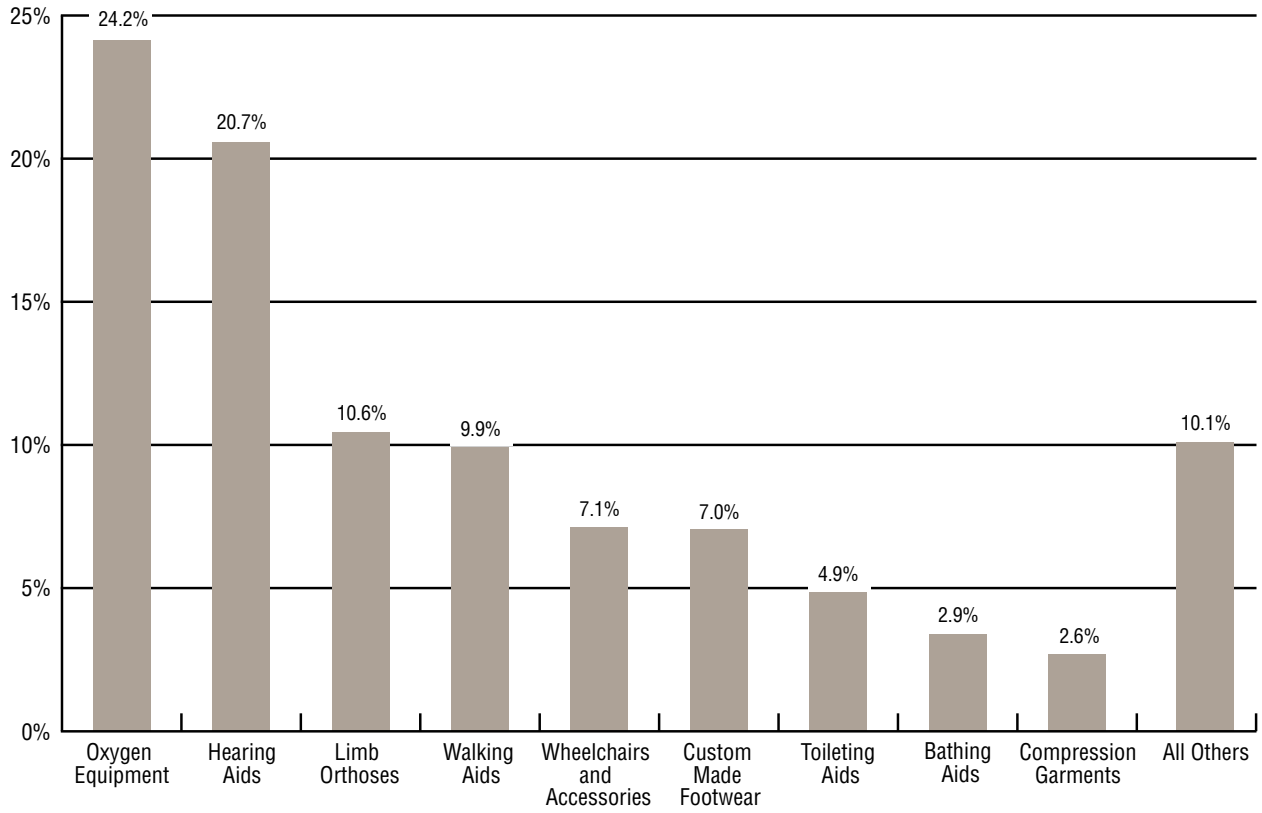
NIHB Medical Equipment by Category and Claims Incidence
2014/15

Figure 4.13 demonstrates variation in medical equipment claims by specific category.

Claims for oxygen equipment accounted for 24.2% of all medical equipment claims in 2014/15. Hearing aids were the next highest at 20.7%, followed by limb orthoses at 10.6% and walking aids at 9.9%.

The most significant increase in the proportion of total medical equipment claims over the fiscal year 2013/14 was in oxygen equipment which increased by 0.7 percentage points.

The most significant decrease in the proportion of total medical equipment claims was in hearing aids which declined 2.1 percentage points as a share of total claims for medical equipment over the previous fiscal year.



Source: HICPS adapted by Business Support, Audit and Negotiations Division

NIHB Dental Expenditure and Utilization Data

SECTION 5

The NIHB Program recognizes the importance of good oral health in contributing to the overall health of First Nations and Inuit clients, and covers a broad range of dental services in an effort to address the unique oral health needs of this client population.

In 2014/15, the NIHB Program paid for dental claims made by a total of 290,110 First Nations and Inuit clients. The total expenditure for these claims was $201.9 million or 19.6% of total NIHB expenditures. The dental benefit accounts for the third largest Program expenditure.

First Nations and Inuit experience a higher rate of dental disease such as periodontal disease and caries compared to other Canadians. Poor oral health can contribute to a greater incidence and severity of other medical conditions such as diabetes, respiratory illnesses and cardiovascular diseases. The broad range of dental services covered by the NIHB Program provides the opportunity to ensure that proper oral care required for overall good health is available to First Nations and Inuit clients. In 2014/15, through the NIHB Program's Dental Benefit, the oral health needs of approximately 180,000 clients who required intraoral radiograph services, 168,000 clients who received scaling procedures, and 125,000 clients who required restoration treatments were addressed.

Coverage for NIHB Dental benefits is determined on an individual basis, taking into consideration the client's current oral health status, client history and accumulated scientific research. Dental services must be provided by a licensed dental professional, such as a dentist, dental specialist, or denturist.

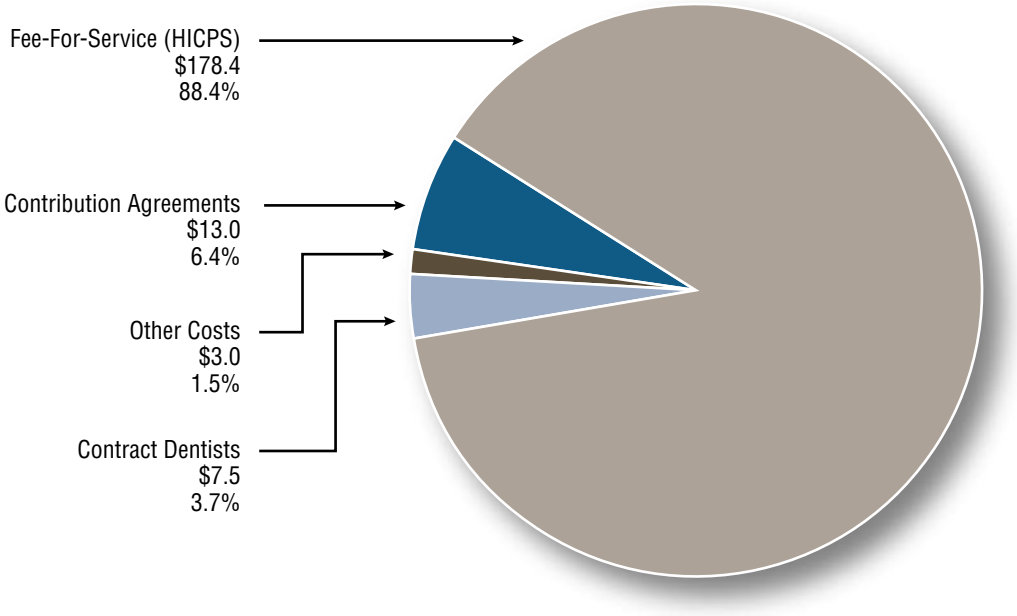
NIHB Dental services are determined on individual assessment and are based on current Program policies. Some dental services require predetermination prior to the initiation of treatment. Predetermination is a review that determines if the proposed dental service is covered under the Program's criteria, guidelines and policies. During the predetermination process, the NIHB Program reviews the dental services submitted against its established Dental Policy Framework and the NIHB Dental Benefits Guide which outline clear definitions of the types of benefits available to clients.

The range of dental services covered by the NIHB Program, includes:

- Diagnostic services such as examinations and radiographs;
- Preventive services such as scaling, polishing, fluorides and sealants;
- Restorative services such as fillings and crowns;
- Endodontic services such as root canal treatments;
- Periodontal services such as deep scaling;
- Removable prosthodontic services such as dentures;
- Oral surgery services such as extractions;
- Orthodontic services to correct significant irregularities in teeth and jaws; and
- Adjunctive services such as general anaesthesia and sedation.

FIGURE 5.1

Distribution of NIHB Dental Expenditures ($ Millions)
2014/15



Total NIHB Dental Expenditures: $201.9M

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

NIHB Dental expenditures totalled $201.9 million in 2014/15. Figure 5.1 illustrates the distinct components of dental expenditures under the NIHB Program. Fee-for-service dental costs paid through the Health Information and Claims Processing Services (HICPS) system represented the largest expenditure component, accounting for $178.4 million or 88.4% of all NIHB Dental costs.

The next highest component was contribution agreements, which accounted for $13.0 million or 6.4% of total dental expenditures. Contribution allocations were used to fund the provision of dental benefits through agreements such as those with the Mohawk Council of Akwesasne in Ontario and the Bigstone Cree Nation in Alberta.

Expenditures for contract dentists providing services to clients in remote communities totalled $7.5 million or 3.7% of total costs.

Other costs totalled $3.0 million or 1.5% in 2014/15. The majority of these costs are related to claims processing and payment services.

FIGURE 5.2

Total NIHB Dental Expenditures by Type and Region ($ 000's)
2014/15

NIHB Dental expenditures totalled $201.9 million in 2014/15. The regions of Ontario (23.2%), Saskatchewan (18.7%), Alberta (17.8%) and Manitoba (16.6%) had the largest proportion of overall dental costs.

REGION	OPERATING			Total Operating Costs	Total Contribution Costs	TOTAL COSTS
	Fee-For-Service	Contract Dentists	Other Costs			
Atlantic	$ 8,238	$ 0	$ 0	$ 8,238	$ -	**$ 8,238**
Quebec	15,697	0	0	15,697	102	**15,799**
Ontario	37,781	2,580	50	40,410	6,349	**46,759**
Manitoba	28,959	4,483	0	33,442	85	**33,527**
Saskatchewan	34,155	0	0	34,155	3,524	**37,679**
Alberta	33,170	56	0	33,226	2,748	**35,974**
North	19,856	368	0	20,224	189	**20,413**
Headquarters	-	-	2,943	2,943	-	**2,943**
Total	**$ 178,410**	**$ 7,487**	**$ 2,993**	**$ 188,890**	**$ 12,996**	**$ 201,886**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

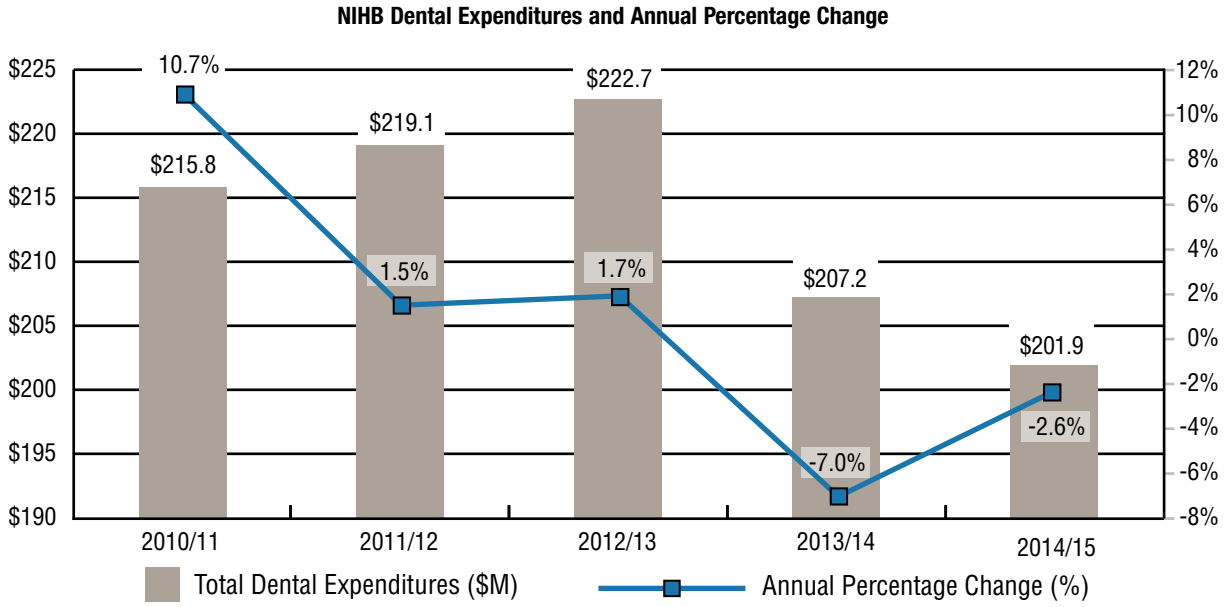
FIGURE 5.3

Annual NIHB Dental Expenditures
2010/11 to 2014/15

NIHB Dental expenditures decreased by 2.6% during fiscal year 2014/15. This decrease in overall NIHB Dental expenditures can be attributed to the transfer of eligible First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with the transfer of responsibility for the management and delivery of non-insured dental benefits, through a phased approach between July and October 2013. If FNHA related expenditures were removed from the 2013/14 dental benefits final expenditures total, overall year over year growth in 2014/15 would have been 2.6%.

Over the last five years, annual growth rates for NIHB Dental expenditures have ranged from a high of 10.7% in 2010/11 to a low of -7.0% in 2013/14.

The Ontario Region had the highest total dental expenditure at $46.8 million and the Atlantic Region had the lowest total dental expenditure at $8.2 million.



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

NIHB Dental Expenditures ($ 000's)					
REGION	2010/11	2011/12	2012/13	2013/14	2014/15
Atlantic	$ 6,481	$ 7,164	$ 9,660	$ 8,609	$ 8,238
Quebec	15,245	15,138	15,239	15,216	15,799
Ontario	40,594	41,848	42,259	43,972	46,759
Manitoba	29,399	29,861	30,734	33,649	33,527
Saskatchewan	35,317	36,941	36,219	36,399	37,679
Alberta	33,421	34,543	34,501	34,928	35,974
North	22,537	20,079	19,773	20,415	20,413
Headquarters	2,614	2,864	2,779	2,978	2,943
Total	$ 215,796	$ 219,057	$ 222,706	$ 207,179	$ 201,886

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

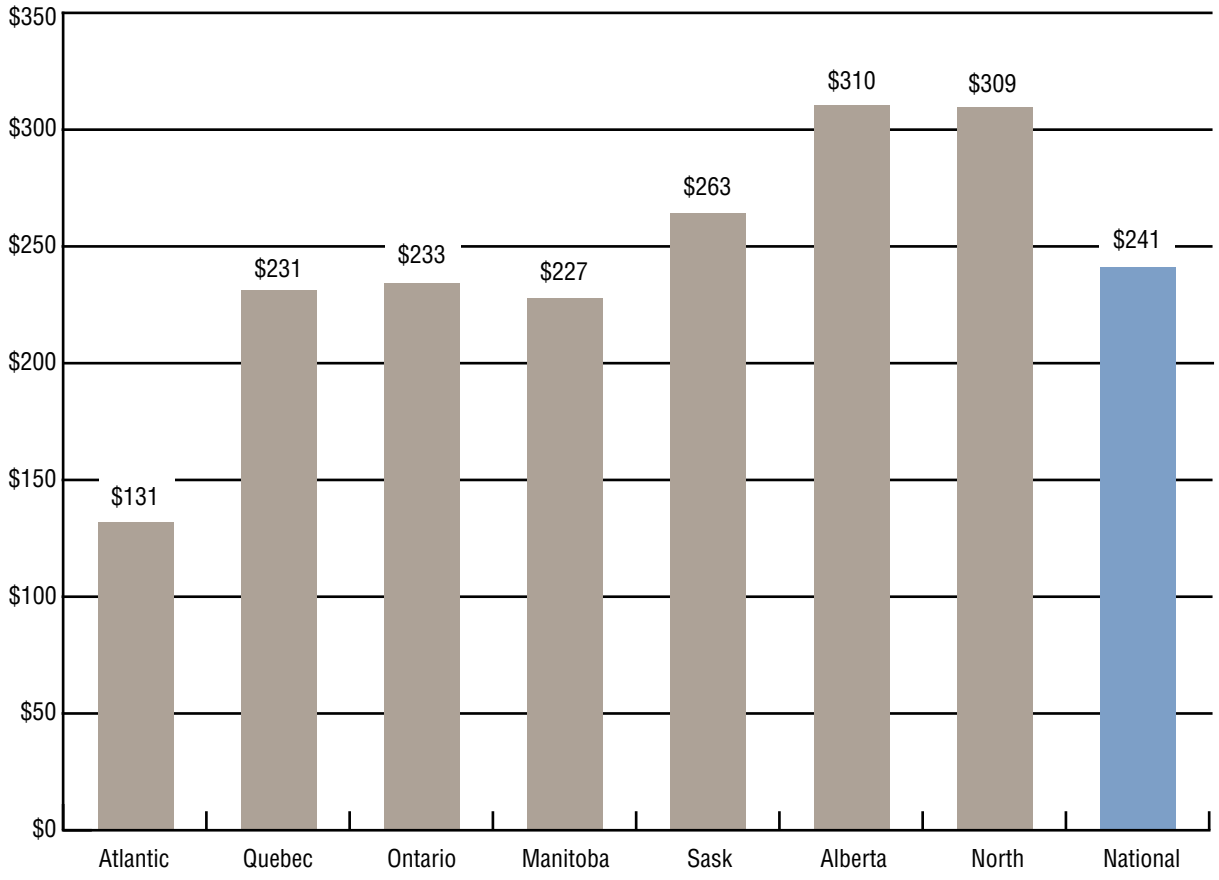
FIGURE 5.4

Per Capita NIHB Dental Expenditures by Region
2014/15

In 2014/15, the national per capita NIHB Dental expenditure was $241, a decrease of 4.4% from the $253 recorded in 2013/14.

The Alberta Region had the highest per capita dental expenditure at $310, followed closely by the Northern Region at $309. The Atlantic Region had the lowest per capita dental cost at $131 per eligible client. The lower per capita cost in the Atlantic Region can be partly attributed to an increase in the eligible client population in this region as a result of the registration of 24,017 Qalipu Mi'kmaq First Nations clients. A large number of these clients have alternative dental coverage. The lower level of dental benefit utilization for these new clients has impacted the dental per capita cost for the Atlantic Region as a whole.

Per capita values reflect total NIHB Dental expenditures as divided by the total eligible NIHB client population. These values do not include additional financial resources provided to First Nations and Inuit populations through other Health Canada programs or through transfers and other arrangements.



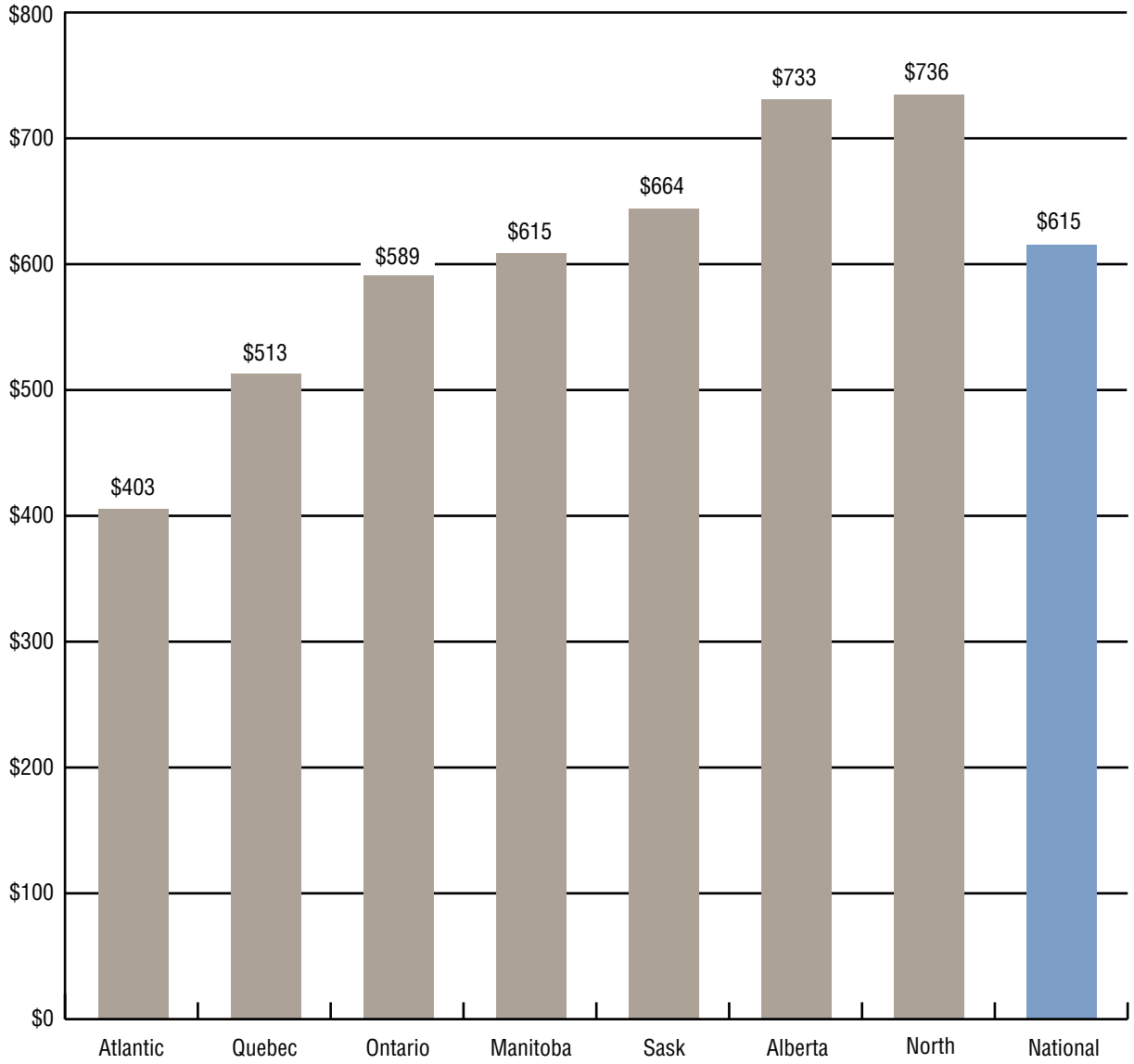
Source: SVS and FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 5.5

NIHB Dental Fee-For-Service Expenditures per Claimant by Region
2014/15

In 2014/15, the national NIHB Dental expenditure per eligible client receiving at least one dental benefit was $615. This represents an increase of 5.6% over the $582 recorded in 2013/14.

The Northern had the highest dental expenditure per claimant at $736 followed by the Alberta Region at $733, an increase of 4.7% from the $700 recorded in the previous year.



Source: FIRMS and HICPS adapted by Business Support, Audit and Negotiations Division

FIGURE 5.6

NIHB Dental Utilization Rates by Region
2010/11 to 2014/15

Utilization rates reflect those clients who, during the fiscal year, received at least one dental service paid through the Health Information and Claims Processing Services (HICPS) system as a proportion of the total number of clients eligible to receive benefits as registered on the Status Verification System (SVS) in that year.

In 2014/15, the national utilization rate for dental benefits paid through the HICPS system was 35%, consistent with the previous three fiscal years. National NIHB Dental utilization rates have remained stable over the past five years.

Dental utilization rates vary across the regions with the highest dental utilization rate found in the Quebec Region (45%). The lowest dental utilization rate was in the Manitoba Region (32%). It should be noted that the dental utilization rates understate the actual level of service as data does not include:

- Health Canada dental clinics (except in the Yukon);
- Contract dental services provided in some regions;
- Services provided by Health Canada Dental Therapists or other FNIHB dental programs such as the Children's Oral Health Initiative (COHI); and
- Dental services provided through contribution agreements. For example, HICPS data does not capture any services utilized by the Bigstone Cree Nation. If this client population was removed from the Alberta Region's population, the utilization rate for dental benefits for Alberta would have been 42% in 2014/15. The same scenario would apply for the Ontario Region. If the Akwesasne client population in Ontario were to be removed, the utilization rate for dental benefits in Ontario would have been 34%. If both the Bigstone and Akwesasne client populations were removed from the overall NIHB population, the national utilization rate for dental benefits would have been 36%.

Over the two year period between 2013/14 and 2014/15, 396,384 distinct clients received NIHB Dental services resulting in an overall 48% utilization rate over this period.

REGION	Dental Utilization					
	2010/11	2011/12	2012/13	2013/14	2014/15	NIHB Dental Utilization Last Two Years 2013/15
Atlantic	36%	28%	34%	34%	33%	44%
Quebec	46%	44%	44%	45%	45%	56%
Ontario	33%	32%	32%	32%	32%	42%
Manitoba	31%	31%	31%	32%	32%	45%
Saskatchewan	38%	37%	36%	36%	36%	52%
Alberta	40%	39%	39%	41%	39%	55%
Yukon	39%	38%	37%	39%	37%	54%
N.W.T.	42%	42%	41%	43%	41%	57%
Nunavut	45%	43%	42%	43%	42%	59%
National	37%	36%	36%	36%	35%	48%

Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

FIGURE 5.7

NIHB Dental Claimants by Age Group, Gender and Region
2014/15

Of the 824,033 clients eligible to receive dental benefits through the NIHB Program, 290,110 (35%) claimants received at least one dental procedure paid through the Health Information and Claims Processing Services (HICPS) system in 2014/15.

Of this total, 162,744 were female (56%) and 127,366 were male (44%), compared to the total eligible NIHB population where 51% were female and 49% were male.

The average age of dental claimants was 29 years, indicating clients tend to access dental services at a slightly younger age compared to pharmacy services (34 years of age). The average age for female and male claimants was 30 and 28 years of age respectively.

Approximately 40% of all dental claimants were under 20 years of age. Forty-three percent of male claimants were in this age group compared to 37% of female claimants. Approximately 4% of all claimants were seniors (ages 65 and over) in 2014/15.

REGION	Atlantic			Quebec			Ontario			Manitoba		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	192	212	404	730	676	1,406	1,542	1,656	3,198	1,989	1,951	3,940
5–9	681	743	1,424	1,660	1,587	3,247	3,328	3,225	6,553	3,028	3,101	6,129
10–14	880	933	1,813	1,511	1,586	3,097	3,269	3,356	6,625	2,588	2,935	5,523
15–19	1,033	1,243	2,276	1,211	1,425	2,636	2,756	3,205	5,961	2,026	2,826	4,852
20–24	792	1,039	1,831	1,136	1,419	2,555	2,279	3,173	5,452	1,812	2,760	4,572
25–29	704	947	1,651	913	1,324	2,237	1,956	2,800	4,756	1,513	2,229	3,742
30–34	611	889	1,500	844	1,143	1,987	1,755	2,491	4,246	1,396	1,861	3,257
35–39	578	820	1,398	879	1,119	1,998	1,664	2,310	3,974	1,184	1,685	2,869
40–44	672	875	1,547	899	1,179	2,078	1,738	2,394	4,132	1,189	1,713	2,902
45–49	686	885	1,571	966	1,268	2,234	1,849	2,544	4,393	1,135	1,569	2,704
50–54	605	832	1,437	955	1,197	2,152	1,799	2,554	4,353	1,015	1,377	2,392
55–59	530	790	1,320	745	1,045	1,790	1,548	2,160	3,708	738	993	1,731
60–64	407	632	1,039	497	708	1,205	1,045	1,597	2,642	494	716	1,210
65+	548	703	1,251	778	1,193	1,971	1,564	2,610	4,174	506	797	1,303
Total	**8,919**	**11,543**	**20,462**	**13,724**	**16,869**	**30,593**	**28,092**	**36,075**	**64,167**	**20,613**	**26,513**	**47,126**
Average Age	**34**	**35**	**35**	**31**	**34**	**33**	**31**	**34**	**32**	**26**	**28**	**27**

Source: HICPS adapted by Program Analysis Division

REGION	Saskatchewan			Alberta			North			TOTAL		
Age Group	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–4	1,934	1,949	3,883	2,033	1,950	3,983	1,206	1,156	2,362	9,866	9,829	19,695
5–9	3,441	3,737	7,178	3,198	3,418	6,616	1,402	1,430	2,832	16,994	17,474	34,468
10–14	2,888	3,306	6,194	2,768	2,986	5,754	1,181	1,543	2,724	15,302	16,872	32,174
15–19	2,055	2,905	4,960	2,137	2,593	4,730	1,155	1,584	2,739	12,588	15,999	28,587
20–24	1,960	2,984	4,944	1,621	2,389	4,010	1,240	1,753	2,993	10,985	15,722	26,707
25–29	1,784	2,689	4,473	1,396	2,132	3,528	1,005	1,475	2,480	9,397	13,764	23,161
30–34	1,463	2,168	3,631	1,302	1,857	3,159	835	1,220	2,055	8,359	11,786	20,145
35–39	1,319	1,884	3,203	1,176	1,606	2,782	697	926	1,623	7,597	10,491	18,088
40–44	1,403	1,918	3,321	1,070	1,476	2,546	728	952	1,680	7,809	10,641	18,450
45–49	1,335	1,768	3,103	1,066	1,354	2,420	704	910	1,614	7,830	10,455	18,285
50–54	1,035	1,455	2,490	860	1,267	2,127	573	765	1,338	6,928	9,567	16,495
55–59	699	989	1,688	599	858	1,457	329	511	840	5,229	7,433	12,662
60–64	469	612	1,081	375	568	943	306	402	708	3,624	5,311	8,935
65+	508	784	1,292	495	675	1,170	427	567	994	4,858	7,400	12,258
Total	22,293	29,148	51,441	20,096	25,129	45,225	11,788	15,194	26,982	127,366	162,744	290,110
Average Age	26	28	27	25	27	26	27	29	28	28	30	29

FIGURE 5.8

NIHB Fee-for-Service Dental Expenditures by Sub-Benefit
2014/15

The NIHB Program recognizes the importance of oral health in contributing to the overall health and well-being of individuals by providing eligible clients with a broad range of dental services to ensure proper oral care.

In 2014/15, expenditures for Restorative Services (crowns, fillings, etc.) were the highest of all dental sub-benefit categories at $79.7 million. Preventative Services (scaling, sealants, etc.) at $23.0 million and Diagnostic Services (examinations, x-rays, etc.) at $22.6 million were the next highest sub-benefit categories. Rounding out the top 5 was Oral Surgery (extractions, etc.) at $19.1 million and Endodontic Services (root canal treatments, etc.) at $10.6 million.

In 2014/15, the three largest dental procedures by expenditure were Composite Restorations ($65.7 million), Scaling ($17.5 million) and Extractions ($12.9 million).

Fee-For-Service Top 5 Dental Sub-Benefits ($ Millions) and Percentage Change			
Dental Sub-Benefit	2013/14	2014/15	% Change from 2013/14 (FNHA Clients Excluded)
Restorative Services	$ 76.7	$ 79.3	3.4%
Preventive Services	22.0	22.9	4.0%
Diagnostic Services	21.4	22.5	5.3%
Oral Surgery	17.4	19.1	9.7%
Endodontic Services	10.0	10.5	5.6%

Fee-For-Service Top 5 Dental Procedures ($ Millions) and Percentage Change			
Dental Procedure	2013/14	2014/15	% Change from 2013/14 (FNHA Clients Excluded)
Composite Restorations	$ 62.1	$ 65.7	5.8%
Scaling	16.8	17.5	4.3%
Extractions	11.9	12.9	8.3%
Root Canal Therapy	8.2	8.7	5.8%
Intraoral Radiographs	7.1	7.5	4.9%

Source: HICPS adapted by Business Support, Audit and Negotiations Division

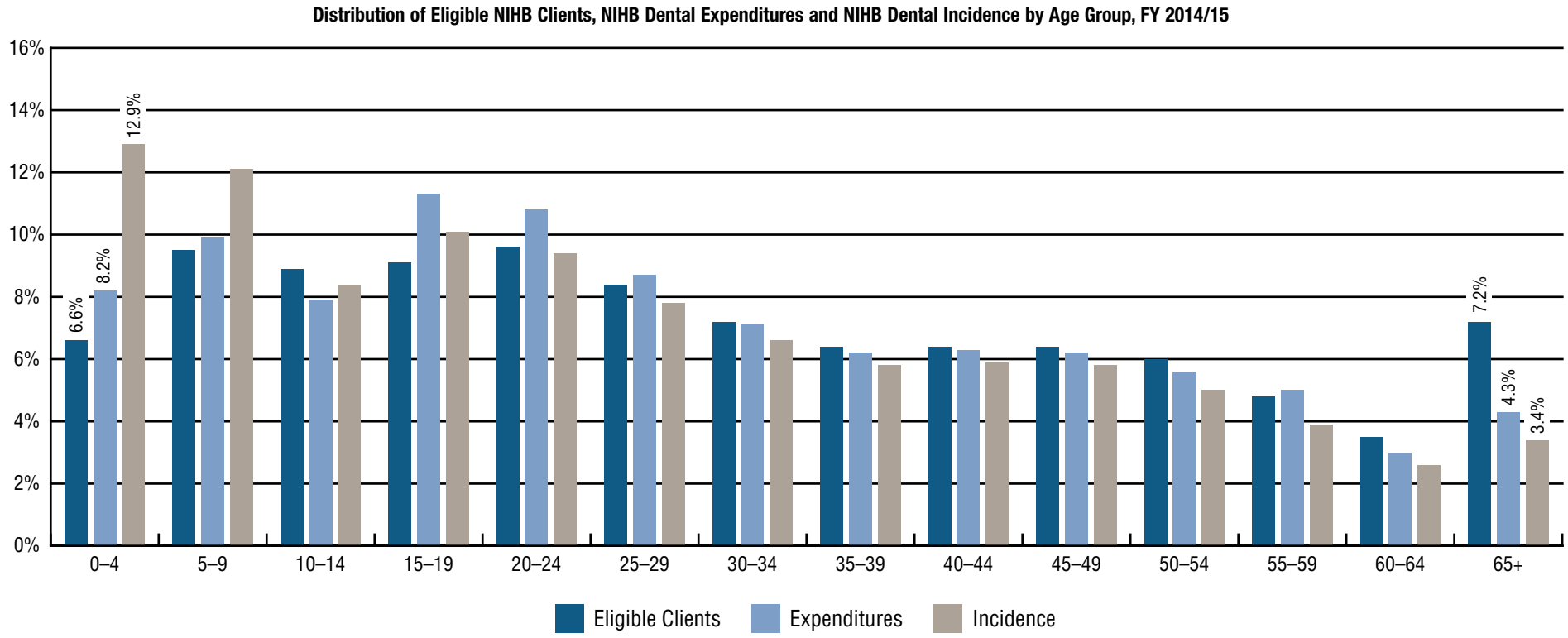
FIGURE 5.9

Distribution of Eligible NIHB Population, Dental Expenditures and Incidence by Age Group
2014/15

The main drivers of NIHB Dental expenditures are increased rates of utilization and increases in the fees charged for services by dental professionals. The type of dental service provided also has an impact on expenditures.

The ratio of incidence to expenditures is relatively consistent across most age groupings; however, there are notable exceptions. For children aged 0 to 9, a larger number of low-cost procedures (e.g., low-cost restorative procedures such as fillings) are provided. The result was a ratio of incidence to expenditures of 25.1% to 18.1%.

With respect to the ratio of eligible clients to expenditures, a relatively stable relationship exists across most age groups. The notable exceptions to this pattern are youth aged 15 to 19 and clients who are 65 years of age and older. The ratios of eligible clients to expenditures for youth aged 15 to 19 are 9.1% to 11.3% and for clients who are 65 years of age or older they are 7.2% to 4.3% respectively.



Source: HICPS and SVS adapted by Business Support, Audit and Negotiations Division

NIHB Medical Transportation Expenditure and Utilization Data

SECTION 6

In 2014/15, Non-Insured Health Benefits Medical Transportation expenditures amounted to $356.6 million or 34.7% of total NIHB expenditures. The medical transportation benefit is the second largest Program expenditure.

NIHB Medical Transportation benefits are needs driven and funded in accordance with the policies set out in the NIHB Medical Transportation Policy Framework to assist eligible clients to access medically necessary health services that cannot be obtained on reserve or in their community of residence.

NIHB Medical Transportation benefits are operationally managed by regional offices. These benefits are also managed by First Nations or Inuit Health Authorities, organizations or territorial governments who, under a contribution agreement, have assumed responsibility for the administration and coverage of medical transportation benefits to eligible clients. In 2014/15, a total of 364 contribution agreements were issued for medical transportation.

NIHB Medical Transportation benefits include:

- Ground Travel (private vehicle; commercial taxi; fee-for-service driver and vehicle; band vehicle; bus; train; snowmobile taxi; and ground ambulance);
- Air Travel (scheduled flights; chartered flights; helicopter; and air ambulance);
- Water Travel (motorized boat; boat taxi; and ferry);
- Living Expenses (meals and accommodations); and
- Transportation costs for health professionals to provide services to isolated communities.

NIHB Medical Transportation benefits may be provided for clients to access the following types of medically required health services:

- Medical services defined as insured services by provincial/territorial health plans (e.g., appointments with physicians, hospital care);
- Diagnostic tests and medical treatments covered by provincial/territorial health plans;
- Alcohol, solvent, drug abuse and detox treatments;
- Traditional healers; and
- Non-Insured Health Benefits (vision, dental, mental health).

NHB Medical Transportation benefits may also be provided to approved medical and non-medical escorts for clients travelling to access medically necessary health services.

In addition to facilitating client travel to appointments for these medical services, significant efforts have been made over the past few years to bring health care professionals to the communities of residence of clients living in under-serviced and/or remote and isolated communities. These efforts enhance access to medically necessary services in communities and can be more cost effective than bringing individual clients to the service provider.

FIGURE 6.1

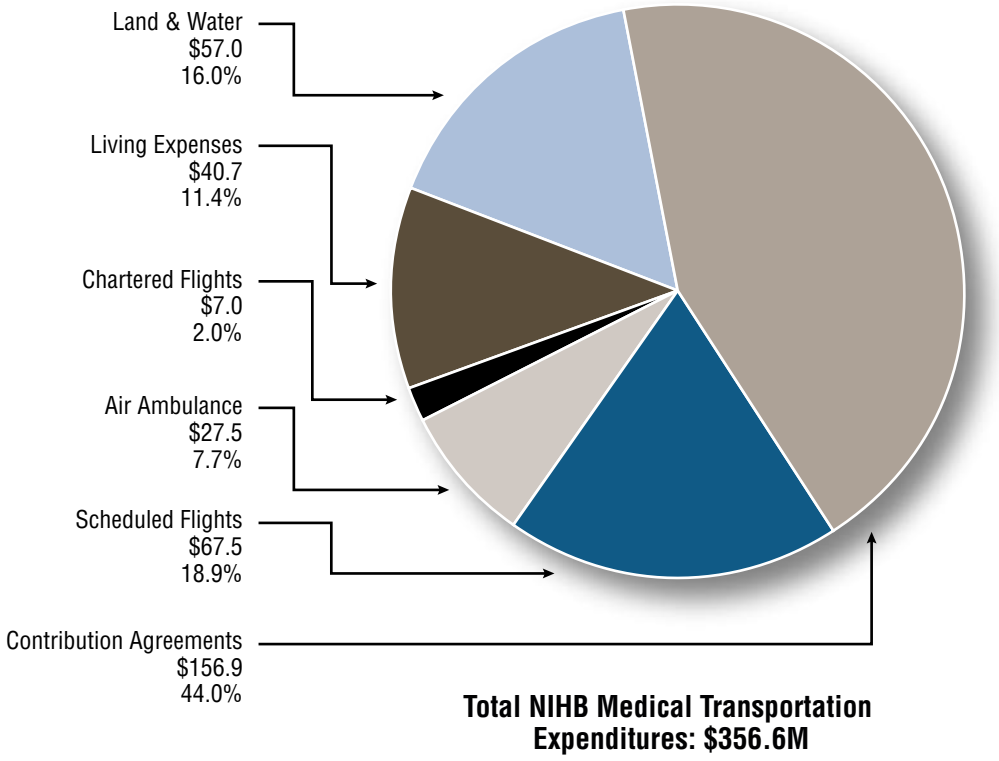
Distribution of NIHB Medical Transportation Expenditures ($ Millions)
2014/15

In 2014/15, NIHB Medical Transportation expenditures totalled $356.6 million. Figure 6.1 illustrates the components of medical transportation expenditures under the NIHB Program.

Contribution agreements represented the largest component, accounting for $156.9 million, or 44.0% of the total benefit.

Scheduled flights at $67.5 million (18.9%) and land and water transportation at $57.0 million (16.0%) were the largest medical transportation operating expenditures, accounting for one-third of the total benefit.

Rounding out medical transportation expenditures are costs for living expenses at $40.7 million (11.4%), air ambulance at $27.5 million (7.7%) and chartered flights at $7.0 million (2.0%).



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

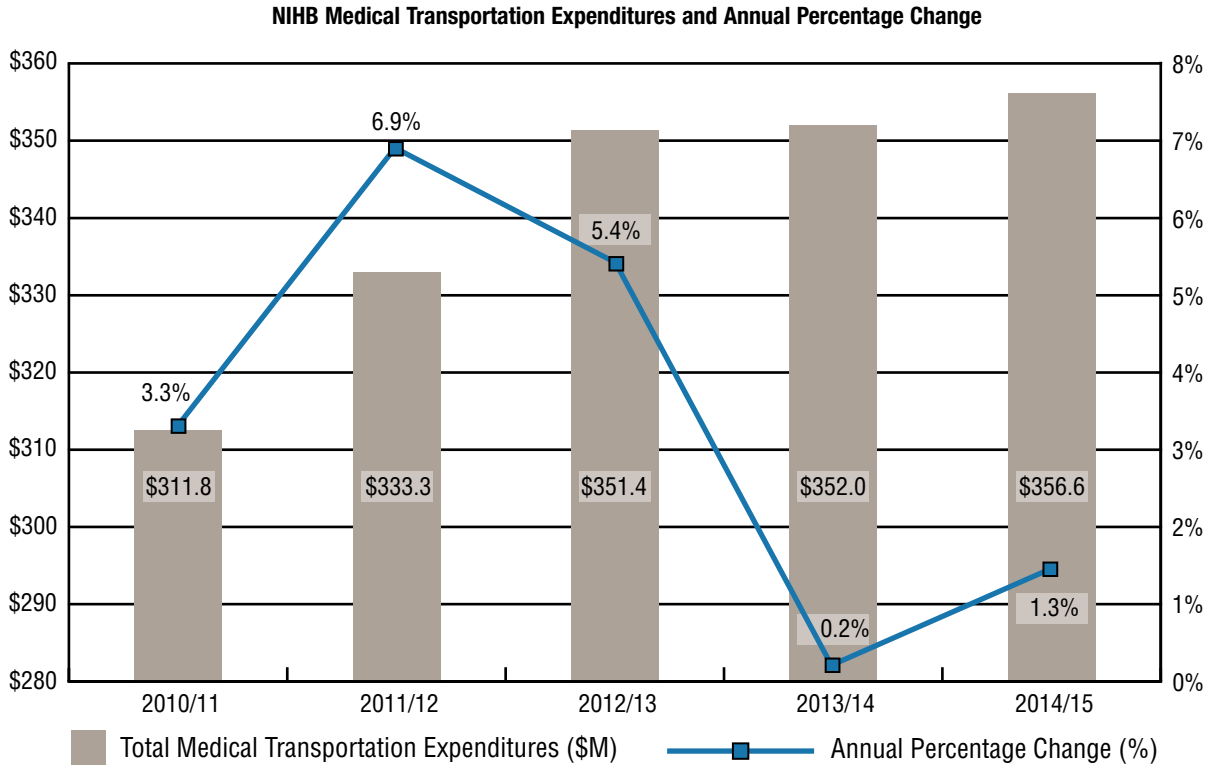
FIGURE 6.2

Annual NIHB Medical Transportation Expenditures
2010/11 to 2014/15

NIHB Medical Transportation expenditures increased by 1.3% in 2014/15. This low increase in overall NIHB Medical Transportation expenditures can be attributed to the transfer of eligible First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with the transfer of responsibility for the management and delivery of non-insured medical transportation benefits.

Over the past five years, overall medical transportation costs have grown by 14.4% from $311.8 million in 2010/11 to $356.6 million in 2014/15. On a regional basis, the highest growth rates over this period were in the Atlantic Region where expenditures grew by 39.6% from $5.3 million in 2010/11 to $7.4 million in 2014/15. This high growth is largely attributed to the uptake of medical transportation services by the Qalipu Mi'kmaq First Nations clients eligible to receive NIHB benefits since September 26, 2011. This was followed by the Northern Region with an increase of 32.3% from $36.5 million in 2010/11 to $48.2 million in 2014/15.

The Manitoba Region had the highest total medical transportation expenditure at $115.7 million and had the largest net increase in expenditures over the past five years as medical transportation costs grew by $20.8 million over this period. The Ontario Region had the second largest net increase in expenditures over the past five years at $13.4 million followed by the Saskatchewan Region at $9.6 million.



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

NIHB Medical Transportation Expenditures ($ 000's)					
REGION	2010/11	2011/12	2012/13	2013/14	2014/15
Atlantic	$ 5,314	$ 5,841	$ 6,875	$ 6,916	$ 7,419
Quebec	18,943	21,708	22,578	21,945	23,506
Ontario	52,358	54,725	59,251	62,865	65,781
Manitoba	94,940	101,609	109,409	111,016	115,705
Saskatchewan	41,896	45,084	45,793	47,180	51,543
Alberta	35,877	37,371	39,216	41,451	44,403
North	36,464	40,455	41,727	44,703	48,246
Total	$ 311,760	$ 333,304	$ 351,424	$ 352,036	$ 356,610

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 6.3

NIHB Medical Transportation Expenditures by Type and Region ($ 000's)
2014/15

NIHB Medical Transportation expenditures increased by 1.3% to $356.6 million in 2014/15. If expenditures associated with the FNHA in British Columbia were excluded from fiscal year 2013/14 final NIHB Program expenditures, then the actual increase in NIHB Medical Transportation benefits would have been 5.8% in 2014/15.

Saskatchewan had the largest percentage increase in medical transportation expenditures in 2014/15 at 9.2%. The Northern Region followed with a 7.9% increase in expenditures.

In 2014/15, the Manitoba Region had the highest overall NIHB Medical Transportation expenditure at $115.7 million, primarily as a result of air transportation which totalled $60.4 million. High medical transportation costs in the region reflect in part the large number of First Nations clients living in remote or fly-in only northern communities.

The Ontario Region represented the second highest medical transportation expenditure total in 2014/15 at $65.8 million. The regions of Saskatchewan and Alberta followed at $51.5 million and $44.4 million, respectively.

TYPE	Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	North	TOTAL
Scheduled Flights	$ 963	$ 236	$ 21,604	$ 35,703	$ 6,899	$ 1,105	$ 976	**$ 67,486**
Air Ambulance	7	28	48	20,762	3,784	1,353	1,493	**27,471**
Chartered Flights	0	0	376	3,899	1,609	1,145	0	**7,030**
Living Expenses	860	27	14,465	15,516	4,498	4,323	990	**40,679**
Land & Water	1,926	302	4,029	13,976	21,767	14,412	584	**57,006**
Total Operating	**$ 3,755**	**$ 592**	**$ 40,522**	**$ 89,856**	**$ 38,558**	**$ 22,338**	**$ 4,043**	**$ 199,671**
Total Contributions	$ 3,664	$ 22,913	$ 25,259	$ 25,849	$ 12,985	$ 22,065	$ 44,203	**$ 156,938**
TOTAL	**$ 7,419**	**$ 23,506**	**$ 65,781**	**$ 115,705**	**$ 51,543**	**$ 44,403**	**$ 48,246**	$ 356,610
% Change from 2013/14	**7.3%**	**7.1%**	**4.6%**	**4.2%**	**9.2%**	**7.1%**	**7.9%**	**1.3%**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

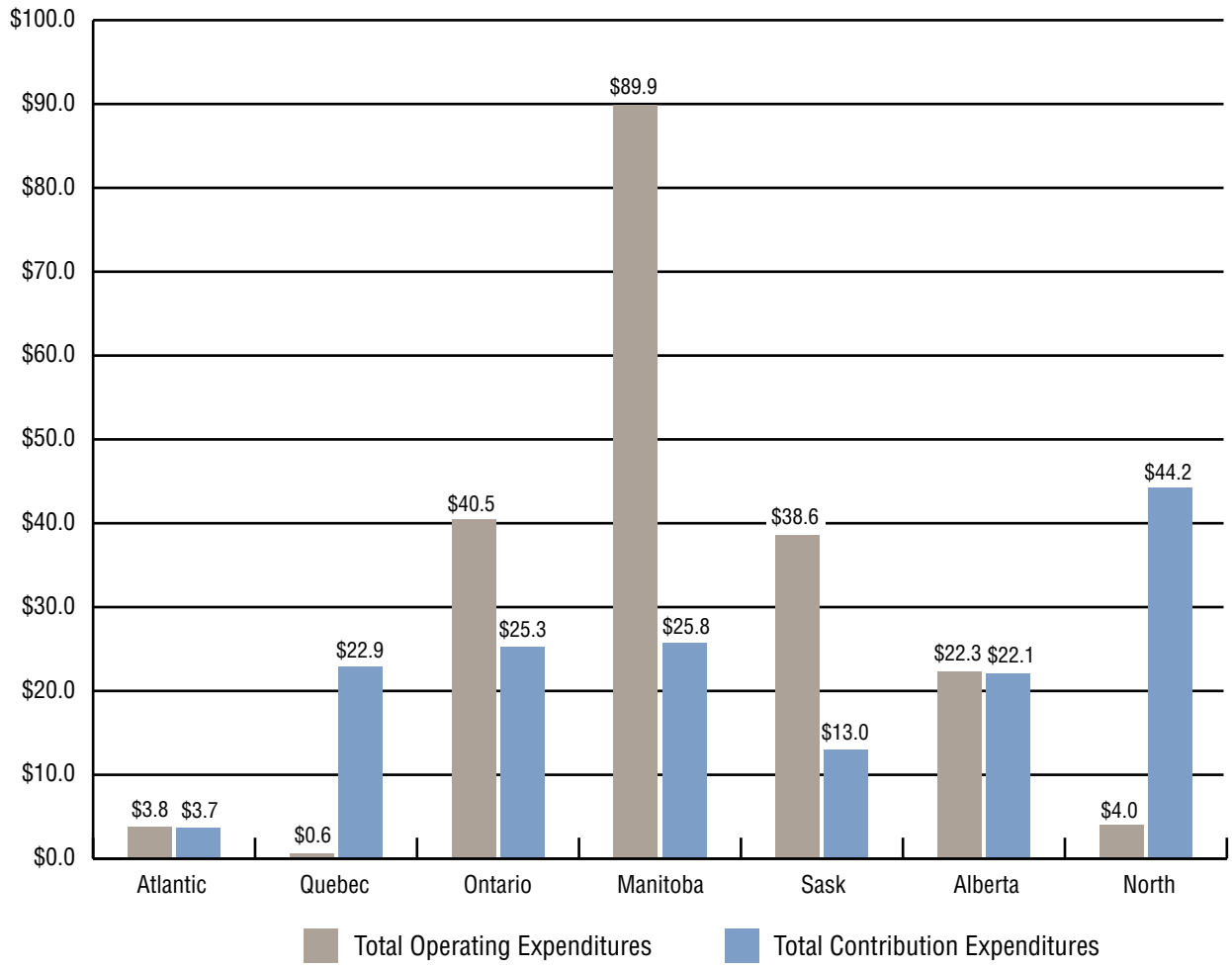
FIGURE 6.4

NIHB Medical Transportation Contribution and Operating Expenditures by Region ($ Millions)
2014/15

Figure 6.4 compares contribution funding to direct operating costs in NIHB Medical Transportation. Contribution funds are provided to First Nations bands, territorial governments and other organizations to manage elements of the medical transportation benefit (e.g., coordinating accommodations, managing ground transportation, etc.). In 2014/15, a total of 364 contribution agreements were in place for the medical transportation benefit. Direct operating costs are funded to provide medical transportation benefits that are managed by Health Canada's regional offices.

The Manitoba Region had the largest operating expenditure for NIHB Medical Transportation in 2014/15 at $89.9 million. This higher cost in the Manitoba Region is due in part to approximately 62,800 clients living in 24 remote or fly-in only communities in the northern areas of the province and the fact that First Nations clients receive their health services primarily in Winnipeg. The Ontario Region was the next largest at $40.5 million, followed closely by the Saskatchewan Region at $38.6 million. Together these three regions accounted for 84.6% of all operating expenditures on medical transportation.

In 2014/15, the Northern Region had the largest contribution expenditures for NIHB Medical Transportation at $44.2 million, followed by the regions of Manitoba and Ontario at $25.8 million and $25.3 million, respectively. Almost all NIHB Medical Transportation services were delivered via contribution agreements in Quebec.



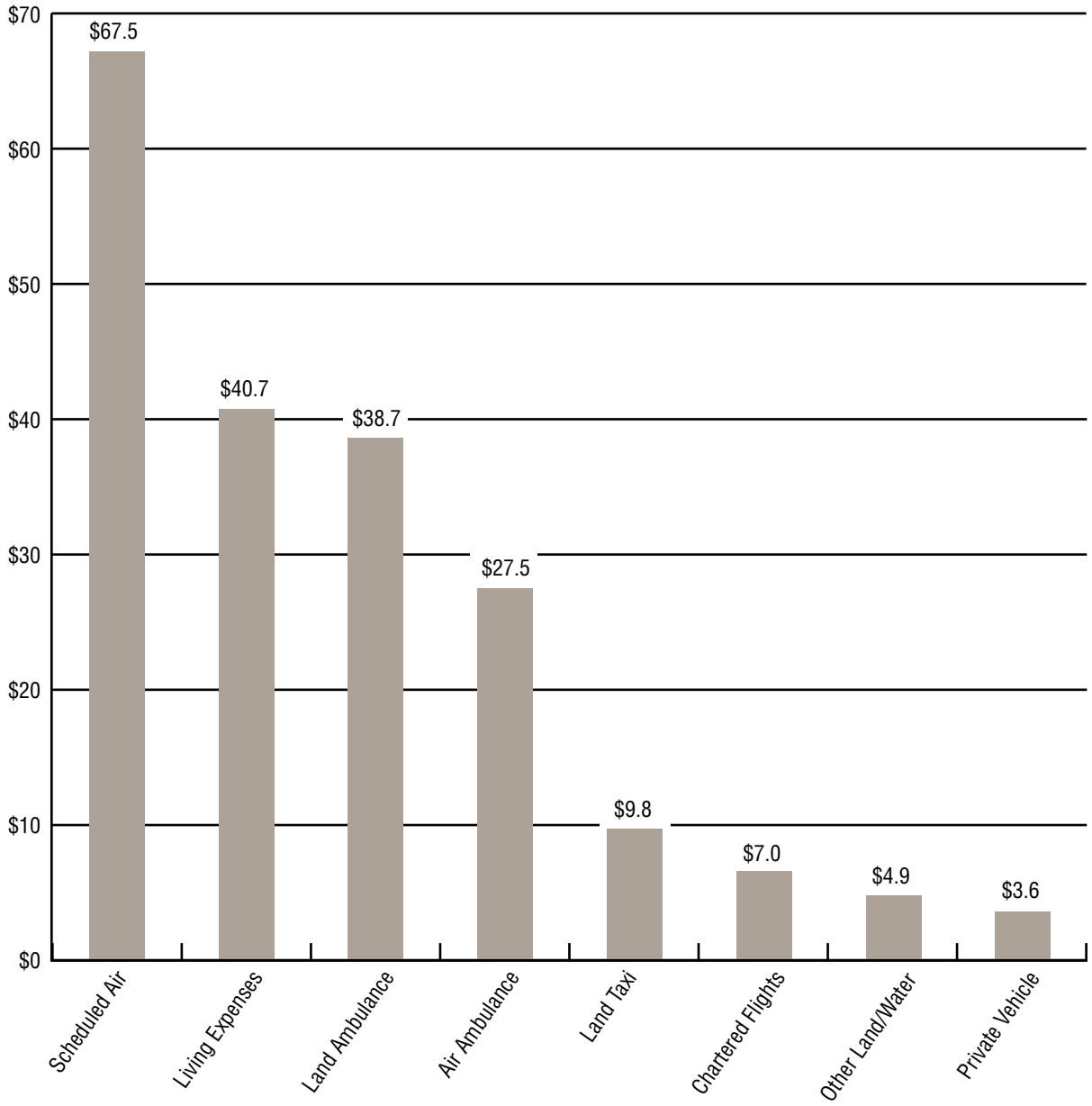
Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 6.5

NIHB Medical Transportation Operating Expenditure by Type ($ Millions)
2014/15

In 2014/15, scheduled flights represented the largest portion of NIHB's Medical Transportation operating expenditures at $67.5 million or 33.8% of the total national operating expenditures. Living expenses, which include accommodations and meals, were the second highest at $40.7 million representing 20.4% of operating expenditures. Land ambulance costs followed at $38.7 million or 19.4%, and air ambulance costs comprised $27.5 million or 13.8% of medical transportation operating costs.

Private vehicle expenditures ($3.6 million) consist of the costs reimbursed through a per-kilometre allowance for private vehicle use by a client to access medically necessary eligible health services. The NIHB private vehicle kilometric allowance rates are directly linked to the National Joint Council's (NJC) Government Commuting Assistance Directive Lower Kilometric Rates.



Source: FIRMS adapted by Business Support, Audit and Negotiations Division

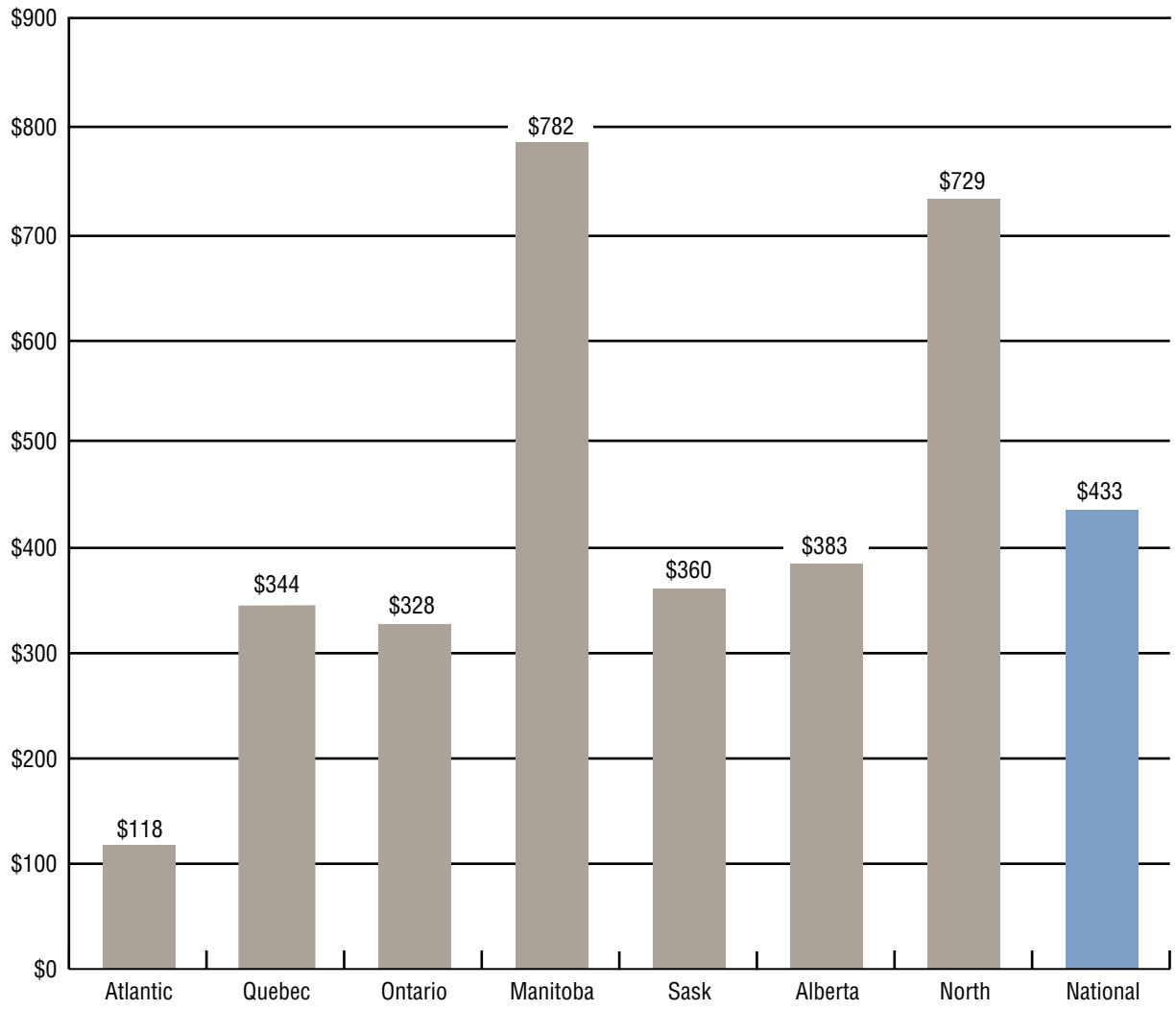
FIGURE 6.6

Per Capita NIHB Medical Transportation Expenditures by Region
2014/15

In 2014/15, the national per capita expenditure for NIHB Medical Transportation benefits was $433.

Manitoba recorded the highest per capita expenditure in medical transportation at $782, followed by the Northern Region at $729. These expenditures reflect the large number of First Nations and Inuit clients living in remote or fly-in only northern communities that need to be sent south for health services covered by the NIHB Program.

In contrast, the Atlantic Region had the lowest per capita expenditure at $118, a very slight increase from $112 in the previous year. Compared to other regions, this lower per capita cost is reflective of the geography of the region, the relative ease of access to health services, and the lack of dependence on air travel.



Source: SVS and FIRMS adapted by Business Support, Audit and Negotiations Division

NIHB Vision Benefits, Mental Health Counselling Benefits and Other Health Care Benefits Data

SECTION 7

In 2014/15, total expenditures for NIHB Vision benefits ($29.2 million), Mental Health Counselling benefits ($15.6 million) and Other Health Care benefits ($4.0 million) amounted to $48.7 million, or 4.7% of total NIHB expenditures for the fiscal year.

Vision care benefits are covered in accordance with the policies set out in the NIHB Vision Care Policy Framework. The NIHB Program covers:

- Eye examinations, when they are not insured by the province/territory;
- Eyeglasses that are prescribed by a vision care professional;
- Eyeglass repairs; and
- Other vision care benefits depending on the specific medical needs of the client.

Vision care benefits are provided by an NIHB recognized provider. A vision care provider must be licensed/certified, authorized, and in good standing with the regulatory body of the province/territory in which they practice.

NIHB Mental Health Counselling is primarily short-term crisis intervention mental health counselling benefits to address at-risk situations. This service is provided by a recognized professional mental health therapist when no other service is available to the client. The NIHB Program may cover the following services:

- The initial assessment;
- Development of a treatment plan;
- Mental health treatment by an eligible NIHB Provider as per NIHB Program directives;
- Individual, conjoint (with a couple), family, or group (with unrelated individuals) counselling sessions; and
- Fees and associated travel costs for the professional mental health therapist when it is deemed cost-effective to provide such services in a community.

NIHB Other Health Care includes expenditures related to funding arrangements with the FNHA for Bill C-3 and Qalipu clients, and for payment of Inuit premiums in British Columbia. *Other expenditures also include funding for Program oversight and partner contribution agreements.*

FIGURE 7.1

NIHB Vision Expenditures and Growth by Region ($ 000's)
2014/15

NIHB Vision expenditures totalled $29.2 million in 2014/15. Regional operating expenditures accounted for $25.7 million or 88.2% of total expenditures while contribution costs accounted for $3.4 million or 11.8%.

In 2014/15, the Alberta Region had the highest expenditures in NIHB Vision benefits at $6.5 million, a percentage share of 22.4%, followed by the Saskatchewan Region at $6.1 million (20.8%) and the Ontario Region at $5.7 million (19.6%).

In 2014/15, the largest net increase in expenditures took place in the Alberta Region, where total vision care costs grew by $596 thousand. The highest percentage change in NIHB Vision expenditures was in the Manitoba Region with an increase of 10.4%.

REGION	Operating	Contributions	TOTAL
Atlantic	$ 2,666	$ 0	$ 2,666
Quebec	1,622	0	1,622
Ontario	5,179	537	5,717
Manitoba	4,519	281	4,800
Saskatchewan	6,066	0	6,066
Alberta	5,347	1,185	6,531
North	304	1,438	1,743
Total	**$ 25,710**	**$ 3,441**	**$ 29,145**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

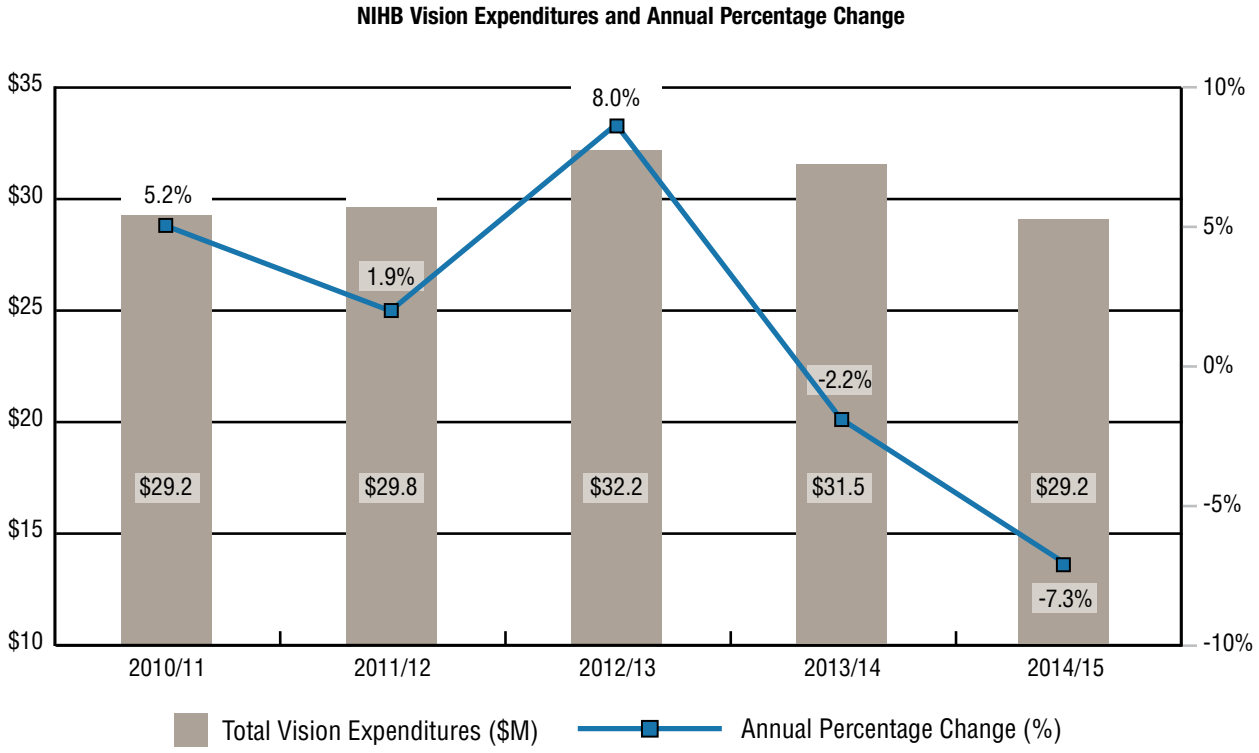
FIGURE 7.2

Annual NIHB Vision Expenditures
2010/11 to 2014/15

In 2014/15, NIHB Vision expenditures decreased by 7.3%, compared to the 2.2% decrease recorded in 2013/14. This decrease in overall NIHB Vision expenditures can be partially attributed to the transfer of eligible First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA) along with the transfer of responsibility for the management and delivery of non-insured vision benefits.

Over the past five years, overall vision benefit costs have remained steady, the total value unchanged from $29.2 million in 2010/11 to $29.2 million in 2014/15. On a regional basis, the highest expenditure growth rate over this five year period was in the Atlantic Region where expenditures grew by 51.6% from $1.8 million in 2010/11 to $2.7 million in 2014/15. This growth is primarily attributed to the uptake of vision services by the Qalipu Mi'kmaq First Nations clients eligible to receive NIHB benefits since September 26, 2011.

The largest net increases in expenditures over the past five years took place in the Saskatchewan Region where total vision benefit costs grew by $1.4 million over this period, followed closely by the Manitoba Region where costs grew by $1.2 million. The significant drop in Northern Region vision expenditures in fiscal year 2014/15 is due to a change in financial coding for specific Vision benefit contribution agreements in Nunavut and N.W.T.



Source: FIRMS adapted by Program Analysis Division

NIHB Vision Expenditures ($ 000's)					
REGION	2010/11	2011/12	2012/13	2013/14	2014/15
Atlantic	$ 1,758	$ 2,021	$ 2,969	$ 2,757	$ 2,666
Quebec	1,336	1,404	1,570	1,619	1,622
Ontario	5,183	5,425	5,412	5,721	5,717
Manitoba	3,612	3,813	4,048	4,348	4,800
Saskatchewan	4,658	4,449	5,676	5,611	6,066
Alberta	5,778	5,822	5,836	5,936	6,531
North	3,550	3,387	3,370	3,763	1,743
Total	$ 29,219	$ 29,780	$ 32,167	$ 31,459	$ 29,151

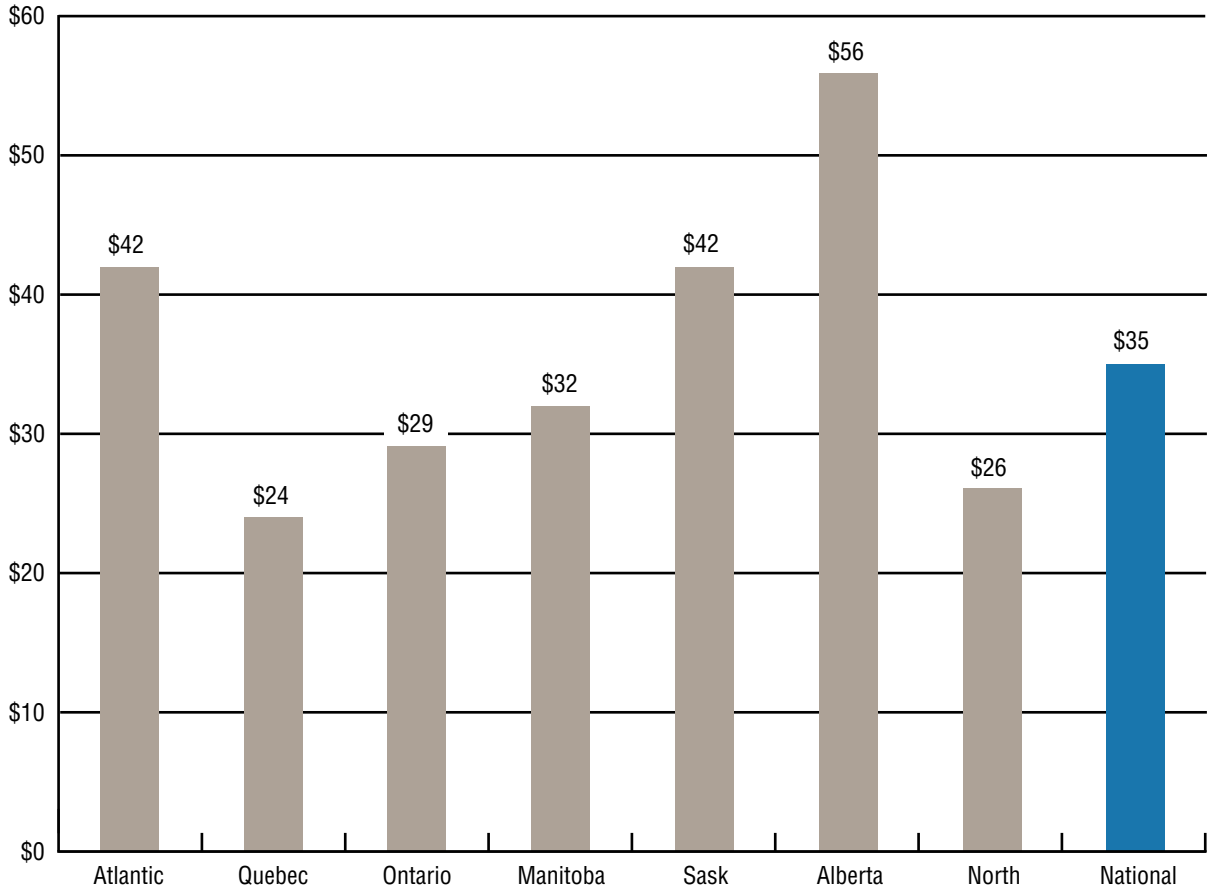
Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 7.3

Per Capita NIHB Vision Expenditures by Region
2014/15

In 2014/15, the national per capita expenditure in NIHB Vision benefits was $35.

Alberta had the highest per capita expenditure at $56, followed by the Atlantic Region and Saskatchewan Region at $42 each. The lowest per capita NIHB Vision benefit expenditure was in the Quebec Region at $24.



Source: SVS and FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 7.4

NIHB Mental Health Counselling Expenditures by Region ($ 000's)
2014/15

Prior to 2014/15, NIHB Mental Health Counselling expenditures were reported under Other Health Care. In this edition of the NIHB Annual Report, and going forward, expenditures associated with the provision of mental health counselling services to NIHB clients will be reported separately from other Program expenditures classified under Other Health Care.

In 2014/15, NIHB Mental Health Counselling expenditures amounted to $15.6 million. Regional operating expenditures accounted for $11.1 million or 71.3% of total expenditures while contribution costs accounted for $4.5 million or 28.7%.

In 2014/15, the Alberta Region had the highest percentage share of NIHB Mental Health Counselling expenditures at 38.6% followed by the Manitoba and Ontario regions at 26.3% and 18.0% respectively.

In the Northern Region, the NIHB Program does not provide mental health counselling benefits as this is the responsibility of the territorial governments.

REGION	Operating	Contributions	TOTAL
Atlantic	$ 112	$ 58	**$ 169**
Quebec	973	175	**1,148**
Ontario	2,803	0	**2,803**
Manitoba	3,412	687	**4,099**
Saskatchewan	771	580	**1,351**
Alberta	3,040	2,970	**6,010**
North	0	0	**0**
Total	**$ 11,112**	**$ 4,469**	**$ 15,581**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

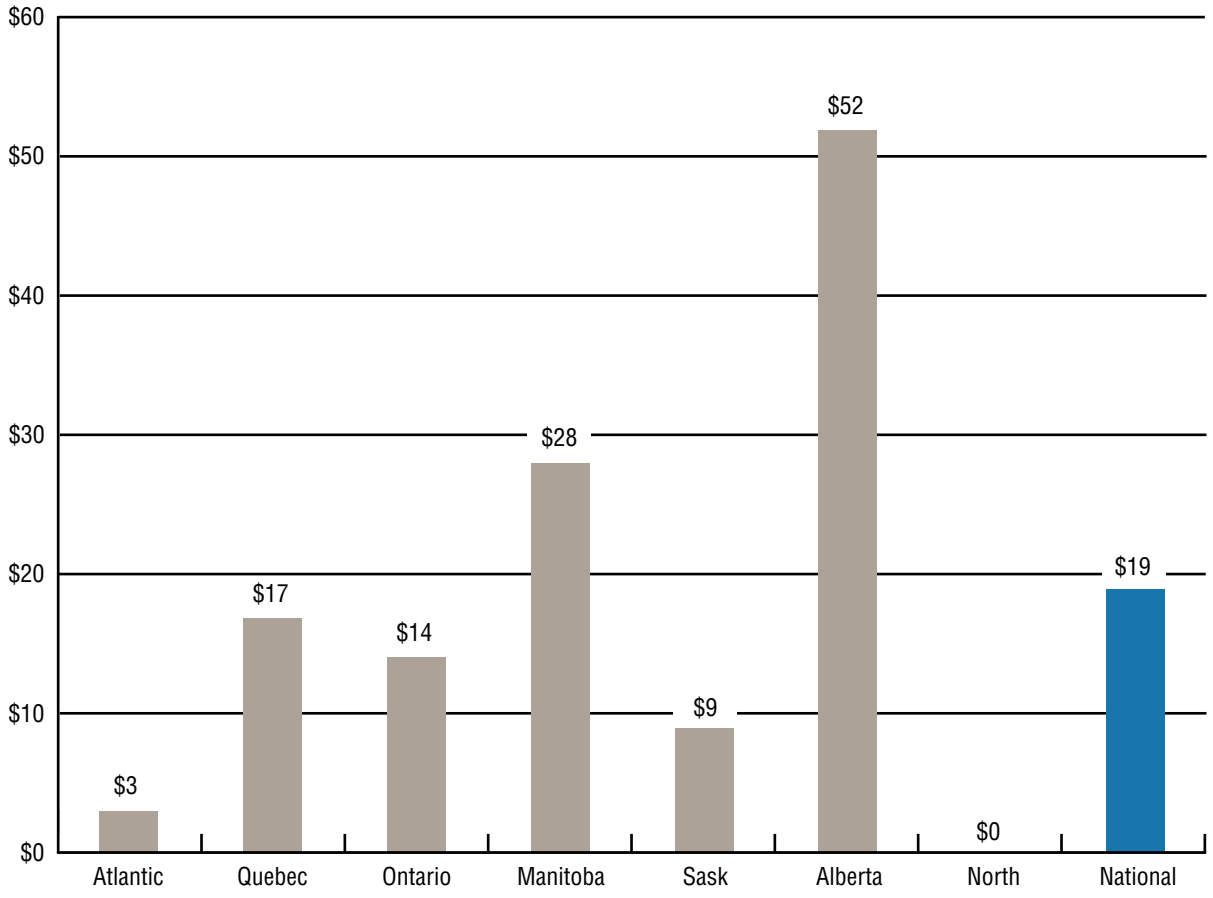
FIGURE 7.5

Per Capita NIHB Mental Health Counselling Expenditures by Region ($ 000's)
2014/15

In 2014/15, the national per capita expenditure for NIHB Mental Health Counselling was $19.

The Alberta Region had the highest per capita expenditure at $52, followed by the Manitoba Region at $28 per eligible client.

Mental health services in the Yukon, Northwest Territories and Nunavut are delivered by the territorial governments.



Source: SVS and FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 7.6

NIHB Other Health Care Expenditures by Region ($ 000's)
2014/15

In 2014/15, NIHB Other Health Care expenditures totalled $4.0 million. The majority of these expenditures are related to contribution agreements including funding arrangements with the FNHA for Bill C-3 and Qalipu clients, and for payment of Inuit premiums in British Columbia. Other expenditures in this category include partner contribution agreements related to Program oversight.

REGION	Operating	Contributions	TOTAL
Atlantic	$ 21	$ 0	**$ 21**
Quebec	10	0	**10**
Ontario	2	0	**2**
Manitoba	0	0	**0**
Saskatchewan	0	0	**0**
Alberta	0	0	**0**
North	1	0	**1**
Headquarters	287	3,684	**3,971**
Total	**$ 321**	**$ 3,684**	**$ 4,005**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

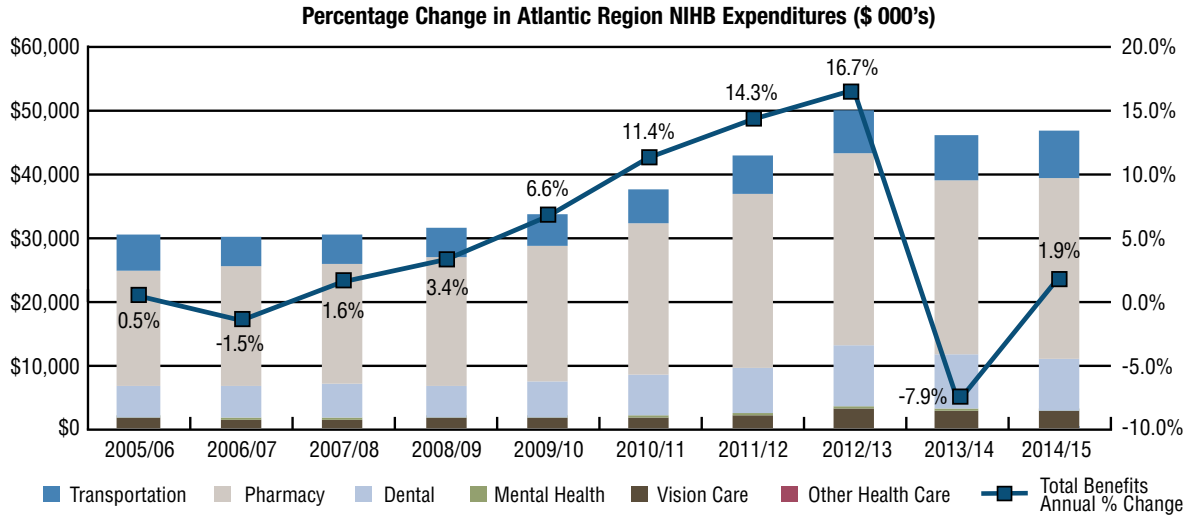
Regional Expenditure Trends 2005/06 to 2014/15

SECTION 8

FIGURE 8.1

Atlantic Region
2005/06 to 2014/15

Annual expenditures in the Atlantic Region for 2014/15 totalled $46.9 million, an increase of 1.9% over the $46.0 million spent in 2013/14. On September 26, 2011, the creation of the new Qalipu Mi'kmaq First Nation band was announced. The formation of this band was the result of a settlement agreement that was negotiated between the Government of Canada and the Federation of Newfoundland Indians (FNI). The addition of these new clients resulted in a 2 year surge in Atlantic Regional expenditures. The decrease in expenditures in 2013/14 can be attributed to the transfer of authority to the First Nations Health Authority for clients registered to Atlantic First Nations residing in British Columbia. As of March 31, 2015, a total of 24,017 Qalipu clients were registered in the Status Verification System (SVS) and were eligible to receive benefits through the NIHB Program.



Pharmacy expenditures in 2014/15 increased by 3.2% to $28.4 million, medical transportation costs increased by 7.3% to $7.4 million and dental expenditures decreased by 4.3% to $8.2 million. Mental health expenditures decreased by 27.9% and vision care expenditures decreased by 3.3%.

Pharmacy expenditures accounted for more than half of the Atlantic Region's total expenditures at 60.5%. Dental expenditures ranked second at 17.6%, followed by medical transportation at 15.8%. Vision care and mental health expenditures accounted for 5.7% and 0.4% of total expenditures respectively.

Annual Expenditures by Benefit ($ 000's)

Atlantic Region	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Medical Transportation	$ 5,590	$ 4,401	$ 4,585	$ 4,655	$ 5,048	$ 5,314	$ 5,841	$ 6,875	$ 6,916	$ 7,419
Pharmacy	18,293	18,938	18,984	20,119	21,357	23,689	27,571	29,979	27,517	28,398
Dental	4,831	5,128	5,204	4,945	5,426	6,481	7,164	9,660	8,609	8,238
Mental Health	201	192	272	251	213	241	254	512	235	169
Vision Care	1,614	1,408	1,495	1,596	1,612	1,758	2,021	2,969	2,757	2,666
Other Health Care	0	0	0	0	0	0	0	0	0	21
Total	$ 30,529	$ 30,067	$ 30,539	$ 31,567	$ 33,656	$ 37,482	$ 42,850	$ 49,995	$ 46,033	$ 46,912

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

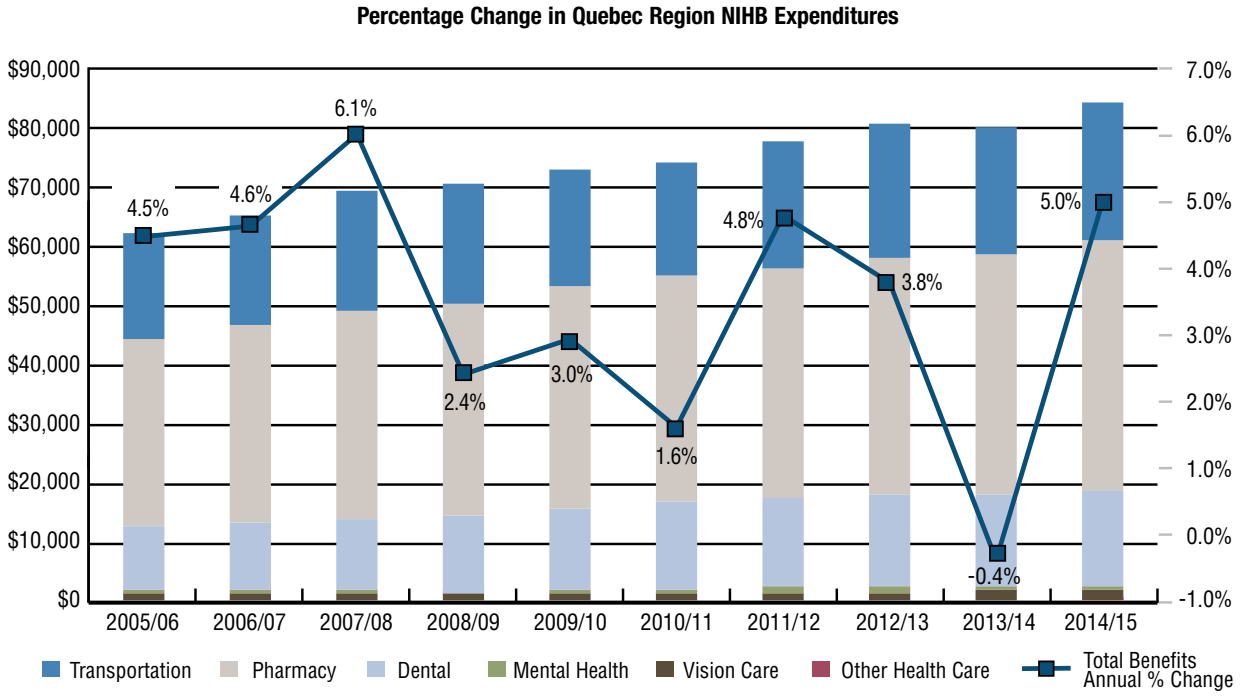
FIGURE 8.2

Quebec Region
2005/06 to 2014/15

Annual expenditures in the Quebec Region for 2014/15 totalled $84.7 million, an increase of 5.0% from the $80.6 million spent in 2013/14.

Medical transportation costs in 2014/15 increased by 7.1% to $23.5 million, while pharmacy expenditures increased by 4.3% to $42.6 million and dental expenditures increased by 3.8% to $15.8 million. Mental health expenditures increased 14.5%, and vision care expenditures increased only slightly by 0.2%.

Pharmacy expenditures accounted for half of the Quebec Region's total expenditures at 50.3%. Medical transportation expenditures ranked second at 27.8%, followed by dental at 18.7%. Vision care and mental health expenditures accounted for 1.9% and 1.4% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
Quebec Region	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Medical Transportation	$ 17,886	$ 18,473	$ 20,133	$ 20,502	$ 19,918	$ 18,943	$ 21,708	$ 22,578	$ 21,945	$ 23,506
Pharmacy	31,771	33,486	35,372	36,069	37,358	38,234	38,827	40,393	40,825	42,581
Dental	10,970	11,603	12,141	12,895	14,159	15,245	15,138	15,239	15,216	15,799
Mental Health	750	583	471	375	459	597	875	1,135	1,003	1,148
Vision Care	1,135	1,270	1,257	1,220	1,280	1,336	1,404	1,570	1,619	1,622
Other Health Care	0	0	0	0	0	0	0	0	0	10
Total	$ 62,512	$ 65,414	$ 69,374	$ 71,060	$ 73,174	$ 74,355	$ 77,951	$ 80,915	$ 80,608	$ 84,666

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

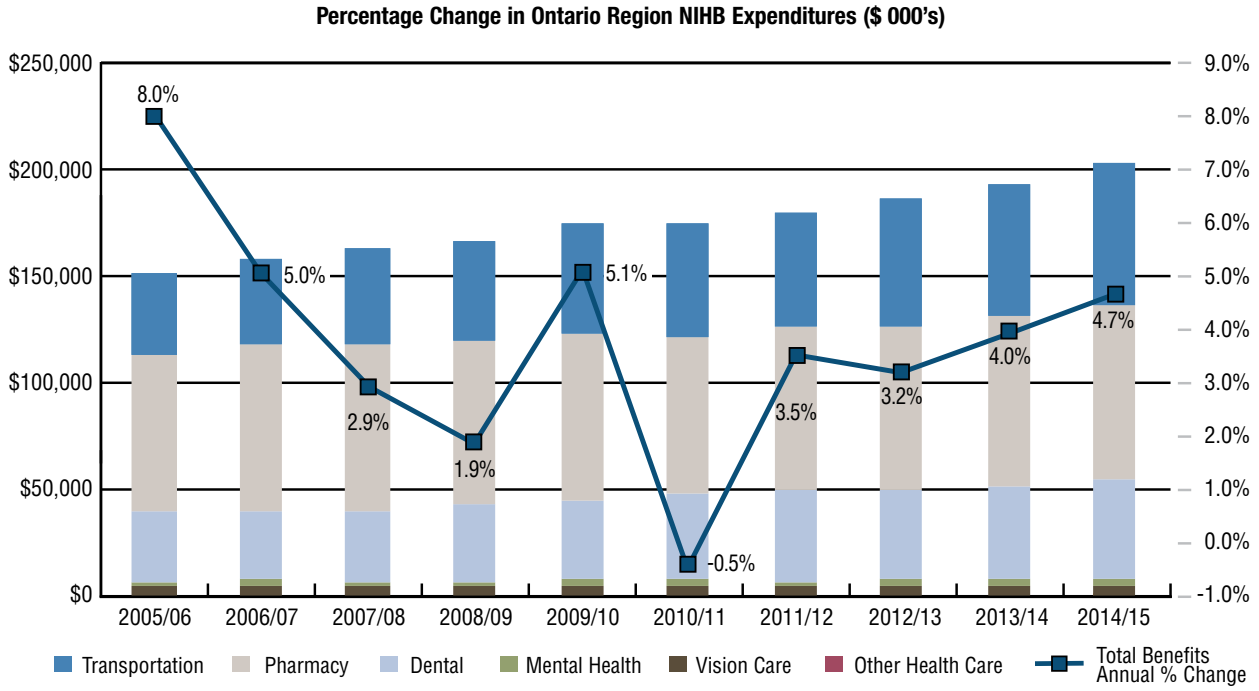
FIGURE 8.3

Ontario Region
2005/06 to 2014/15

Annual expenditures in the Ontario Region for 2014/15 totalled $203.0 million, an increase of 4.7% from the $193.9 million spent in 2013/14.

Ontario had the highest expenditures in dental care, followed by Saskatchewan and Alberta. In Ontario, pharmacy expenditures in 2014/15 increased by 4.4% to $82.0 million, while medical transportation costs increased by 4.6% to $65.8 million and dental expenditures increased by 6.3% to $46.8 million. Vision care and mental health expenditures decreased by 0.1% and 2.1% respectively.

Pharmacy expenditures accounted for 40.4% of the Ontario Region's total expenditures. Medical transportation costs ranked second at 32.4%, followed by dental at 23.0%. Vision care and mental health expenditures accounted for 2.8% and 1.4% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Ontario Region	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Medical Transportation	$ 38,553	$ 40,572	$ 45,618	$ 46,848	$ 51,889	$ 52,358	$ 54,725	$ 59,251	$ 62,865	$ 65,781
Pharmacy	73,223	77,788	77,191	77,244	77,564	73,887	76,430	77,131	78,510	81,982
Dental	32,064	32,777	33,467	35,457	38,047	40,594	41,848	42,259	43,972	46,759
Mental Health	2,213	2,530	2,172	2,158	2,603	2,632	2,349	2,490	2,862	2.803
Vision Care	5,458	5,485	5,366	5,204	5,343	5,183	5,425	5,412	5,721	5,717
Other Health Care	0	0	0	0	0	0	0	0	0	2
Total	$ 151,510	$ 159,152	$ 163,814	$ 166,910	$ 175,447	$ 174,653	$ 180,778	$ 186,544	$ 193,929	$ 203,043

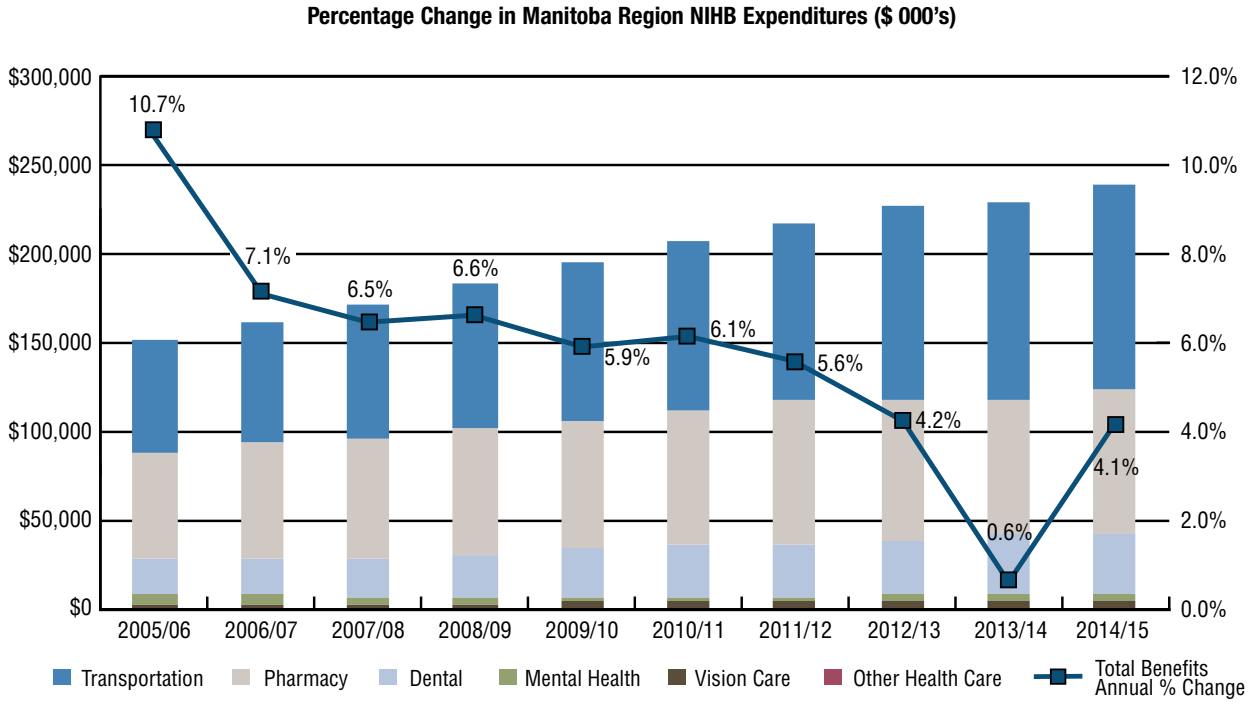
Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 8.4

Manitoba Region
2005/06 to 2014/15

Annual expenditures in the Manitoba Region for 2014/15 totalled $239.2 million, an increase of 4.1% from the $229.7 million spent in 2013/14. Pharmacy expenditures in 2014/15 increased by 5.2% to $81.1 million, while medical transportation costs increased by 4.2% to $115.7 million. Dental expenditures decreased slightly by 0.4% to $33.5 million. Vision care and mental health expenditures increased by 10.4% and 13.2% respectively.

Unlike most other regions, pharmacy expenditures in Manitoba do not represent the largest proportion of total expenditures. Due to the higher proportion of clients living in northern or remote communities in Manitoba, medical transportation expenditures comprised almost half of the Manitoba Region's total expenditures at 48.4%. Pharmacy costs ranked second at 33.9%, followed by dental at 14.0%. Vision care and mental health expenditures accounted for 2.0% and 1.7% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)

Manitoba Region	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Transportation	$ 63,322	$ 69,047	$ 76,082	$ 83,193	$ 89,078	$ 94,940	$ 101,609	$ 109,409	$ 111,016	$ 115,705
Pharmacy	59,409	64,966	69,317	71,081	72,789	76,496	80,639	80,676	77,034	81,059
Dental	20,326	20,756	21,696	24,444	26,954	29,399	29,861	30,734	33,649	33,527
Mental Health	5,690	4,786	2,964	2,619	3,143	2,930	3,109	3,429	3,622	4,099
Vision Care	2,864	2,841	2,936	3,157	3,407	3,612	3,813	4,048	4,348	4,800
Other Health Care	0	0	0	0	0	0	0	0	0	0
Total	$ 151,610	$ 162,396	$ 172,994	$ 184,494	$ 195,371	$ 207,377	$ 219,031	$ 228,295	$ 229,670	$ 239,190

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

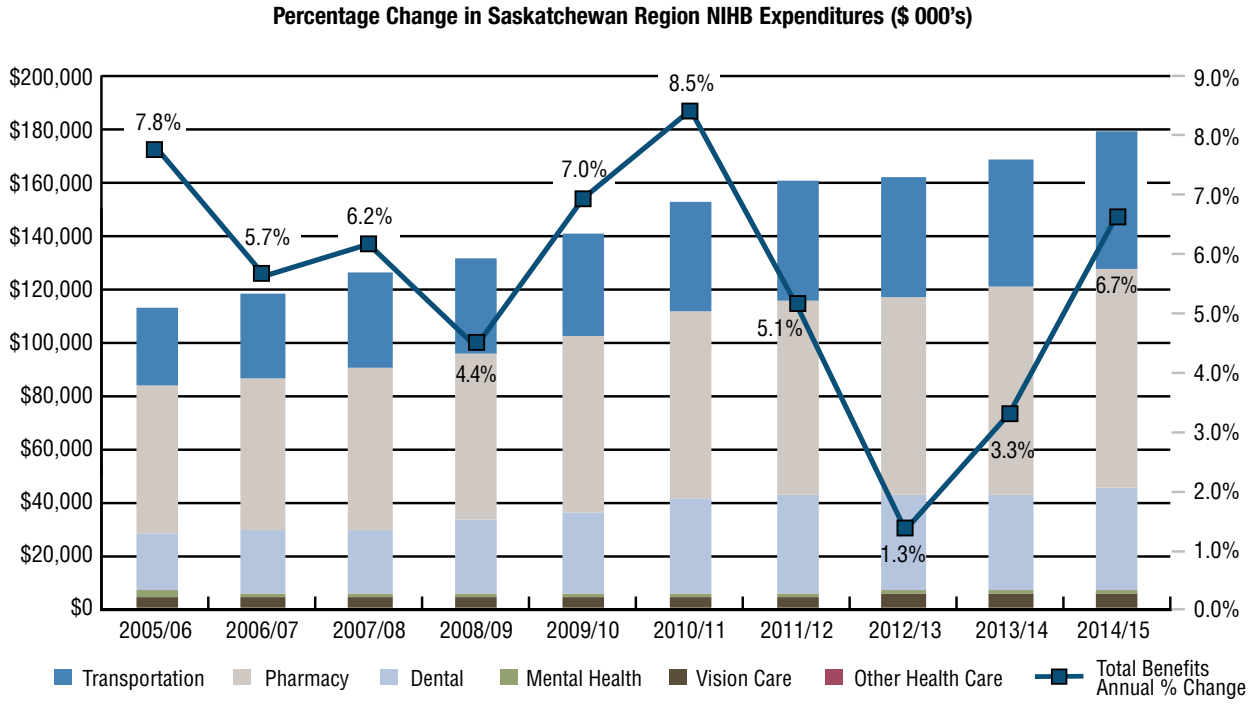
FIGURE 8.5

Saskatchewan Region
2005/06 to 2014/15

Annual expenditures in the Saskatchewan Region for 2014/15 totalled $180.0 million, an increase of 6.7% from the $168.8 million spent in 2013/14.

Saskatchewan had the highest expenditures in pharmacy, followed closely by Ontario and Manitoba. In Saskatchewan, pharmacy expenditures in 2014/15 increased by 6.1% to $83.4 million, while medical transportation costs increased by 9.2% to $51.5 million and dental expenditures increased by 3.5% to $37.7 million. Vision care and mental health expenditures increased by 8.1% and 32.9% respectively.

Pharmacy expenditures comprised the largest portion of the Saskatchewan Region's total expenditures at 46.3%, medical transportation costs ranked second at 28.6%, followed by dental at 20.9%. Vision care and mental health expenditures accounted for 3.4% and 0.8% of total expenditures respectively.



Annual Expenditures by Benefit ($ 000's)										
Saskatchewan Region	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Transportation	$ 28,786	$ 31,816	$ 36,108	$ 36,239	$ 38,971	$ 41,896	$ 45,084	$ 45,793	$ 47,180	$ 51,543
Pharmacy	55,687	58,083	60,749	62,809	66,639	70,625	73,293	74,646	78,546	83,361
Dental	22,038	23,219	24,636	28,102	30,777	35,317	36,941	36,219	36,399	37,679
Mental Health	2,237	2,244	942	870	812	896	1,499	1,038	1,017	1,351
Vision Care	4,072	3,835	4,126	4,166	4,222	4,658	4,449	5,676	5,611	6,066
Other Health Care	0	0	0	0	0	0	0	0	0	0
	$ 112,820	**$ 119,197**	**$ 126,561**	**$ 132,185**	**$ 141,420**	**$ 153,393**	**$ 161,265**	**$ 163,372**	**$ 168,752**	**$ 180,000**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

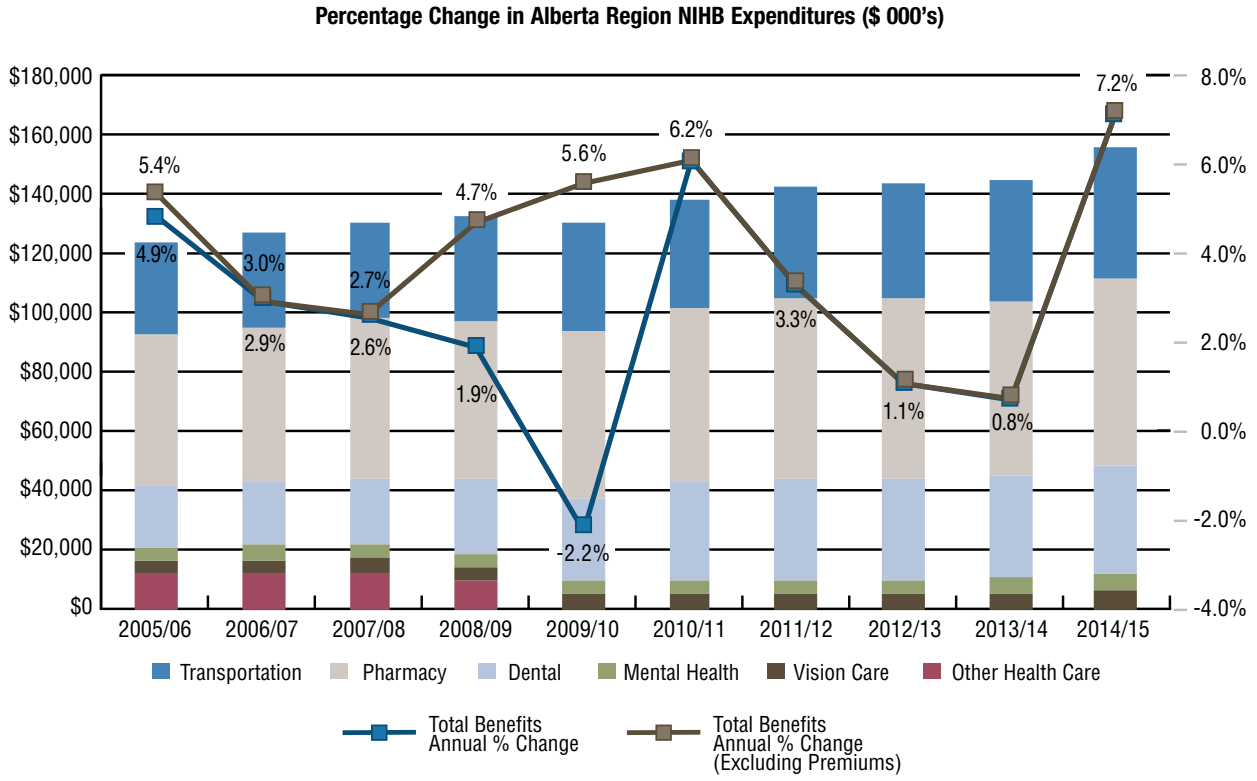
FIGURE 8.6

Alberta Region
2005/06 to 2014/15

Annual expenditures in the Alberta Region for 2014/15 totalled $156.6 million, an increase of 7.2% from the $146.1 million spent in 2013/14. Pharmacy expenditures in 2014/15 increased by 8.3% to $63.6 million, while medical transportation costs increased by 7.1% to $44.4 million and dental expenditures increased by 3.0% to $36.0 million. Vision care and mental health expenditures increased by 10.0% and 21.2% respectively.

Pharmacy expenditures accounted for 40.6% of the Alberta Region's total expenditures. Medical transportation costs ranked second at 28.4%, followed closely by dental at 23.0%. Vision care and mental health expenditures accounted for 4.2% and 3.8% of total expenditures respectively.

The decreased growth rate recorded in 2009/10 is primarily the result of the NIHB Program no longer covering provincial health premiums in the Alberta Region because the Government of Alberta eliminated Alberta Health Care insurance premiums for all Albertans as of January 1, 2009.



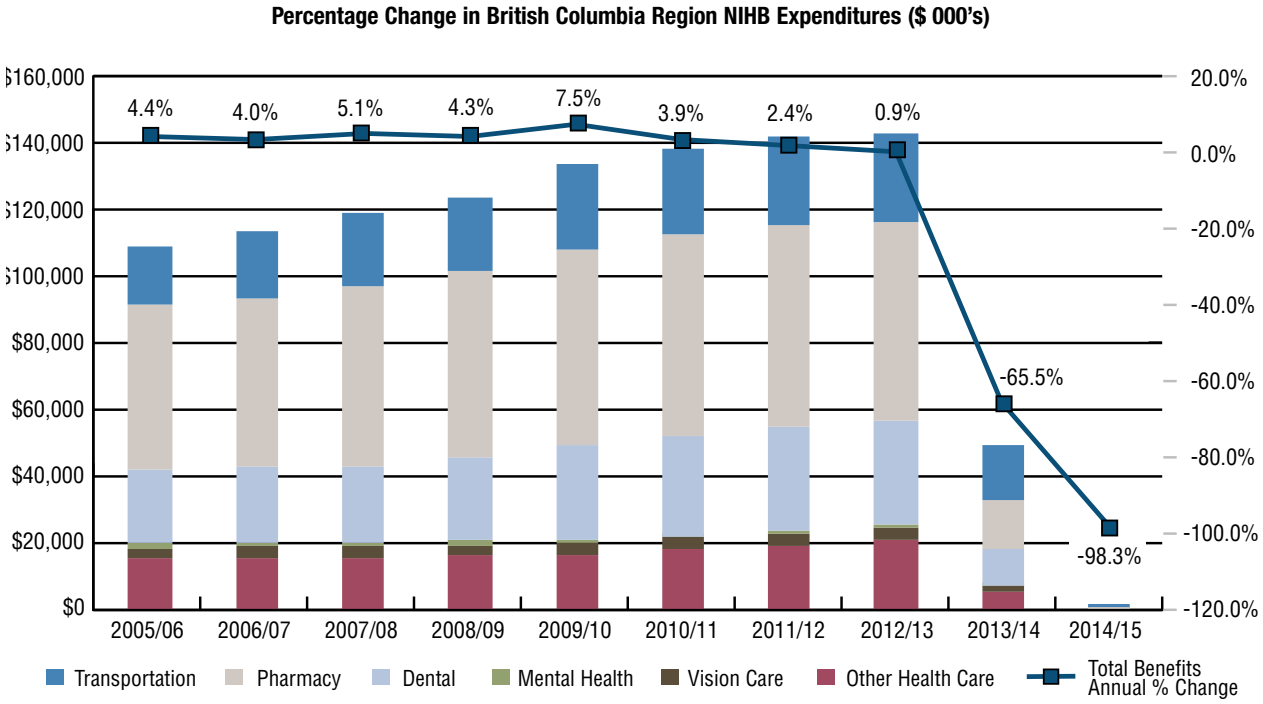
Annual Expenditures by Benefit ($ 000's)										
Alberta Region	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Transportation	$ 30,712	$ 32,204	$ 32,107	$ 35,357	$ 36,601	$ 35,877	$ 37,371	$ 39,216	$ 41,451	$ 44,403
Pharmacy	51,141	52,424	54,353	54,189	56,570	59,738	61,621	60,584	58,777	63,632
Dental	20,594	21,006	22,391	25,016	27,756	33,421	34,543	34,501	34,928	35,974
Mental Health	4,537	4,736	4,343	3,940	4,363	3,903	3,957	4,791	4,959	6,010
Vision Care	4,762	4,690	4,942	5,225	5,377	5,778	5,822	5,836	5,936	6,531
Other Health Care	12,381	12,709	12,961	9,920	0	0	0	0	0	0
Sub-Total (Excluding Premiums)	111,746	115,060	118,135	123,726	130,666	138,717	143,313	144,928	146,051	156,550
Total	$ 124,127	$ 127,769	$ 131,096	$ 133,646	$ 130,666	$ 138,717	143,313	$ 144,928	$ 146,051	$ 156,550

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

FIGURE 8.7

British Columbia Region
2005/06 to 2014/15

Annual expenditures in the British Columbia Region for 2014/15 totalled $0.8 million. This decrease in overall expenditures in this region can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA). The FNHA has assumed the programs, services, and responsibilities formerly delivered by Health Canada's First Nations Inuit Health Branch (FNIHB) to First Nation clients residing in British Columbia.



Annual Expenditures by Benefit ($ 000's)										
British Columbia Region	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**	**2010/11**	**2011/12**	**2012/13**	**2013/14**	**2014/15**
Transportation	$ 16,944	$ 20,284	$ 21,613	$ 22,711	$ 25,547	$ 25,967	$ 26,510	$ 26,573	$ 15,960	$ 7
Pharmacy	49,734	50,387	54,290	56,104	58,862	60,097	60,890	59,858	14,939	263
Dental	22,439	22,588	22,968	24,718	28,042	30,187	30,620	31,543	11,013	554
Mental Health	1,486	1,177	1,120	1,165	924	882	889	940	453	1
Vision Care	3,049	3,232	3,120	3,251	3,253	3,344	3,461	3,285	1,704	7
Other Health Care	15,606	15,951	16,250	16,510	17,110	18,428	19,868	21,257	5,406	0
Total	**$ 109,259**	**$ 113,620**	**$ 119,361**	**$ 124,458**	**$ 133,739**	**$ 138,905**	**$ 142,239**	**$ 143,455**	**$ 49,475**	**$ 831**

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

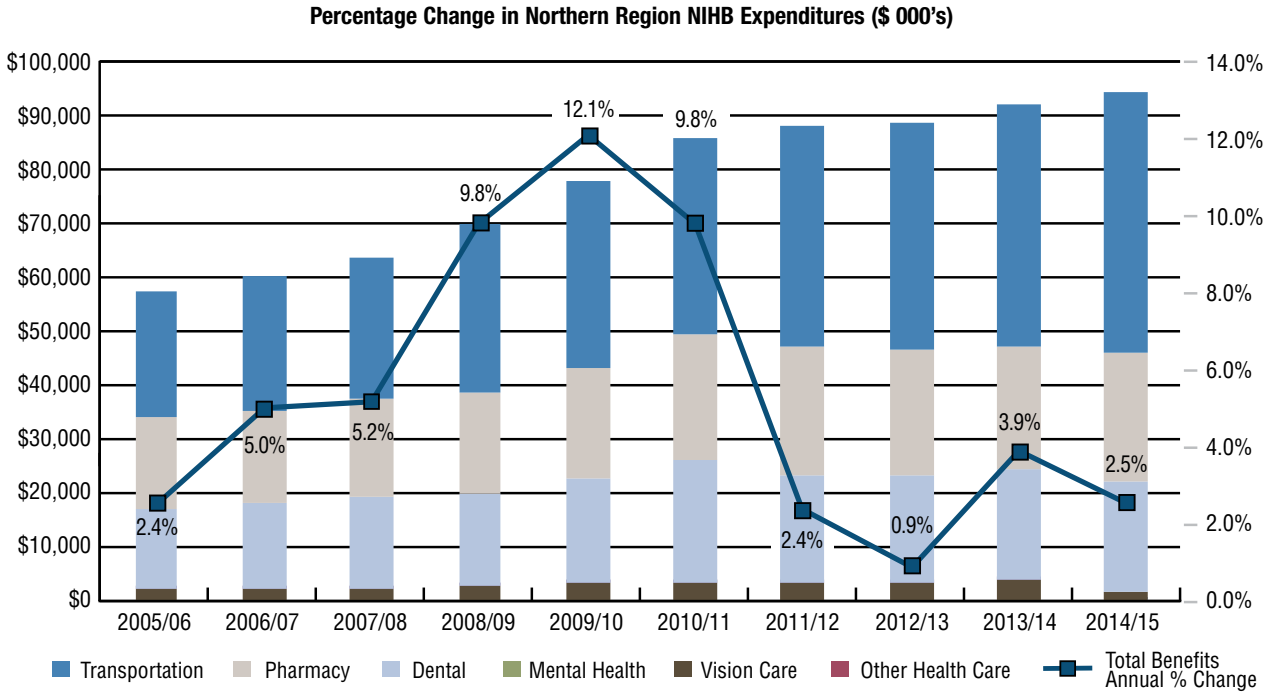
FIGURE 8.8

Northern Region
2005/06 to 2014/15

Annual expenditures in the Northern Region for 2014/15 totalled $94.3 million, an increase of 2.5% from the $92.0 million spent in 2013/14.

Medical Transportation expenditures in 2014/15 increased by 7.9% to $48.2 million while Pharmacy costs increased by 3.4% to $23.9 million. Dental expenditures were stable at $20.4 million.

Similar to Manitoba, Medical Transportation expenditures comprised the largest portion of the Northern Region's total expenditures at 51.1%.



Annual Expenditures by Benefit ($ 000's)

Northern Region	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Transportation	$ 23,586	$ 24,805	$ 26,049	$ 30,942	$ 34,622	$ 36,464	$ 40,455	$ 41,727	$ 44,703	$ 48,246
Pharmacy	16,567	17,318	18,243	19,073	20,555	23,190	23,863	23,682	23,144	23,941
Dental	15,249	16,022	16,752	16,874	19,627	22,537	20,079	19,773	20,415	20,413
Mental Health	1	22	4	1	1	2	4	4	2	0
Vision Care	2,015	2,133	2,380	2,759	3,284	3,550	3,387	3,370	3,763	1,743
Other Health Care	0	0	0	0	0	0	0	0	0	1
Total	$ 57,419	$ 60,301	$ 63,430	$ 69,649	$ 78,089	$ 85,744	$ 87,787	$ 88,557	$ 92,027	$ 94,343

Source: FIRMS adapted by Business Support, Audit and Negotiations Division

Initiatives and Activities

SECTION 9.1

Health Information and Claims Processing Services (HICPS)
2014/15

Claims for the Non-Insured Health Benefits (NIHB) Program pharmacy, dental and medical supplies and equipment (MS&E) benefits provided to eligible First Nations and Inuit clients are processed via the Health Information and Claims Processing Services (HICPS) system. HICPS includes administrative services and programs, technical support and automated information management systems used to process and pay claims in accordance with NIHB Program client/benefit eligibility and pricing policies.

The NIHB Program is responsible for developing, maintaining and managing key business processes, systems and services required to deliver eligible non-insured health benefits. Since 1990, the NIHB Program has retained the services of a private sector contractor to administer the following core claims processing services on its behalf:

- Claim processing and payment operations;
- Claim adjudication and reporting systems development and maintenance;
- Provider registration and communications;
- Systems in support of pharmacy and MS&E benefits prior approval and dental predetermination processes;
- Provider audit programs and audit recoveries; and
- Standard and ad hoc reporting.

The current HICPS contract is with Express Scripts Canada (formally ESI Canada). This contract came into force on December 6, 2009, following a competitive contracting process led by Public Works and Government Services Canada (PWGSC).

The NIHB Program manages the HICPS contract as the project authority in conjunction with PWGSC, the contract authority.

As of March 31, 2015, there were 27,388 active providers* registered with the HICPS claims processor to deliver NIHB Pharmacy, MS&E and Dental benefits. The number of active providers by region and by benefit is outlined in the table below. The number of claims settled through the HICPS system is highlighted in Figure 9.1.1.

Number of NIHB Providers by Region and Benefit, April 2013 to March 2015

REGION	Pharmacy	MS&E	Dental
Atlantic	785	201	990
Quebec	1,919	189	2,767
Ontario	3,756	693	5,493
Manitoba	440	83	729
Saskatchewan	414	71	492
Alberta	1,288	246	2,275
British Columbia	1,371	444	2,488
Yukon	9	7	51
Northwest Territories	9	7	56
Nunavut	6	2	89
Total	**9,997**	**1,943**	**15,430**

Source: HICPS adapted by Business Support, Audit and Negotiations Division

* An active provider refers to a provider who has submitted at least one claim in the 24 months prior to March 31, 2015.

FIGURE 9.1.1

Number of Claim Lines Settled Through the Health Information and Claims Processing Services (HICPS) System in 2014/15

REGION	Pharmacy	Dental	MS&E	Total
Atlantic	1,237,046	146,147	31,996	**1,415,189**
Quebec	2,580,019	215,364	28,040	**2,823,423**
Ontario	5,377,732	575,580	36,721	**5,990,033**
Manitoba	3,357,338	421,184	72,292	**3,850,814**
Saskatchewan	2,932,224	464,848	74,697	**3,471,769**
Alberta	2,370,993	434,822	52,376	**2,858,191**
British Columbia	123,302	35,272	1,501	**160,075**
Yukon	94,648	20,989	2,820	**118,457**
Northwest Territories	292,126	90,224	9,117	**391,467**
Nunavut	260,365	123,792	12,501	**396,658**
Total Claim Lines	**18,625,793**	**2,528,222**	**322,061**	**21,476,076**

Source: HICPS adapted by Business Support, Audit and Negotiations Division

Figure 9.1.1 sets out the total number of pharmacy, dental and MS&E claims settled through the HICPS system in fiscal year 2014/15. During this period, a total of 21,476,076 claim lines were processed through HICPS, an increase of 1.4% over the previous fiscal year. Of that, a total of 160,075 claim lines were processed through HICPS in the British Columbia Region, a decrease of 83.2% over the previous fiscal year. This decrease in the number of claim lines settled through HICPS can be attributed to the transfer of First Nation clients residing in British Columbia to the First Nations Health Authority (FNHA). The FNHA assumed the programs, services, and responsibilities formerly delivered by Health Canada's First Nations and Inuit Health Branch (FNIHB) for First Nation clients residing in British Columbia.

Claim Lines vs. Prescriptions

It is important to note that the Program reports annually on claim lines. This is an administrative unit of measure as opposed to a health care unit of measure. A claim line represents a transaction in the claims processing system and is not equivalent to a prescription. Prescriptions can contain a number of different drugs with each one represented by a separate claim line. Prescriptions for a number of drugs may be repeated and refilled many times throughout the year. In the case of repeating prescriptions, each time a prescription is refilled, the system will log another transaction (claim line). Therefore, it is possible for an individual who has a prescription that repeats multiple times in a year to have numerous related claim lines associated with the single prescription. Some prescriptions (e.g., Methadone) are dispensed daily and will increase the per capita number of claim lines.

SECTION 9.2

Provider Audit Activities
2014/15

The NIHB Program is a publicly-funded program that must account for the expenditure of those public funds. The Provider Audit Program contributes to the fulfillment of this overall requirement. As part of the program's risk management activities, Health Canada has mandated its claims processor to maintain a set of pre-payment and post-payment verification processes, including a provider audit program.

During 2014/15, the claims processor carried out audit activities as directed by the NIHB Program. The audit activities address the need of the NIHB Program both to comply with accountability requirements for the use of public funds and to ensure provider compliance with the terms and conditions of the Program as outlined in the NIHB Provider Claims Submission Kit, Provider Agreement and other relevant documents. The objectives of the audit program are to detect billing irregularities, to validate active licensure of providers, to ensure that services paid for were received by eligible NIHB clients and to ensure that providers retained appropriate documentation in support of each claim. Claims not meeting the billing requirements of the NIHB Program are subject to audit recovery.

There are five components of the Provider Audit Program for the pharmacy, medical supplies and equipment and dental benefit areas. These are:

1) Next Day Claims Verification (NDCV) Program which consists of a review of a defined sample of claims submitted by providers the day following receipt by Express Scripts Canada;
2) Client Confirmation Program (CCP) which consists of a monthly mail-out to a randomly selected sample of NIHB clients to confirm the receipt of the benefit that has been billed on their behalf;
3) Provider Profiling Program which consists of a review of the billings of all providers against selected criteria and the determination of the most appropriate follow-up activity if concerns are identified;
4) On-Site Audit Program which consists of the selection of a sample of claims for administrative validation with a provider's records through an on-site visit; and
5) Desk Audit Program which consists of the selection of a sample of claims for administrative validation with a provider's records. Unlike on-site audits, a desk audit serves to validate records through the use of fax or mail. Generally, a smaller number of claims are reviewed during a desk audit.

During 2014/15, the primary issues identified as a result of on-site audits were as follows:

- Documentation to support paid claims was either not available for audit review or did not meet the NIHB Program requirements;
- Paid claims did not match the item/service provided to the client; and
- Items/services were claimed prior to client(s) receiving the services/items;

Completion of the audit process often spans more than one fiscal year. Although the complete audit recovery for any audit may overlap into another fiscal year, recoveries from on-site audits are recorded in the fiscal year in which they are received.

FIGURE 9.2.1

Audit Recoveries by Benefit and Region
2014/15

Figure 9.2.1 identifies audit recoveries, Next Day Claims Verification (NDCV) and Client Confirmation Program (CCP) savings* from all components of the Provider Audit Program during the 2014/15 fiscal year.

DENTAL				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	2	$ 488	$ 40,004	$ 40,492
Quebec	6	2,373	51,419	53,792
Ontario	5	85	178,529	178,614
Manitoba	13	15,782	92,232	108,014
Saskatchewan	2	4,211	77,879	82,090
Alberta	7	63,766	156,125	219,696
British Columbia	6	24,538	6,496	25,627
Yukon	1	5,332	4,367	9,157
N.W.T.	2	46,430	22,596	68,787
Nunavut	5	1,998	10,742	12,740
Total	49	$ 165,003	$ 640,390	$ 799,010

PHARMACY				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	9	$ 27,525	$ 52,897	$ 80,423
Quebec	8	315,660	98,571	414,231
Ontario	13	290,546	260,931	551,478
Manitoba	20	238,298	131,151	369,449
Saskatchewan	11	84,975	40,363	125,339
Alberta	14	196,105	92,678	288,783
British Columbia	6	135,920	121,454	257,375
Yukon	0	0	15	15
N.W.T.	0	0	286	286
Nunavut	0	0	29	29
Total	81	$ 1,289,031	$ 798,378	$ 2,087,410

MEDICAL SUPPLIES AND EQUIPMENT				
REGION	Audits Completed	Recoveries	NDCV/CCP Savings	Total Recoveries/ Savings
Atlantic	0	$ 0	$ 52,505	$ 52,505
Quebec	0	0	98,569	98,569
Ontario	2	5,555	260,786	266,341
Manitoba	0	2,473	131,151	133,624
Saskatchewan	1	30,801	40,098	70,899
Alberta	4	17,674	92,046	109,719
British Columbia	6	5,328	1,157	6,485
Yukon	0	0	15	15
N.W.T.	0	0	286	286
Nunavut	0	0	28	28
Total	13	$ 61,830	$ 676,642	$ 738,471

* All claims that are reversed prior to being paid to providers are deemed savings to the Program. Subsequent appeals to these reversals may lead to claims being paid in full to providers' once appropriate billing and supporting documentation has been provided for review. NDCV savings listed in the recovery charts above, per benefit, take into account the provider appeals process.

SECTION 9.3

The Drug Review Process

The NIHB Program is a member of the Federal/Provincial/Territorial (F/P/T) Common Drug Review (CDR) process, whereby drugs that are new chemical entities, new combination drug products, or existing drug products with new indications on the Canadian market are reviewed on behalf of all participating F/P/T public drug plans. For these drug products, the CDR, through the Canadian Drug Expert Committee (CDEC), helps support and inform public drug plan listing decisions about new drugs based on rigorous evidence-based reviews of relevant clinical and cost effectiveness data. The CDR was set up by F/P/T public drug plans to reduce duplication of effort in reviewing drug submissions, to maximize the use of limited resources and expertise, and to enhance the consistency and quality of drug reviews, thereby contributing to the quality and sustainability of Canadian public drug plans. The NIHB Program and other drug plans make listing decisions based on CDEC recommendations and other specific relevant factors, such as the particular circumstances of NIHB clients.

The Canadian Agency for Drugs and Technologies in Health (CADTH) provides a list of requirements for manufacturers' submissions and a summary of procedures for the Common Drug Review Process. Inquiries about the CDR process should be directed to:

Common Drug Review (CDR)
Canadian Agency for Drugs and Technologies in Health
865 Carling Avenue, Suite 600
Ottawa, Ontario K1S 5S8
Telephone: 613-226-2553
Website: **www.cadth.ca**

Line extensions of existing drug products on the Drug Benefit List, drug class reviews and reviews of existing listing criteria are subject to a separate process which involves referral to the NIHB Drugs and Therapeutics Advisory Committee (DTAC). The NIHB DTAC is an advisory body of highly qualified health professionals who bring impartial and practical expert medical and pharmaceutical advice to the NIHB Program to promote improvement in the health outcomes of First Nations and Inuit clients through effective use of pharmaceuticals.The membership of this Committee includes practicing physicians and pharmacists from community and hospital settings, and also includes First Nations physicians.

The NIHB DTAC generally meets up to six times per year. Their approach is evidence-based and the advice reflects medical and scientific knowledge, current utilization trends, current clinical practice, health care delivery and specific departmental client healthcare needs. This expert advice is intended to facilitate NIHB policy development and decisions that will optimize client health benefits within the Program's budgetary allocations.

DTAC is focused on providing recommendations to the NIHB Program in order to maintain a cost effective drug formulary as well as provide necessary expert advice on initiatives that change broad practices, and thus impact health outcomes of the entire client population. A process of continuous quality improvement will guide the Program and a learning organization approach will be nurtured.

SECTION 9.4

Drug Exception Centre (DEC)

The NIHB Drug Exception Centre (DEC) was established in December 1997 to process and expedite pharmacists' requests for drug benefits that require prior approval, to help ensure consistent application of the NIHB drug benefit policy across the country, and to ensure an evidence-based approach to funding drug benefits. The DEC handles requests for prior approval from pharmacy providers across Canada.

The DEC supports the implementation of the Prescription Drug Abuse Strategy to address and prevent potential misuse of prescription drugs. The Program has set limits on medications of concern, and developed a structured approach towards client safety which includes the implementation of the Prescription Monitoring Program across the country.

FIGURE 9.4.1

Total NIHB Drug Exception Centre Requests/ Approvals
2014/15

The DEC is a single call centre that provides efficient responses to all requests for drugs that are not on the NIHB Drug Benefit List or require prior approval, for extemporaneous mixtures containing exception or Limited Use (LU) drugs, for prescriptions on which prescribers have indicated "No Substitution", and for claims that exceed $999.99.

Status	Open Benefit (unrestricted)	Open Benefit (restricted)	Exceptions	Limited Use	Total
Total Requested	22,015	7,584	28,543	66,651	**124,793**
Total Approved	19,801	7,024	25,988	49,280	**102,093**

Open Benefit (unrestricted): Drugs included on the NIHB Drug Benefit List for which the total dollar value exceeds Point of Sale limit, the pre-determined frequency limit has been reached or for which more than a three-month supply is requested.

Open Benefit (restricted): Drugs included on the NIHB Drug Benefit List which have been restricted due to safety concerns. These drugs are part of the Prescription Drug Abuse Strategy, such as opioids, benzodiazepines, stimulants and gabapentin.

Exceptions: Drugs not included on the NIHB Drug Benefit List, as well as requests for drugs for which the physician has indicated "No Substitution".

Limited Use: Drugs covered only if they are prescribed for conditions which meet specific criteria for Program coverage.

SECTION 9.4.2

Drug Exception Centre Special Authorization Process

The Special Authorization Process for pharmacy providers has been in effect since November 2009. This program has accelerated the internal DEC process to extend medication approvals to approximately 60 additional drugs for chronic conditions. These drugs have been granted extended authorization periods beyond one year, and some will now have an indefinite authorization period, thereby facilitating access for NIHB clients and eliminating unnecessary calls by pharmacists to the DEC.

For Limited Use (LU) medications with an indefinite authorization, it is only necessary for the pharmacy provider to confirm that the client meets the clinical criteria once by obtaining a prior approval and then the client will be set up on indefinite approval.

For other drugs that continue to have a defined authorization period (i.e., 2, 3 or 5 years), a new approval must be completed according to the authorization period.

Implementing extended authorization periods for drugs used in certain chronic conditions has significantly reduced the administrative burden on pharmacy providers and enabled the DEC to deal with more complicated reviews, such as supporting the implementation of Prescription Drug Abuse Strategy.

Increased Efficiency of HICPS System to Facilitate Prior Approvals for Specific Drugs

The Health Information and Claims Processing System (HICPS) has the capacity to automatically adjudicate a number of medications to facilitate access for clients and pharmacists and to reduce calls to the DEC. For these specific drugs, the System provides a prompt to pharmacists to continue with the Prior Approval process automatically and if the pharmacists select this prompt, the request is automatically sent to the DEC for review without necessitating a call to the DEC. In this way, the DEC can immediately send a Benefit Evaluation Questionnaire (BEQ) to the physician and thereby reduce the workload of pharmacists.

SECTION 9.5

Changes in Medical Supplies and Equipment (MS&E)

Ostomy Price File

NIHB implemented a national price file to simplify the administration of requests for select ostomy supplies on March 16, 2015. Information concerning the ostomy supplies covered is available on the Program's Medical Supplies and Equipment Benefit List at: www.healthcanada.gc.ca/nihb.

SECTION 9.6

New Provider Enrolment Process for Vision Care and Mental Health Providers

Beginning in February 2015, Health Canada initiated a nationally consistent process to enroll vision care and mental health counselling providers. This process is intended to ensure that all the applicable terms and conditions are clearly outlined for all providers and to support national consistency of administration.

For both benefit areas, only providers who have enrolled will be able to obtain prior approval for services and bill Health Canada directly.

The process for mental health providers is administered jointly with the Indian Residential Schools Resolution Health Support Program (IRS RHSP) to support linkages between the NIHB Program and the IRS RHSP.

SECTION 9.7

Negotiations Secretariat

The NIHB Negotiations Secretariat was created in 2005 to ensure a strategic approach to negotiations with providers which optimizes benefits to clients, reflects value for money, and is sustainable within existing Program resources. During 2014/15, the Negotiations Secretariat completed compensation adjustments for pharmacy providers in Ontario, Manitoba, Saskatchewan, Alberta and Northern Region. The Negotiations Secretariat also reviewed the NIHB national dental compensation framework and determined new compensation rates.

SECTION 9.8

Privacy

The NIHB Program recognizes an individual's right to privacy and is committed to protecting this right and to safeguarding the personal information in its possession. When a request for benefits is received, the NIHB Program collects, uses, discloses and retains an individual's personal information according to the applicable privacy legislation.

As a Program of the federal government, NIHB must comply with the *Privacy Act*, the *Charter of Rights and Freedoms*, the *Access to Information Act*, as well as Treasury Board of Canada privacy and data protection policies including the Privacy Impact Assessment (PIA) Policy. The latter requires all federal government programs to conduct PIAs on their processes, services and systems involved with the collection, use, disclosure and retention of personal information in order to identify any privacy-related risks and to mitigate or eliminate them.

The NIHB Program has also taken measures to protect the privacy of personal information used for claims processing. As the claims processor for NIHB, Express Scripts Canada (ESC) is required to abide by contractual privacy obligations with respect to life cycle management of personal information used for processing and settlement of NIHB claims. Regular privacy audits are conducted on an annual basis to ensure compliance as per the terms outlined in the Health Information and Claims Processing Services (HICPS) system contract.

SECTION 9.9

Client and Provider Communications

The Non-Insured Health Benefits (NIHB) Program is continually seeking ways to improve communications with clients, providers and stakeholders regarding benefit coverage and administration.

The NIHB Program regularly produces newsletters and updates to inform clients and providers about any changes to NIHB policy and benefit coverage information. For example, NIHB registered providers for Dental, Pharmacy and Medical Supplies and Equipment receive policy updates and relevant information regarding benefits through both quarterly Provider newsletters and fax broadcasts.

The Provider newsletters are distributed by Health Canada's claims processing contractor, Express Scripts Canada (ESC), to registered providers and are available via the ESC website (password required) at: www.provider.express-scripts.ca

The NIHB website is a key venue for disseminating Program information. *NIHB Program updates* provide information for clients regarding updates to coverage that have taken place each month. They can be found on the Health Canada website at: www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/newsletter-bulletin-eng.php

In 2013/14, the NIHB Program produced a joint publication in collaboration with the Inuit Tapiriit Kanatami (ITK) for Inuit clients entitled, *Your Health Benefits – A Guide for Inuit to Access Non-Insured Health Benefits*, which contains essential information about all the non-insured health benefit programs available to Inuit: Health Canada's NIHB Program, the Nunatsiavut Non-Insured Health Benefits (NIHB) Program (administered by the Nunatsiavut Government), and Nunavik's Insured/Non-Insured Health Benefits (INIHB) Program (administered by the Nunavik Board of Health and Social Services). The *Guide* provides an overview of these three programs and explains eligibility, what is covered, and access to benefits. This *Guide* complements a similar publication produced jointly with the Assembly of First Nations (AFN) for First Nations clients in 2012-2013. The *Guide* is available on the Health Canada website at: www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/yhb-vss-inuit/index-eng.php

SECTION 9.10

Collaboration with First Nations and Inuit Partners

In 2014, the Minister of Health agreed to undertake a multi-year Joint Review of the NIHB Program in partnership with the Assembly of First Nations. The overall objective of the review is to identify and implement actions that enhance client access to benefits, identify gaps in benefits, streamline service delivery to be more responsive to client needs, and increase Program efficiencies. The Joint Review is guided by a Steering Committee comprised of First Nations and FNIHB representatives. The Steering Committee held its inaugural meeting in October 2014, followed by two subsequent meetings in early 2015. The Committee has developed and approved a critical path that identifies key activities, deliverables and timelines for the Joint Review.

The first meeting of the Inuit NIHB Senior Bilateral Committee (INSBC) was held in December 2014 and included representatives from NICoH and Inuit regions, along with Health Canada NIHB and Regional Executives (Northern, Atlantic and Quebec Regions). The INSBC has a mandate to address Inuit perspectives, areas of concern and recommendations to improve the quality, access, and delivery of NIHB benefits to Inuit, and to provide for comprehensive involvement of Inuit in NIHB policy development and program delivery, with the overall goal of improving the status of Inuit health.

Client Safety

SECTION 10

Prescription drugs have the capacity to heal but also the capacity to do harm if not used correctly. Public drug plans, like the Non-Insured Health Benefits (NIHB) Program, bear a responsibility to those they serve. Timely information to health professionals and analysis of individual situations and broader trend observations are crucial in ensuring that clients are well served.

The NIHB Program continues to place a high priority on addressing cases of concern and on enhancing and encouraging the safe use of prescription medications. The NIHB Program has invested considerable time and effort in designing and modernizing its prescription drug benefit with these responsibilities in mind. The Program has adopted four strategies to improve the safety of our clients.

- Point of Sale (POS) warning and rejection messages;
- Client and Program level trend analysis of prescription drug use;
- Evaluations and recommendations from independent experts; and
- Specific drug safety initiatives.

SECTION 10.1

Point of Sale (POS) Warning and Rejection Messages

2014/15

The NIHB Program sends messages electronically in real-time at the POS to warn pharmacy providers about potential client safety issues including drug interactions and repeat prescriptions. Certain warning messages also require the pharmacy providers to report back with specific codes that give the Program information about the actions they have taken related to the warning code received.

Warning messages are important tools that supplement pharmacists' professional judgment at the POS. The NIHB Program actively monitors the number of pharmacy claims that are flagged with warning messages or rejected by this system.

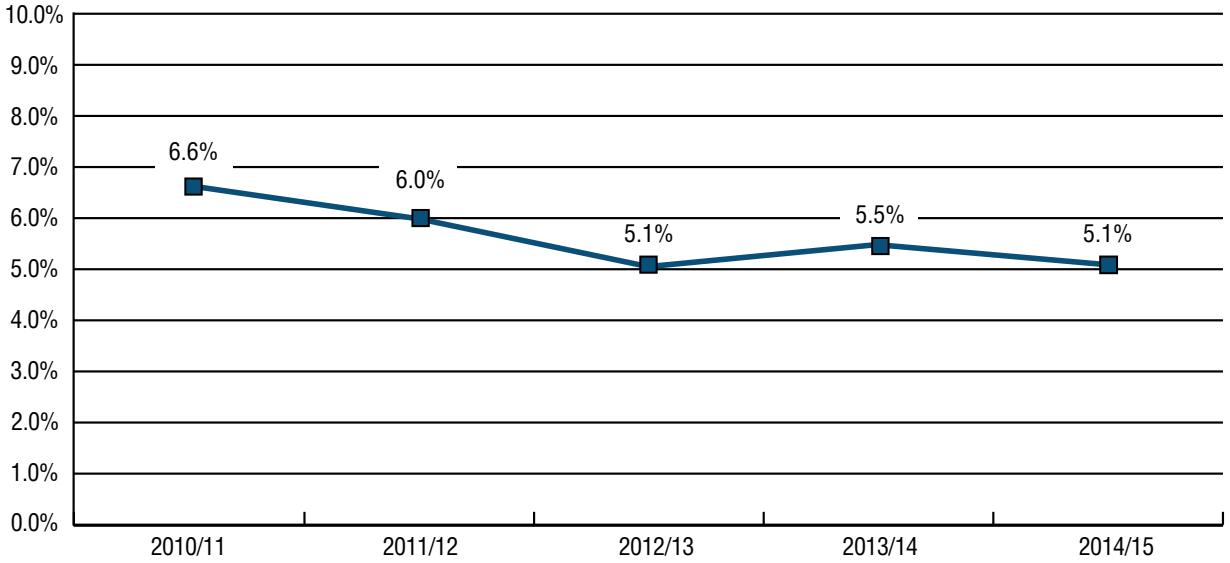
Figure 10.1.1 shows percentage of claims affected by warning messages sent by the NIHB Program to pharmacies across the country since 2010/11. The Program issues approximately one million warning messages per year. The information provided via these warning messages provides additional information to pharmacists and, as a result, enhances their ability to exercise their professional judgment when serving NIHB clients.

The NIHB Program also sends rejection messages to pharmacists when a client's claims history indicates potential misuse or overuse of a range of prescription medications. Unlike warning messages, it is not possible for a pharmacy provider to override or to submit electronic response codes. Instead when a rejection message is received, a pharmacy provider must contact NIHB's Drug Exception Centre (DEC), a national toll-free call centre. The DEC will provide more information to the pharmacy provider regarding the reason for coverage rejection and follow up with the prescribing physician before the Program will authorize coverage for the pharmacy benefit in question. The NIHB Program reserves the right to refuse coverage for pharmacy benefits when there is evidence that suggests client safety may be at risk.

An example of a rejection message is when a client exceeds the maximum allowable quantities for acetaminophen and acetaminophen-based opioids. Clients are often unaware of the long-term consequences of commonly available acetaminophen-based products. Negative health effects can result from prolonged use, including serious liver damage if recommended dosages are exceeded. In 2014/15, the Program rejected a total of 2,775 claims for products that contain acetaminophen, as compared to 1,600 in 2013/14. The increase in rejected claims was driven by an NIHB policy change in October 2013 which decreased the maximum allowable dose of acetaminophen, from 4000mg daily to 3600mg daily.

FIGURE 10.1.1

Percentage of Pharmacy Claim Line with a Warning Message
2010/11 to 2014/15



Source: HICPS adapted by Business Support, Audit and Negotiations Division

Another example of a rejection message is the NE code, created in 2006 to address the health risks associated with the misuse of specific drugs of concern. These drugs include opioids (such as morphine, codeine, and oxycodone which are used to relieve pain), benzodiazepines (so-called "minor" tranquilizers, sleep aids and anti-anxiety medications) and methadone (a long-acting synthetic opioid used to treat opioid addiction or pain). In designing this warning message, it was important to recognize that all of these drugs have clinically valid applications. Therefore, the warning message was designed to focus attention on cases where there were concerns about potential misuse, and where continued utilization was difficult to justify.

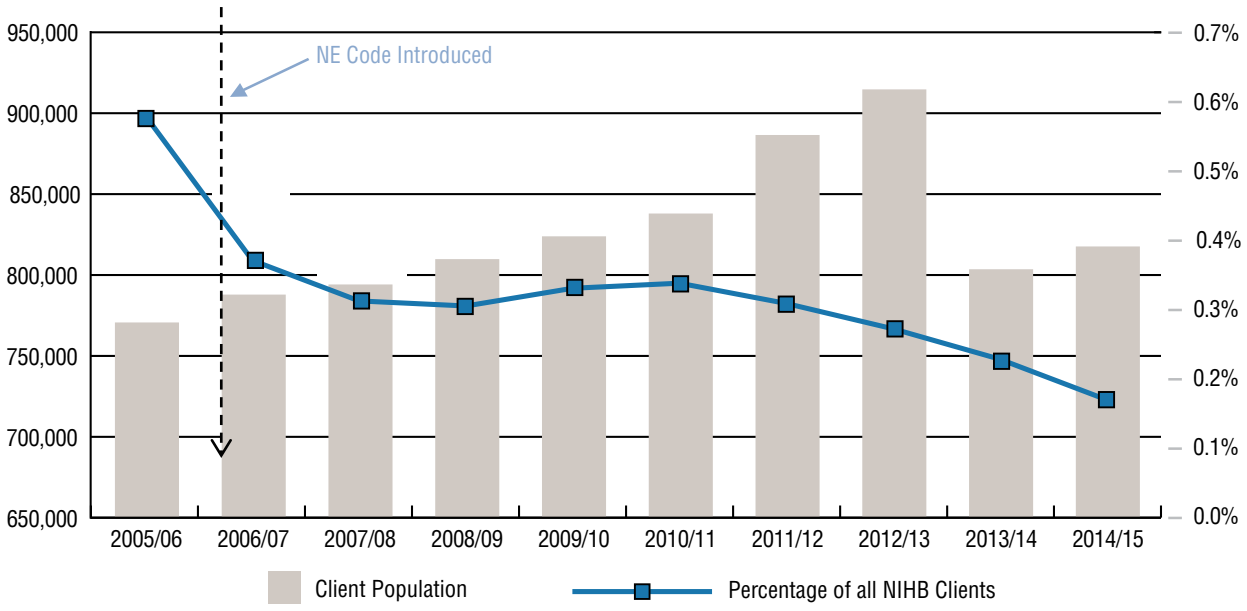
This intervention addresses situations where clients access:

- 3 or more active prescriptions for benzodiazepines
- 3 or more opioids
- 3 or more benzodiazepines and 3 or more opioids
- a prescription for methadone in association with opioid-based drugs

A message is provided to pharmacists indicating that potential misuse of prescription drugs should be explored. It is one more tool to supplement their professional judgment and to protect client safety. To evaluate the impact of the warning message to pharmacists, the NIHB Program has measured the number and percentage of clients who accessed three or more benzodiazepines, three or more opioids, or opioids in conjunction with methadone treatment. In 2014/15, there were approximately 1,400 clients with concurrent claims for opioids, benzodiazepines and methadone. This represents 0.2% of the total eligible population. NIHB continues to monitor concurrent use of these drug classes.

FIGURE 10.1.2

The number and percentage of clients claiming 3 or more benzodiazepines, 3 or more opioids, or opioids in association with methadone
2005/06 to 2014/15



Source: HICPS adapted by Business Support, Audit and Negotiations Division

SECTION 10.2

Client and Program Level Trend Analysis of Prescription Drug Use
2014/15

The NIHB Program actively analyzes broad patterns of utilization, prescribing, and dispensing on an on-going basis. This work is conducted by a team of licensed pharmacists, pharmacy technicians and experts in data analysis. Once patterns are identified, the Program intervenes to prevent the recurrence of inappropriate prescription drug use.

Client Level Analysis

In January of 2007, NIHB launched the Prescription Monitoring Program (PMP) which focuses on the potential misuse of benzodiazepine, opioid, gabapentin, and stimulant drugs. The NIHB PMP process starts by identifying clients at highest potential risk for misuse of these drugs by reviewing the number of prescribing physicians (which may be an indication of "doctor shopping"), the number of pharmacy providers and the number or dose of opioids, benzodiazepines, gabapentin or stimulants claimed. Enrolment may restrict clients to a specific physician or require clients to have future claims verified and authorized by a pharmacist at NIHB's Drug Exception Centre. If the client or their health care provider cannot provide evidence to support the continuation of the drug therapy in question, the Program reserves the right to refuse coverage for the pharmacy benefit requested.

The NIHB PMP complements existing activities and promotes the optimal use of medications by allowing the Program to enhance interventions when concerned about how a client is using their medications. The NIHB PMP operates in all regions

of Canada, with the exception of Quebec, and monitored over 10,000 clients in 2014/15.

Program Level Analysis

NIHB's Prescription Drug Abuse Surveillance Strategy tracks how drugs like methadone, opioids, benzodiazepines and stimulants are prescribed and dispensed. NIHB has an electronic system that closely monitors claims for these drugs and lets health providers know if there is a concern. The goal of these measures is to protect client safety.

For example, during 2011/12, the Program identified a rapid increase in the prescribing of benzodiazepines to First Nations and Inuit clients in certain areas. NIHB alerted the physicians and pharmacists involved and informed them that their prescribing and dispensing of benzodiazepines was much higher than the average. A dose limit on benzodiazepines was also put in place. This resulted in a decrease of benzodiazepine prescribing in these areas.

SECTION 10.3

Evaluations and Recommendations from Independent Experts
2014/15

The NIHB Program receives recommendations on client safety and drug listing decisions from the Drug and Therapeutic Advisory Committee (DTAC). The DTAC is comprised of qualified health professionals who share their knowledge and provide recommendations to the NIHB Program in an evidence-based manner that reflects current and relevant medical and clinical practices. The DTAC will continue to strengthen client safety initiatives related to the NIHB Prescription Drug Abuse Strategy.

SECTION 10.4

Specific Drug Safety Initiatives
2014/15

Methadone for Addiction

Methadone is an opioid that can be used to treat chronic pain but is predominantly used to treat opioid dependence. The concurrent use of methadone and/or opioids and benzodiazepines should be avoided.

The NIHB Program worked on a national strategy to make methadone maintenance therapy (MMT) a limited use (LU) benefit. When a client begins receiving methadone maintenance therapy, the client is placed in the NIHB Prescription Monitoring Program (NIHB PMP) for the duration of MMT treatment, which ensures that only one prescriber writes prescriptions for opioids, benzodiazepines, stimulants and/or gabapentin in order to maximize safety and effectiveness and minimize the risk of harm, abuse and diversion.

This policy was implemented in New Brunswick in August 2011, the rest of the Atlantic Provinces in March 2012, Saskatchewan in May 2013, Manitoba in September 2013, Alberta in March 2014 and Ontario in January 2015. Other regions will be added in the future.

Improved Access to Suboxone™ for Addiction

Suboxone is a medication used to treat opioid dependence.

Previously, the NIHB Program provided coverage for Suboxone in special circumstances. This included coverage for those unable to take methadone, whether due to lack of access or serious reactions to the medication.

As of September 15, 2014, the NIHB Program has changed how it covers Suboxone to ensure that it is more readily available as a treatment option for clients. Health care providers now have the choice of prescribing Suboxone or methadone. Clients receiving Suboxone will be placed in the NIHB Prescription Monitoring Program (NIHB-PMP) for the duration of treatment, which ensures that only one prescriber writes prescriptions for opioids, benzodiazepines, stimulants and/or gabapentin in order to maximize safety and effectiveness and minimize the risk of harm, abuse and diversion.

Changing the Listing Status of Kadian™ (a type of opioid)

As of November 17, 2014, the NIHB Program changed the way it covers Kadian, a medication used to treat chronic pain as well as drug addiction. Prescribers now need to provide the NIHB Program with additional information when requesting coverage. When Kadian is prescribed for drug addiction, the client is placed in the NIHB-PMP.

This ensures that only one prescriber writes prescriptions for opioids, benzodiazepines, stimulants and/or gabapentin in order to maximize safety and effectiveness and minimize the risk of harm, abuse and diversion. These changes ensure clients have safe and appropriate access to drugs like Kadian.

Introduction of a Dose Limit for Stimulants

Stimulants (for example, Dexedrine or Concerta) are medications used to treat attention disorders in children or adults. On February 25th, 2015 the NIHB Program set a new dose limit for stimulants to help ensure that clients are using these drugs safely. Dose limits are the maximum quantity of these drugs that a client can receive per day.

NIHB has contacted doctors whose clients exceed this dose limit to inform them of the change. If the doctor has provided NIHB with justification, some clients may continue to receive the higher dose.

Reduction in the Benzodiazepine Dose Limit

In March 2013, the NIHB Program introduced a dose limit for benzodiazepines, equal to 120mg diazepam equivalent per day. This limit was gradually decreased to 40 mg diazepam equivalence in 2015.

Reduction in the Opioid Dose Limit

To ensure appropriate opioid use amongst NIHB clients, beginning in September 2013, the NIHB Program implemented an opioid dose limit for clients with chronic non-cancer/non-palliative pain. This limit is calculated based on the total daily dose of all opioids a client is receiving covered through the Program. This limit, currently 450mg of morphine equivalence per day, will continue to gradually decrease until an acceptable level is reached. Many NIHB clients were seen with doses beyond the recommended limits, which can be harmful. According to the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, "chronic non-cancer pain can be managed effectively in most patients with dosages at or below 200 mg/day of morphine or equivalent. Consideration of a higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes."

CONCLUSION

The NIHB Program is taking an active, evidence-based approach to further develop client safety activities. This approach stresses the appropriate use of medications with a view to achieving the best possible health outcomes for the NIHB Program's First Nations and Inuit clients. Significant interventions are now in place and the NIHB Program is committed to monitoring and measuring the impact of these interventions and working with expert advisors, stakeholders, and other key players to identify further improvements to the NIHB client safety regime.

The NIHB Program remains committed to ongoing evaluations of its client safety regime and will continue to report on these issues on an annual basis by way of the *Non-Insured Health Benefits Annual Report*.

DENTAL BENEFIT

One of the objectives of the NIHB Program dental benefit is to provide dental services based on evidence-based standards of care and professional judgment, consistent with current best practices of health services delivery.

The *NIHB Sedation and General Anaesthesia Policy* is one example of the Program's commitment to client safety. Anaesthesia services are provided in conjunction with eligible dental services and require predetermination, in other words, approval prior to commencement of treatment. Coverage for sedation and general anaesthesia services is provided with a frequency of once in any twelve month period. In extenuating circumstances, additional sessions would be considered for coverage. This policy, while respecting the professional expertise of dental providers, encourages the minimal risk approach to the use of sedation and general anaesthesia in conjunction with associated dental services.

Another measure the NIHB Program has in place to ensure client safety is the enrollment of dental providers. The Program requires that dental providers are licensed and in good standing with their respective provincial or territorial regulatory body and as such, are servicing eligible NIHB clients under the adherence of legal and ethical obligations of those agreements.

The NIHB Program is taking an active evidence-based approach to further develop client safety within the dental benefit policies. This approach stresses the appropriate use of dental services, within Program coverage, with a view of achieving the best possible health outcomes for eligible First Nations and Inuit clients. The NIHB Program is committed to monitoring the impact of these policies and working with expert advisors, stakeholders, and other ke-y players to identify further improvements to the NIHB client safety measures.

NIHB Program Administration

FIGURE 11.1

Non-Insured Health Benefits Administration Costs ($ 000's)
2014/15

Figure 11.1 provides the Program administration funds expended by each region as well as NIHB headquarters (HQ) in Ottawa. In 2014/15, total NIHB administration costs were $54.1 million representing an increase of $929 thousand or 1.7% over the previous fiscal year.

The roles of NIHB headquarters include:

- Program policy development and determination of eligible benefits;
- Development and maintenance of the HICPS system and other national systems such as the Medical Transportation Reporting System (MTRS);
- Audits and provider negotiations;
- Adjudicating benefit requests through the NIHB Drug Exception Centre and Orthodontic Review Centre; and
- Maintaining productive relationships with stakeholders at the national level as well as with other federal departments and agencies.

The roles of the NIHB regions include:

- Adjudicating benefit requests for medical transportation, medical supplies and equipment, dental, vision benefits, and short-term crisis intervention mental health counselling;
- Working with NIHB headquarters on policy development, provider negotiations and audits; and
- Maintaining productive relationships with stakeholders at the provincial/territorial level as well as with provincial/territorial officials.

CATEGORIES	Atlantic	Quebec	Ontario	Manitoba	Saskatchewan	Alberta	Northern Region	HQ	Total
Salaries	$ 1,320	$ 1,716	$ 3,397	$ 2,664	$ 2,727	$ 2,784	$ 1,074	$ 10,315	$ 25,997
Capital	0	0	0	0	0	0	0	0	0
EBP	264	343	679	533	545	557	215	2,063	5,199
Operating	83	66	416	142	66	213	40	1,989	3,015
Sub Total	$ 1,666	$ 2,125	$ 4,493	$ 3,339	$ 3,338	$ 3,553	$ 1,329	$ 14,367	$ 34,212
Claims Processing Contract Costs									$ 19,908
Total Administration Costs									$ 54,120

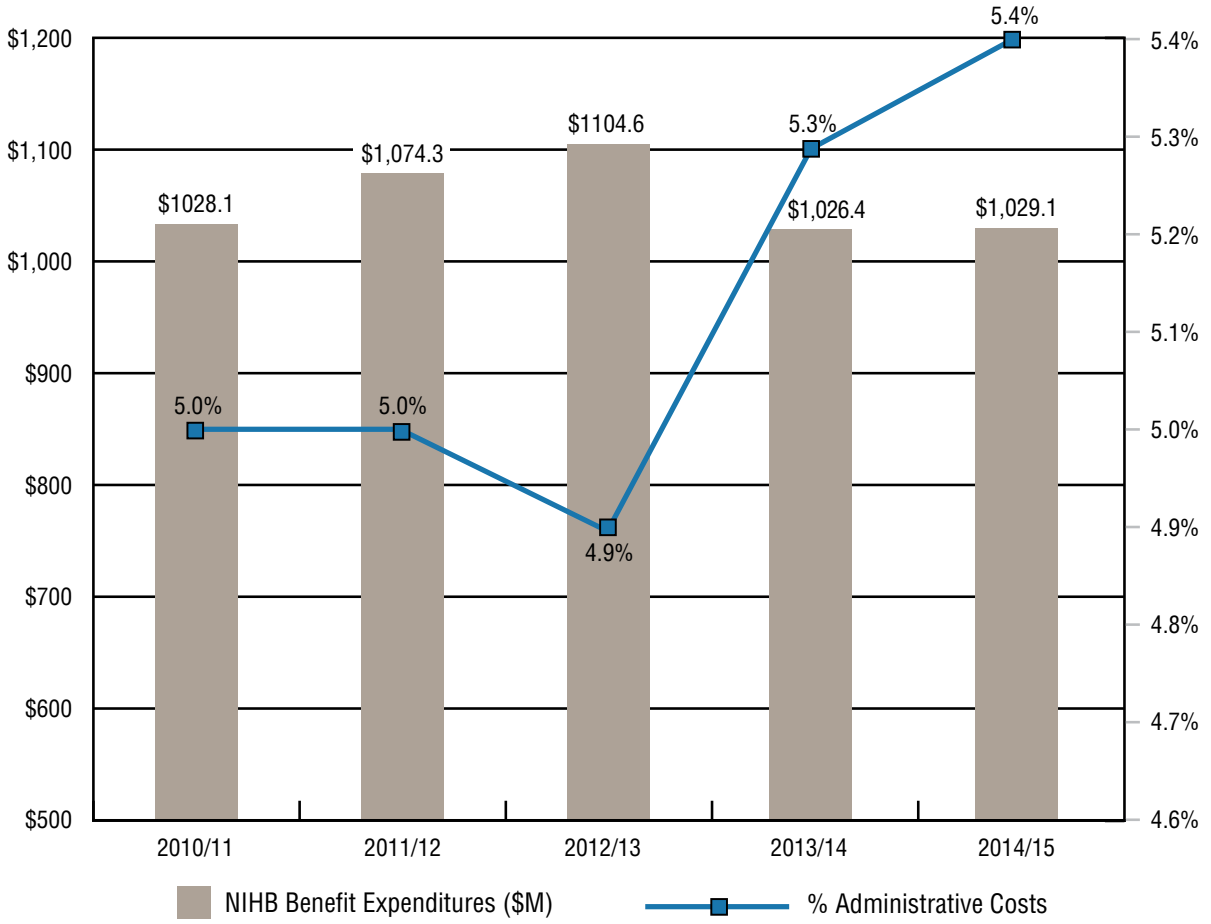
Source: FIRMS adapted by by Business Support, Audit and Negotiations Division

FIGURE 11.2

Non-Insured Health Benefits Administration Costs as a Proportion of Benefit Expenditures ($ Millions)
2010/11 to 2014/15

Figure 11.2 provides the percentage of NIHB Program administrative costs as a proportion of overall NIHB benefit expenditures. In 2014/15, total NIHB expenditures were $1,029.1 million, of which actual benefit expenditures totaled $1,009.2 million and expenditures for claims processing administration amounted to $19.9 million. An additional $34.2 million in expenditures for salaries and operating associated with Program administration are reported separately from total program expenditures. As a result, total NIHB Program administration cost ($54.1 million) as a proportion of actual benefit expenditures ($1,006.5 million) was 5.4% in 2014/15.

Over the past five fiscal years, the percentage of NIHB Program administrative costs as a proportion of total benefit expenditures has ranged from a high of 5.4% in 2014/15 to a low of 4.9% in 2012/13.



Source: FIRMS adapted by by Business Support, Audit and Negotiations Division

FIGURE 11.3

NIHB Program Sustainability

Cost and service pressures on the Canadian health system have been linked to factors such as an aging population and the increased demand for and utilization of health goods, particularly pharmaceuticals, and services. In providing benefits to First Nations and Inuit clients, the NIHB Program faces additional challenges linked to growth in its client base, which is growing at approximately two times the Canadian population growth rate, as well as challenges associated with assisting clients in small and remote communities to access medical services.

Requests for NIHB coverage are driven by the number of eligible clients and their medical needs. The cost of claims is driven by external factors over which the Program has no control.

Client Base	Market Forces	Clinical Evidence
• Changing demographics, including high population growth, an aging population, and uncertainty about the registration of new or existing clients • Health status, including high prevalence of chronic and infectious diseases • Geographic location impacting clients' ability to access health benefits or services	• Introduction and price of new therapies and procedures by the private sector • Provincial/Territorial decisions and insurance industry dynamics • Shift from hospital treatments (insured) to non-insured coverage • Economic factors, including inflation, volatility in the price of gas and oil, and employment status • Lack of healthcare in communities, requiring medical transportation • Changes in scope of practice • Relationships with health professional associations	• Prescribing and treatment decisions of regulated health professionals • Evolving evidence on treatment options • Preventive intervention versus restorative oral treatment

The NIHB Program constantly strives to address these pressures by implementing measures such as promoting the use of generic drug products to ensure that it delivers its benefits within its Parliamentary allocations, while maintaining high quality and timely services to its clients.

Technical Notes

SECTION 12

Information contained in the 2014/15 NIHB Annual Report has been extracted from several databases. All tables and charts are footnoted with the appropriate data sources. These data sources are considered to be of very high quality but, as in any administrative data set, some data may be subject to coding errors or other anomalies. For this reason, users of the data should always refer to the most current edition of the NIHB Annual Report. Please note that some table totals may not add due to rounding procedures.

To address reporting challenges related to in-year transfer of responsibility for First Nations individuals residing in British Columbia to the First Nations Health Authority (FNHA) in 2013/14, select financial and utilization data relating to the British Columbia Region have been suppressed. National totals, however, include these values.

Population Data

First Nations and Inuit population data are drawn from the Status Verification System (SVS) which is operated by FNIHB. SVS data on First Nations clients are based on information provided by Aboriginal Affairs and Northern Development Canada (AANDC). SVS data on Inuit clients are based on information provided by the Governments of the Northwest Territories and Nunavut, and Inuit organizations including the Inuvialuit Regional Corporation, Nunavut Tunngavik Incorporated and the Makivik Corporation.

Pharmacy and Dental Data

Two Health Canada data systems provide information on the expenditures and utilization of the NIHB Pharmacy and Dental benefits. The Framework for Integrated Resource Management System (FIRMS) is the source of most of the expenditure data, while the Health Information and Claims Processing Services (HICPS) system provides detailed information on the utilization of the pharmacy (including Medical Supplies and Equipment) and dental benefit areas.

Medical Transportation Data

Medical transportation financial data are provided through the Framework for Integrated Resource Management System (FIRMS). Medical transportation data are also collected regionally through other electronic systems. Operational data at the regional level are tracked through the Medical Transportation Reporting System (MTRS) for most regions, while the Alberta and Ontario regions use their own systems. Contribution agreement data are also collected, but in a limited manner. In some communities, MTRS is used to collect contribution agreement data, while other communities report data using spreadsheet templates, in-house data management systems, or through paper reports. In some regions, other information such as ambulance data is collected separately.

In 2005, an initiative was launched to collect medical transportation data on a national basis. The Medical Transportation Data Store (MTDS) was created to act as a centralized system for cross regional data. The MTDS serves as a repository for selected operational data, as well as the data collected from medical transportation contribution agreements, and ambulance data systems. The objective of the MTDS is to enable aggregate reporting on medical transportation at a national level in order to further strengthen Program management, provide enhanced data analysis and reporting and aid in decision making.

In 2013/14, a new version of the MTDS was released to enhance the data collection method and improve the reporting capability of the data store. These enhancements ensure that the MTDS responds reliably to NIHB's analytical needs, and allows accurate analysis of Medical Transportation (MT) cost drivers in order to manage the efficiency and effectiveness of the MT benefit. In addition, steps are currently underway to improve data collection related to contribution agreements.

Vision Care, Emergency Mental Health Care, Other Health Care and Premiums Data

Financial data on the NIHB vision care, other health care and premiums benefits are provided through the Framework for Integrated Resource Management System (FIRMS).