NORTH AMERICAN OBSERVATORY on Health Systems and Policies

Rapid Review

Coverage of Grey Area Services in Four Provincial/ Territorial Health Insurance Programs

Prepared for the Yukon Government

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About NAO

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List of Abbreviations

AI	Artificial insemination
ART	Assistive reproductive technology
BC	British Columbia
CHA	*Canada Health Act*
FMRAC	Federation of Medical Regulatory Authorities of Canada
HKRP	Hip and knee replacement rehabilitation
IUI	Intrauterine insemination
IVF	In-vitro fertilization
LTC	Long-term care
MOHLTC	Ministry of Health and Long-Term Care (Ontario)
MSP	Medical Service Plan (British Columbia)
NT/NWT	Northwest Territories
OFP	Ontario Fertility Program
ON	Ontario
OTN	Ontario Telemedicine Network
PE/PEI	Prince Edward Island
PT	Provincial and territorial
UHC	Universal Health Coverage

Introduction and Background

Provincial and territorial (PT) health systems in Canada provide comparable universal health coverage (UHC) for hospital, medical, and diagnostic services to their populations. The *Canada Health Act* (CHA) establishes a broad definition of "insured services" that provides a floor that PT health systems must meet. All Canadian jurisdictions have expanded their coverage programs above this floor, although only a few select services have been added to their respective baskets of UHC services.

For non-UHC services, such as prescription drugs, long-term care (LTC), and vision and dental care, there is considerable variation in the extent to which PTs have designed their coverage programs. These programs mostly serve as safety nets designed to protect vulnerable populations, e.g., those with low income. These rules-based systems have contributed to dissatisfaction among their populations, who want more flexibility for providers to make common sense decisions, rather than relying on limited and often targeted coverage or using "narrow rules to refuse treatment" (1).

However, the focus of this rapid review is on PT coverage of medical services that fall on the boundary, in what could be called the "grey area" of UHC services. Once such services have been defined by a PT government as "medically necessary" or "medically required" as defined by the CHA, they must be provided to all PT residents without any financial cost at the point of delivery. Examples of these types of services include reproductive and abortion services, rehabilitative care, gender reassignment, and patient transportation services, among many others. These grey area services have received little attention in the literature to date, so it is not well known the extent to which, and why, PTs have decided to include them in their UHC programs. While the decisions to determine medical necessity are generally made behind closed doors between medical associations and PT governments (2), considerations when making these decisions include: a) budget impacts of coverage expansions, b) whether other PTs have chosen to publicly cover the service, and c) the strength of political pressure to fund the service (3). Decisions are also influenced by existing legislation and organizational structures that may establish precedents for coverage within the jurisdiction.

This report describes how these selected grey area services are covered in four PT governments. Specifically, we detail the provision of: a) medical transportation (i.e., ambulance) services, b) post-operative rehabilitation services, c) assistive reproductive technology (ART) services, and d) virtual physician visits within the Canadian jurisdictions of British Columbia (BC), Northwest Territories (NT), Ontario (ON), and Prince Edward Island (PE). Throughout the report, we draw on academic and grey literature, as well as from consultations with local experts to provide an overview of the extent to which these services are covered in each jurisdiction, and when possible, how decisions regarding these services' coverage were made. This information provides insight into the variations in service coverage across Canada, and the process by which these services have come to be fully or partially covered.

Methods

This review was undertaken to describe the floor for PT health insurance programs and explore the concept of "grey area" services that are considered medically necessary in some jurisdictions and not others. We selected four grey area services to compare across jurisdictions: 1) medical transport by land ambulance; 2) post-operative rehabilitation, with a focus on total joint replacement; 3) ART; and 4) virtual physician visits. We examine whether there is coverage for these services in four Canadian jurisdictions. BC, NT, ON, and PE were selected for their range of policy decisions around the chosen grey area services, in addition to being neighbouring jurisdictions (NT and BC) and having a comparable population size to Yukon (NT and PE). BC was also a suitable comparator because of the Government of Yukon's arrangements with Vancouver hospitals and specialists for medical referrals (1).

We completed a targeted scan of grey literature and government websites between March and May 2020 to identify policies and information on service coverage for these grey area services. A preliminary scan was performed through government websites to identify base health plan insurance coverage for the selected grey area services. PT laws and regulations pertaining to these service areas were identified. A broader scan of the grey literature was also performed, including of organization websites and media releases to detail the history and ongoing deliberations over such service coverage decisions. Relevant reports and academic publications were compiled to inform the context around grey-area coverage decision-making in Canada. We validated our findings by consulting with key experts from the selected jurisdictions when possible.

We also conducted a supplementary review of coverage for these grey area services in Alberta and Yukon (September 2020) upon request of the funder.

Limitations

This rapid review drew on publicly available information to present an overview of the coverage for these services in the selected jurisdictions. Data collection occurred during the early phases of the COVID-19 pandemic in Canada, which led to rapid changes in the virtual care landscape and the literature search was being conducted.

Analytic Overview

There is considerable variation across jurisdictions in the extent of public coverage, and the specific conditions and limits to coverage for each of the grey area services covered in this review. This section provides a brief overview, including definition of terms, a brief history of coverage for the service, and a summary of who is covered (eligibility), what is covered, how much is covered in terms of the grey service area, and insights into how decisions about coverage were made. Additional details can be found in **Appendices A** and **B**.

Medical Transport by Land Ambulance

Ambulance services are emergency medical services that support the treatment of illnesses and injuries of persons who require urgent medical care. Specifically, "ambulance services" refer to the transportation of persons who require care to, or from (and occasionally between), treatment sites (4). Depending on the region, this may involve transportation by ground or air; our review focuses on land ambulance services.

Public insurance coverage for land ambulance services varies across Canada, with jurisdictional differences in fee structures and population eligibility. Ambulance services may not have been considered medically necessary due to the perception that ambulances were more closely aligned with transportation services, rather than health care (5). However, over time paramedic services have become more integrated within the health care system (5). Many jurisdictions provide partial funding for ambulance services, requiring users to pay a co-payment fee. The price of this fee differs widely across jurisdictions and is justified by some policy makers as a deterrent against inappropriate use, and a means to reduce system costs (5).

Coverage

Coverage for land ambulance services differs across the four jurisdictions included in this review. Three jurisdictions—ON, BC, and PE—have some coverage for insured residents within their provincial health insurance plans. The NT provides no territory-wide public insurance coverage, and ambulance services are available in just 6 of 33 communities (6). Differences in coverage between the jurisdictions can be seen in terms of who is covered, what is covered, and how much of the service fee is covered. Details are available in **Appendix A**.

Who is covered?

Provincial residents with valid health insurance are required to pay a co-payment for ambulance services in ON, BC, and PE (7–9). In NT, fees charged within the six communities that offer ambulance services can vary between community residents and other NT residents visiting from outside the community (10). Ambulance fees are not covered for non-residents visiting the jurisdictions with the exception of ON where ambulance trips for visitors (i.e., Canadian residents from outside of ON insured by their provinces plan) are fully covered provided that their trip is medically necessary, starts at an ON hospital and ends at that same hospital within 24 hours (9). Within each jurisdiction there are also certain populations who are either exempt from co-payment charges or who pay a reduced co-payment fee (see **Appendix A)**.

What is covered?

Public insurance and co-payment charges for ambulance services typically cover the full length of the ambulance trip as well as the emergency medical services provided at the originating site and in transit. BC is the only jurisdiction covered by this review that charges a specific response fee for when ambulance services are requested and are either not required or declined (7). In ON and PE, co-payment fees differ depending on whether or not a physician determines the ambulance trip was medically necessary (8,9). In ON, BC, and PE, interhospital transfers within the province are fully covered. Coverage also exists in ON and PEI for urgent care requiring ambulance trips out of the province (8,9).

How much is covered?

Depending on the service users' eligibility criteria and jurisdiction, public insurance coverage for ambulance services ranges from zero to partial cost of the service (specific details available in **Appendix A**). Ambulance services are not fully covered for the entire population of residents in any of the four jurisdictions featured in this review, and thus are not considered part of the UHC "medically necessary" basket. For the typical user (i.e., a resident with valid health insurance), co-payment charges are lowest in ON and highest in the NT.

Legislation and Decision-Making

ON, BC, and PE each have legislation governing the provision of ambulance services throughout their province. In BC and PE, ambulance services are provided through a single operator: a government entity in BC (BC Emergency Health Services Commission) and a contracted third-party company in PE (Island EMS) (6,13). In ON, the Ministry of Health and Long-Term Care (MOHLTC) oversees legislation for the service, sets fees, and ensures compliance among providers (6,12). Ambulance services in the province are provided through the municipalities, who also co-fund the service with the MOHLTC (14,15). Some First Nations communities in ON also provide their own ambulance services, whose costs are fully covered by the MOHLTC (6).

In NT, there is no territory-wide ambulance service legislation and no comprehensive and coordinated ambulance service system (12). The territorial government provides legislation that allows the NT Regional Health and Social Services Authority, Hay River Health and Social Services Authority, and Tłı̨chǫ Community Service Agency to supply ambulance services. In turn, some municipal governments provide the service, with fees outlined in each community's by-laws. Fees are related to the actions taken, including but not limited to responding to an incident or false alarm, or providing ambulance services.

Regulation and oversight for ambulance and emergency medical services also differs across the jurisdictions. NT is one of the few Canadian jurisdictions where ground ambulance services are not regulated. As a result, there are no territory-wide standards for vehicles, equipment, or training (6). Rather, communities offering ambulance services have different requirements listed in their by-laws, which may include standards for training and operations (6). ON, BC, and PE each have more comprehensive regulatory frameworks guiding the provision of ambulance services. All four jurisdictions have regulatory bodies in place that oversee the paramedics responsible for providing ambulance services. Further, they each have government legislation regulating the certification or licensing of paramedics. ON and PE's regulations also establish standards for other elements of ambulance service provision, including operation, standards of care, obligations of communications services, response time performance plans (in ON), and staffing, vehicle safety, equipment, and supplies (in PE).

Assisted Reproductive Technologies

Assisted Reproductive Technologies (ARTs) are broadly defined as treatments and procedures used to facilitate conception for persons experiencing infertility, single parents, or same sex couples (16). For the purposes of this report, ARTs will include in-vitro fertilization (IVF), artificial insemination (AI), intrauterine insemination (IUI), and fertility preservation. Public coverage (with limits and conditions) of some ARTs in Canada is limited to ON and Quebec, with tax refunds available in Manitoba and New Brunswick. Of the four jurisdictions included in this review, ON alone provides public coverage for ARTs, though policies regarding coverage have been discussed in the other jurisdictions.

In December 2015, the MOHLTC initiated the Ontario Fertility Program (OFP) (17) with the aim of increasing the accessibility of treatment. Funding for the program is provided through Transfer Payment Agreements (TPAs) between the province and individual ART clinics (18). While ARTs are generally provided without any public funding and limited public oversight in most of Canada,[1] ON is unusual in that it has 50 clinics participating in the OFP and these clinics receive government funding alongside private payments, potentially from the same clients (21).

Coverage (Ontario)

Who is covered?

Under the OFP, ON residents with a valid ON health card who meet additional eligibility requirements are publicly covered for some ARTs (22). To be eligible for IVF treatment, ON residents must be under 43 years of age and have not received any other ON-funded IVF treatments, unless acting as a surrogate. No additional eligibility criteria are in place for AI and IUI treatments. Fertility preservation is provided to ON residents under the age of 43 at one treatment cycle per patient, and patients must provide a medical reason for seeking gamete preservation, such as getting a treatment for a medical condition that may cause infertility. Specifically, eligibility depends on three conditions: “hold a valid Ontario health card; be diagnosed by a physician as having a medical condition where the planned treatment for that condition is known to affect fertility and may lead to infertility; and have not yet received one funded FP cycle per lifetime (patients can receive funded FP separate from funded IVF)" (23). Residents meeting these three

[1] In Canada, most fertility services are regulated through physician regulatory bodies and clinical practice guidelines. Following the 1993 report by the Royal Commission on New Reproductive Technologies (19), the federal government passed the *Assisted Human Reproduction Act 2004* (AHRA). The mandate of the Commission was to: "inquire into and report on current and potential medical and scientific developments related to new reproductive technologies, considering in particular their social, ethical, health, research, legal and economic implications and the public interest." The objective of the AHRA was to protect and promote the health, safety, rights, and dignity of Canadians who use ARTs. Soon after the AHRA was enacted, Quebec’s provincial government challenged the constitutional validity of the Act on the grounds that it encroached on the legislative authority of the provinces (2010 SCC 61, 2010). Eventually, in December 2010, the Supreme Court of Canada stated that the bulk of ART regulation and oversight was within provincial jurisdiction and ruled that large swaths of the Act *ultra vires* constitutionally invalid (2010 SCC 61, 2010). In jurisdictions where there is public coverage for ART services, the Government of Quebec and Collège des médecins du Québec (CMQ) closely regulate ARTs in Quebec, and the College of Physician and Surgeons of Ontario (CPSO) regulates fertility services through the Out-of-Hospital Premises Inspection Program (OHPIP) (20).

conditions are universally eligible for coverage: factors such as sex, gender, sexual orientation, or family status cannot be used to determine coverage.

What is covered?

OFP funding covers most procedures and treatments for IVF, AI, IUI, and fertility preservation treatments with varying limitations. It does not cover the cost of related fertility drugs, genetic testing, storage, lab fees, or fertility preservation beyond gamete storage for one treatment cycle per patient (22). Coverage for IVF is limited to one IVF cycle per patient per lifetime and is strictly tied to a single embryo transfer (SET) requirement. The OFP covers cycle monitoring, embryo freezing and thawing, fertilization and embryology services, and fresh or frozen embryo transfers for IVF patients. For IUI patients, the program covers cycle monitoring and the insemination procedure, but excludes sperm washing. Finally, cycle monitoring, one attempt at gamete retrieval, and one batch of gamete storage is included with fertility preservation. Further details on coverage and limitations are available in **Appendix A**.

How much is covered?

OFP funding amounts to $50–$70 million[2] per program year. IVF cycles are capped at $5,000 per year, at one cycle per patient (17). One IVF cycle includes the one-at-a-time transfer of all viable embryos in order to ensure multiple chances of pregnancy and reduce the risk of multiple births (24). While the exact coverage figures will vary between patients, the portion of the IVF cost covered by the OFP is approximately $7,000–$13,000. Patients may still expect to pay approximately $1,000 out-of-pocket in storage and lab fees, depending on the clinic, as well as up to $5,000 if they require fertility medications. There are no provincial coverage limits on the total number of treatment cycles for AI or IUI in the participating OFP clinics, though the availability of funded AI treatments will depend on the level of demand and funding capacity at each individual clinic. The OFP covers approximately $725 for cycle monitoring and insemination, but patients will pay the sperm washing fees for each cycle ($500–$800). Beyond provincial coverage, residents have the option of paying out-of-pocket with treatment costs estimated at $10,000–$20,000 per IVF cycle or around $1,500 per IUI cycle (not including drugs, genetic testing, or sperm/embryo storage) (21).

Legislation and Decision-Making

The Ontario Ministry of Children and Youth Services established an Expert Panel on Infertility and Adoption in July 2008 “to provide advice on how to improve Ontario's adoption system and improve access to fertility monitoring and assisted reproduction services” (25). In 2009, this expert panel recommended expanding funding for ARTs in ON, . found that the main barrier to family building through ARTs was cost, and reported that the demand for multiple-embryo transfer among patients who pay privately (in order to increase their chance of pregnancy) has been associated with multiple births and subsequently poor health outcomes that can increase later health care costs for mothers and their children (20,25,26). These recommendations were not immediately adopted, but fertility access was revisited as a priority in 2014 when the *Building Opportunity and Securing our Future Act* was passed (27). An advisory panel was commissioned by the MOHLTC to provide research and recommendations for implementing a fertility program, which later established the OFP in December 2015, with the explicit aim of promoting single embryo transfers in order to prevent multiple births (28–30). While there is no research on the impact of these changes in ON

[2] All amounts in Canadian dollars

specifically, research from Quebec suggests lower rates of multiple births after single-embryo transfer policies were implemented (31). OFP funding is distributed to fertility clinics based on the volume of patients they treat, and with the condition that only one embryo can be implanted per cycle. The clinics are responsible for determining eligibility (22).

No UHC for ARTs exists in the other three jurisdictions covered in this review, although the BC government has considered providing some targeted support. In 2018, BC's budget mentioned that advocacy groups recommended funding one cycle of IVF for patients below a certain income level and tax credits for all other patients. However, according to advocates, "it wasn't approved, competing with higher priorities such as the opioid crisis" (32).

While there are more than 33 IVF clinics across the country, several jurisdictions are without any IVF facilities due in large part to small populations (Newfoundland and Labrador, PE, Yukon, and NT) (33). In 2018, PE Health Minister Robert Mitchell expressed his consideration to offer tax breaks to couples undergoing IVF, similar to Manitoba and New Brunswick (34). More recently, in April 2019, an agenda item of the PEI Progressive Conservative party was the introduction of a $5 million women's health fund (35), some of which would go towards covering IVF treatments in the province (36).

In NT, advances in reproduction technology were mentioned in the 2011 legislative assembly transcripts in the context of amending the *Vital Statistics Act* (37). This relative lack of discussion about ARTs funding in NT may be due to its higher overall fertility rates (38). Based on 2016 data from Statistics Canada, the fertility rate in NT was 1.79 compared to 1.62 in Yukon and 1.54 for Canada as a whole (39).

Post-Operative Hip and Knee Replacement Rehabilitation

Rehabilitation refers to the process of enabling individuals with an impairment, such as those with recent injury or illness, disabilities, or with degenerative conditions, to restore their independence, functioning, and quality of life (40,41). Much rehabilitative care is physical therapy, provided by physiotherapists or physiatrists, focusing on restoring functional ability (42). Other rehabilitation specialists include occupational therapists, speech and language pathologists, and social workers (41). This review focuses on public coverage for post-operative rehabilitation and physiotherapy services for individuals with total joint replacement (hip or knee) after being discharged from hospital. We will refer to such services as post-operative hip and knee replacement rehabilitation (HKRP). Approximately 130,000 hip and knee replacement surgeries are performed every year in Canada (43). While all such surgeries are covered under provincial and territorial UHC plans, HKRP are considered a "grey area" service that varies in funding across jurisdictions.

Coverage

HKRP is not in the UHC programs in any of the four jurisdictions in our study. In NT and ON, there is some public coverage provided on an outpatient basis in community settings, and in BC these are targeted to lower income groups. In PE, HKRP provided in outpatient, hospital-based settings is fully covered, for those with no private insurance coverage (44).

Who is covered?

In ON and NT, all residents with a valid health card are eligible for some public coverage of community-based post-operative rehabilitation and physiotherapy services for hip and knee replacement surgeries. In BC, public coverage is only available to individuals who qualify for the Medical Service Plan (MSP) supplementary benefit (45). Access to the MSP supplementary benefit is based on an annual adjusted net income lower than $42,000 (45,46). In all jurisdictions, individuals eligible for coverage must be referred by a health care provider (physician or nurse practitioner) in order to receive services. In addition, individuals can self-refer for services in NT (47), however HKRP is only covered when care is provided in public facilities and does not extend to services by private practices. Notably, HKRP is not part of UHC in PE: individuals with private insurance are triaged to the private sector for rehabilitation and physiotherapy, and those without private insurance may receive some HKRP in outpatient settings in hospitals[3] .

What is covered?

Unfortunately, the type and frequency of HKRP services that are covered in each jurisdiction are not described in detail. In ON, the number of services and length of treatment for any given condition are determined by the treating physiotherapy provider and are known as an "Episode of Care." An episode of care includes patient assessment, diagnosis, treatment, and discharge summary (48). Only publicly funded (Ontario Health Insurance Plan [OHIP]-funded) physiotherapy clinics, community-based centres, and family health teams can receive public coverage for rehabilitation and physiotherapy services (48). Through contract agreements with the MOHLTC in ON, OHIP-funded physiotherapy clinics receive $312 per episode of care per individual. In BC, public coverage is available for a maximum of 10 visits per year to physiotherapy, chiropractic, massage therapy, naturopathy, acupuncture, and non-surgical podiatry. In order to receive public funding in BC, providers must be enrolled with the MSP (49). There are no specific details about the types of services or duration of coverage in NT or in hospital-based outpatient clinics in PE.

How much is covered?

There is no cost sharing for post-operative rehabilitation and physiotherapy services in ON and NT. PE also covers HKRP services if delivered in outpatient hospital-based clinics (for those without private insurance). In BC, coverage under the MSP is limited to $23 for a maximum of 10 visits toward the following services: physiotherapy, chiropractic, massage therapy, naturopathy, acupuncture, and non-surgical podiatry (50).

Legislation and Decision-Making

Three jurisdictions (NT, ON, BC) have legislation relevant to the provision of publicly funded post-operative rehabilitation and physiotherapy services for hip and knee replacement surgeries. In NT, outpatient physiotherapy services are listed as an insured service under the *Hospital Insurance and Health and Social Services Administration Act, 1990* (51). In ON, community-based physiotherapy services were removed from the province's *Health Insurance Act, 1990* in 2013, and redefined as a publicly funded budget-based program (52). Local Health Integrated Networks (LHINs—to be replaced by Ontario Health) are responsible for planning and funding services in their catchment area, including community-based physiotherapy

[3] Personal communication, Dr Harrison.

services. Legislation on the provision of these services fall under *The Peoples Health Care Act, 2019* (previously the *Local Health Systems Integration Act, 2006*) (53).

In BC, eligibility criteria and a list of supplemental services covered under the MSP, including HKRP, are described in the *Medicare Protection Act, 1996 Medical and Health Care Services Regulation* (46). The province's Medical Services Commission manages the coverage and provision of publicly funded health services, including physiotherapy (54). The commission comprises three members of the government of BC, three representatives from Doctors of BC, and three members from the public (54). Historically, similar to ON, BC had UHC for physiotherapy under the MSP until 2003, when it was delisted except for supplemental benefits beneficiaries (55).

Virtual Physician Visits

Most physician services are considered "insured services" under the CHA and thus are covered in PT universal health coverage programs. Innovations in technology have provided an opportunity to modify the delivery of in-person physician (or specialist) services toward virtual physician visits, which are broadly referred to as a type of virtual care.[4] Virtual care refers to "any interaction whether synchronous or asynchronous in nature between patients and/or members of their circle of care, without direct contact, using any form of communication or information technology" (56). These types of interactions may include video visits, consults, telehomecare, email, and text messaging. The decision to provide public coverage for virtual physician services requires careful consideration of licensing and billing issues related to the provision of care as well as the need to establish standards on how care can be delivered effectively while maintaining patient privacy.

Coverage for virtual physician visits has evolved in response to the recent COVID-19 pandemic. This review describes aspects of public coverage for virtual physician visits prior to March 2020, as well as key changes in coverage in response to the current pandemic.

Coverage

Among the four jurisdictions, BC has the most comprehensive and longstanding coverage model for virtual physician care. Billing codes for virtual physician visits were in place prior to COVID-19 in BC, ON, and NT, although under limited conditions (57–59). In ON, physicians must be enrolled in the Ontario Telemedicine Network (OTN) in order to receive funding for virtual care services (57), while the WestNet Telehealth Pilot began facilitating some telehealth services in NT in 1998 (60).

Coverage for virtual physician visits differs across the four jurisdictions and has more recently evolved in response to the COVID-19 pandemic. All four jurisdictions currently provide some form of coverage for virtual physician services, albeit on a potentially temporary basis.

Who is covered?

In all four jurisdictions, individuals who have valid health cards may be eligible to receive virtual physician services. Health care providers are often responsible for determining if virtual care is a suitable care delivery option for their patients. In BC, as of April 9 2020, in response to the COVID-19 pandemic, individuals who

[4] Previously termed telehealth and telemedicine

were previously ineligible for virtual care coverage under the MSP, including temporary foreign workers, may request coverage (61).

What is covered?

Virtual physician care is far more than telephone consults: as discussed above, the term also includes video visits, telehomecare, email, and text messaging. UHC for these services varies considerably across the four jurisdictions. For example, video visits, including direct-to-patient video and hosted video visits, are covered in ON. Telehealth services described as "a medical practitioner delivered health service provided to a patient through the use of video technology or telephone," including in-office and out-of-office services, are covered in BC. Telephone prescription renewals, with some limitations, are covered in PE (62). Finally, secure text messaging is now available to some patients in ON and BC; however, text messaging is considered an unregulated tool (i.e., it does not meet privacy and security requirements) and is not recommended (63). In BC, specific billing codes apply when emailing and texting medical advice.

Prior to COVID-19, there were a limited number of virtual care services eligible for coverage across the four jurisdictions. In BC, limited-use telemedicine fee codes have been available for over a decade (57). For example, a physician or medical practitioner can claim only one telehealth service per day for the same patient (64). In ON, only direct-to-patient video visits delivered by specialists, general practice physicians, or primary care physicians who were registered in the province's Virtual Care Program were covered between November 15, 2019 and March 31, 2020 (65). In PE, there was a substantial increase in virtual care coverage via Master Agreements (62,66). In addition to expanding billing codes, Health PEI and the Medical Society of PEI (MSPEI) in 2018 began a collaboration with Maple, a nation-wide for-profit company to launch a "telerounding" pilot program that has since been extended (57,67,68).

In NT, telehealth services (video calling) for individuals in remote communities have been available since 1998 for consultations with physicians and specialists through 90 telehealth sites; however, there is little detail on the types of conditions eligible for consultation (69–71). When telehealth first became insured in NT, only some medical specialties were eligible for reimbursement for their services. These included: general practice, cardiology, dermatology, geriatrics, internal medicine, orthopedics, pediatrics, psychiatry, and radiology (but only when urgent) (58). As of January 2020, NT also rolled out Strongest Families, a mental health phone-in service co-funded ($500,000 spread over five years) by Bell Let's Talk, Northwestel, and the NT Government (72).

In all jurisdictions, the number and type of publicly funded virtual physician visits have expanded since March 2020 in response to COVID-19. In BC, the province announced changes to physician compensation for virtual care services and released a temporary MSP payment schedule that allowed physicians to claim consultations, office visits, and non-procedural interventions via telehealth and two temporary fee codes for specialist services (73). The ON government has temporarily allowed for services related to the "assessment of or counselling to insured persons by telephone or video, as well as a temporary sessional fee code" to be listed as an insured service under the *Health Insurance Act* (74). Physicians are encouraged to use their professional judgement and best interests of the patient to identify services appropriate for virtual physician care and obtain patient consent prior to delivering direct-to-patient video visits (75). PE virtual physician visit billing codes were also expanded in response to COVID-19 to cover a wider range of services for general practitioner visits, specialist care, and prescription renewal (66,76–78). Notably, NT responded to COVID-19 by arranging with physicians in Alberta to deliver virtual care for services that were previously provided in person by family physicians and visiting specialists (79). They also recruited locum

physicians and nurses with virtual care training and expedited their licensing process with an NT Emergency License (79).

How much is covered?

Consistent with UHC under all provincial medicare laws, there are no out-of-pocket costs for virtual physician services across the four jurisdictions. However, in BC patients who miss virtual physician appointments may be subject to missed appointment fees, which are payable to the relevant physician practices. For physicians, billed amounts for virtual care services are higher than regular in-office visits which may serve to offset some of the costs of using the required telemedicine technologies.

Legislation and Decision-Making

In Canada, virtual physician services operate within the same legislative framework as other physician services. In most cases, new legislation is not required to permit virtual care services as existing legislation does not exclude these as potentially insured services (58). Despite this, and in response to the COVID-19 pandemic, some health ministers have recently moved to more explicitly include virtual care within their UHC coverage. For example, in March 2020, the ON government introduced an order to list virtual physician care services as insured services under the *Health Insurance Act, 1990* (80).

Physicians and specialists who provide virtual care must continue to adhere to the same legislation and guidelines that regulate in-person visits (e.g., protection of personal health information and patient consent). In 2018, the Federation of Medical Regulatory Authorities of Canada (FMRAC) developed a framework on telemedicine to set out expectations and recommendations for regulatory authorities and physicians to ensure that safe and effective care is maintained when physicians opt for virtual care (86). While FMRAC set out these standards, there is variation in licensing requirements across provincial and territorial regulatory bodies, which can impede physician access to virtual care (62). Regulatory bodies also enact different regulations around the portability of medical licenses (87). For example, through PE's telerounding pilot project, out-of-province physicians from Nova Scotia and Ontario were required to be licensed in PE in order to provide services (81,82). In contrast, BC and ON do not specify that a physician licensed out-of-province must also be licensed within their jurisdictions to provide care (57). Further, NT recently introduced emergency licensing for Alberta-based physicians to help support virtual care services in NT (82).

Although legislation does not directly prohibit virtual care, other barriers to its uptake exist including behavioural, regulatory, and system-level constraints that until recently have contributed to limited use of virtual care services by Canadian physicians (56). Throughout the country, PT governments are responsible for establishing policies and payment models to ensure that physicians are fairly compensated. These fees are negotiated with each jurisdiction's medical association. However, current interpretations of billing regulations in PT health insurance plans have been recognized as a significant barrier to widespread uptake of virtual care in Canada, because several jurisdictions base their payment systems on face-to-face encounters between the patient and physician (57). These requirements further limit the portability of virtual care by reinforcing geographic boundaries for service coverage. Concerns over privacy, security, consent, and standard of care have also limited the implementation of virtual services in Canada.

Conclusions

This review examined public coverage for four grey area health services that provincial and territorial governments may consider "medically necessary" or "medically required" as defined under the CHA. These services could be included in PT health insurance plans and, to be consistent with UHC, available to all PT residents without any financial cost at the point of delivery through either physician extra-billing or facility user charges. Alternatively, these services may be partly covered, or not covered at all and left to the private insurance and private pay markets. Public coverage that targets only part of a population or has user fees or patient contributions is not UHC as defined in Canada, which has a strong form of universality (80). However, what is deemed a "medically necessary" or "medically required" service can be restrictive. This gives rise to important differences among PT health coverage programs, in terms of what exact service is offered to residents free at the point of use, how is need (medical necessity) defined or determined, and what limits or conditions are placed on that coverage.

This rapid review focused on four such grey area services that are considered differently across Canada in terms of the extent and design of public coverage: patient transport by land ambulance, ARTs, HKRP, and virtual physician visits. These services were selected based on existing variation in coverage across PTs, and limited attention in the literature. We examined differences in coverage across ON, BC, PE, and NT, exploring whether these services are offered to all residents at no cost, and how decisions to cover these services were made. We identified a range of coverage across the four jurisdictions in our review:

- Patient transport by land ambulance is consistently outside of UHC programs, were associated with co-payments across all jurisdictions, and with variations across and within jurisdictions.
- There is no coverage for ART, with the exception of ON, where coverage is accompanied by restrictions to eligibility.
- HKPR services are included in one UHC plan (NT when provided in an insured facility), with the remainder either covered universally but outside the UHC program and with coverage limits (ON), covered only for a select group and with co-pays (BC), and covered only in hospital settings for those without private insurance (PE).
- Virtual physician visits in all jurisdictions broadly followed UHC criteria (universal coverage, no extra-billing or user fees), yet there are limitations on the types of services that could be billed prior to COVID-19, and some that persist during COVID-19.

In areas where there has been scientific and technological change, such as with innovation in rehabilitation treatments, new technologies enabling virtual care, and advances in reproductive technologies, the response by governments to include new services in their UHC packages has been understandably slow. A slow response relates to concerns about cost, clinical and cost effectiveness, and provider or patient abuse, among many others. The COVID-19 crisis presented an opportunity—at least in the case of virtual physician visits—that has forced governments to make more rapid decisions as to inclusion in order to address the needs of residents during the pandemic. However, for the other services considered in this study, there are variations across the country, with ART being an extreme example, and it remains to be seen whether the pandemic or other societal pressures may lead governments to decide to expand their basket of UHC services into these and other grey areas of health care.

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Appendix A: Coverage Overview

Table A1. Overview of coverage for land ambulance services

Jurisdiction	Relevant legislation	Coverage details		
		Who/what	Amount	Exceptions
BC	*Emergency Health Services Act (1996)* • *Regulation 471 (Emergency Health Services)* • *Regulation 210 (Emergency Medical Assistants)*	(A) When an ambulance is requested to a residence or workplace but the transportation is not required/refused	$50.00 fee to user	People may be exempt from paying ambulance service fees if they are: recipients of premium assistance; recipients of income assistance; or clients of various federal programs (e.g., Veteran Affairs Canada, Indigenous Services Canada). If these individuals receive an invoice and should be exempt, they are encouraged to contact BC Emergency Health Services.
		(B) BC residents with valid MSP coverage	$80.00 fee to user	
		(C) BC residents with valid MSP coverage who are being transferred between hospitals	Costs fully covered	
		(D) BC residents with valid MSP coverage who are being transferred between a facility (e.g., care or residential home) and hospital	$80.00 fee to user	
		(E) Persons without valid MSP coverage, those with work-related injuries, claims under RCMP and other federal agencies	$848.00 fee to user (excl. air ambulance)	
NT	*Cities, Towns and Villages Act (2003)* Yellowknife *Emergency Response and Protection By-Law No. 4502*	Yellowknife (responses within city limits): • Medical transfer	$1,100.00 (+$75.00/hour waiting time)	In some NT communities, costs for ambulance services are recovered for many clients through insurance programs. These clients may include: Status First Nations and Inuit Persons, Métis, federal and territorial government employees programs, armed forces employees programs, seniors and private vehicle insurance programs.
		• Medical response for Yellowknife residents	$225.00	
		• Medical response for NT residents	$350.00	
		• Medical response for out of territory residents	$400.00	
		• Medical supplies user during response	$10.00 to a max of $25.00	
		Yellowknife (responses outside city limits): • Medical response	$1,500.00 (+$2.00/km)	
	Hay River *Ambulance Services and Fees By-Law 2352-PS-16*	Hay River (responses within town limits) • Hay River residents • Non-Hay River residents	 $500.00 $700.00	
		Hay River (response outside town limits) • Hay River residents • Non-Hay River residents	 $600.00 (+$2.00/km) $1,650.00 (+$2.00/km)	
	Fort Smith *Consolidated Rates and Fees By-Law 1002*	Fort Smith • In-town ambulance service for residents • In-town ambulance service for non-residents	 $319.00 $484.00	
	Behchokǫ̀ (NA)	Behchokǫ̀ (responses in town) • Local • Yellowknife	 $350.00* $900.00*	
	Inuvik (NA)	Inuvik. In town calls	$200.00*	

Jurisdiction	Relevant legislation	Coverage details		
		Who/what	Amount	Exceptions
	Fort Simpson (NA)	Fort Simpson. In town calls	$150.00*	
ON	*The Ambulance Act (1990)* • *Regulation 129* (Costs Associated with the Provision of Land Ambulance Services) • *Regulation 257* (General) • *Regulation 497* (Land Ambulance Services Designation) *The Health Insurance Act (1990)* • *Regulation 552* (General)	Ontario residents with a valid health card whose ambulance service is deemed medically necessary by a physician, originates in Ontario with a final destination in Ontario	$45.00 co-payment to user	Residents are not required to pay the co-payment portion of the services rendered in the following situations: the person receives benefits under the Ontario Works Act, the Ontario Disability Support Program Act, or the Family Benefits Act; the person receives provincial social assistance; the person is being transferred from one hospital or health care facility to another for insured, medically necessary treatment; the person is receiving certain home care services approved for this exemption; the person is living in one of the following facilities licensed or approved by the Ministry of Health and Long-Term Care: long-term care home, home for special care, home or residence for psychiatric patients.
		Ontario residents with a valid health card whose ambulance trip Is deemed medically necessary by a physician, and it originates in Ontario with a final destination outside of the province or country (when treatment is not available in Ontario; OHIP approval may be required)	Costs fully covered	
		Ontario residents without a valid health card, or whose trip is deemed medically unnecessary by a physician and originates in Ontario, regardless of destination	$240.00 co-payment to user	
		Residents from other provinces outside of Ontario who are insured in their province's health care plan, a physician deems the ambulance service as medically necessary, they are transported between an Ontario hospital and a hospital in another province (or between two Ontario hospitals), their trip is for diagnostic or therapeutic services, and they are returned to the hospital of origin within 24 hours	Costs fully covered	
PE	*Ambulance Service Act (1988)* • General Regulations *Emergency Medical Technicians Act (1988)* • General Regulations	Emergency services (within PEI) for PEI Seniors (65+ years)	Costs fully covered	None listed.
		Emergency services (within PEI) for PEI residents	$150.00 co-payment to user	
		Emergency services (within PEI) for non-residents	$600.00 co-payment to user	
		Non-urgent services (within PEI) for PEI Seniors (65+ years)	$150.00 co-payment to user	
		Non-urgent services (within PEI) for PEI residents	$150.00 co-payment to user	
		Non-urgent services (within PEI) for non-residents	$600.00 co-payment to user	
		PEI residents who are referred by a physician to a hospital out-of-province for treatment	Costs fully covered	

*Fees shown are as of September 2004 and may have changed. (83)

Table A2. Overview of coverage for assisted reproduction technology

Jurisdiction	Relevant legislation	Coverage details		
		Who/what	Amount	Exceptions
BC	De-insured in 1988	-	-	-
NT	-	-	-	-
ON	*Assisted Human Reproduction Act (2004)* *Supreme Court of Canada (2010) Reference re AHRA* *The Children's Law Reform Act (1990)* was amended in 2016 when Bill 28 *All Families Are Equal Act* came into force.	The Ontario Fertility Program (OFP) covers the treatment costs of IVF, AI, IUI, and FP The OFP provides funding for 5,000 IVF patients per year and limits IVF to single embryo transfers only Ontario residents with a valid health card qualify for the program Women aged 43 and over are not eligible to receive IVF treatments under the OFP	Full coverage of one treatment cycle per patient per lifetime for IVF and FP patients Full coverage of AI and IUI treatments, with no limit on the number of cycles covered Excludes fertility medications, genetic testing, and storage, among other variable costs	Surrogate mothers may receive one additional IVF cycle FP recipients must provide a medical reason for seeking treatment.
PE	-	-	-	-

Table A3. Overview of coverage for post-surgical rehabilitation and physiotherapy services for total joint replacement in outpatient settings

Jurisdiction	Relevant legislation	Coverage details		
		Who/what	Amount	Exceptions
BC	Medical and Health Care Services Regulation, B.C. Reg. 426/97 – describes supplemental benefits, including physiotherapy services, and eligibility criteria for beneficiaries	• Medical Service Plan (MSP) beneficiaries with supplementary benefits status qualify for coverage • Referral by a physician or nurse practitioner required	The MSP contributes $23 per visit for up to 10 visits related to physiotherapy, chiropractic, massage therapy, naturopathy, acupuncture, and non-surgical podiatry	None.
NT	*Hospital Insurance and Health and Social Services Administration Act, Hospital Insurance Regulations, 1990* – indicates the inclusion of outpatient physiotherapy services as an insured service	• Individuals with a valid health card who have been referred by a physician or nurse practitioner, or self-referred for physiotherapy services	Costs fully covered when provided in a public facility	None.
ON	*Peoples Health Care Act, 2019* – describes jurisdiction over planning and funding services, including community-based physiotherapy services	• Persons with a valid health card who were recently discharged as an inpatient and in need of physiotherapy clinic services that are directly connected to the condition, illness, or injury for which the person was admitted to the hospital, who have a valid health card • Referral by a physician or nurse practitioner required	Costs associated with an episode of care, including assessment, diagnosis, treatment, and discharge summary, are fully covered	None.
PE	None identified	• Persons discharged from hospital who are triaged to receive rehabilitation and physiotherapy services in outpatient hospital clinics	Costs for services provided in outpatient hospital clinics are fully covered.	None.

Table A4. Overview of coverage for virtual physician visits

Jurisdiction	Relevant legislation	Coverage details		
		Who/what	Amount	Exceptions/Limits
BC	The payment schedule for medical practitioners is established under Section 26 of the *Medicare Protection Act*	Persons with a valid health card. As of April 2020, temporary foreign workers are eligible for coverage under the MSP. Services where a health care provider has determined virtual care as a suitable delivery option. This includes, video or telephone consultations, and non-procedural interventions. Text messaging to provide medical advice is available to some patient groups.	Costs for care are fully covered Claims to MSP for missed appointments	Under the regular program, MSP will pay for one telehealth service on the same day for the sample patient, and up to four services for one patient per calendar year. Limits have been suspended due to COVID-19.
NT	*Medical Services Act, 1998* – covers tariff process for insured services. The Insured Services Tariff includes telehealth as an insured service.	Persons with a valid health card. Telephone or video visits.	Costs for care are fully covered. Providers are reimbursed on a fee-for-service basis.	Video technology services are payable once per patient/per day/per medical practitioner.
ON	*Health Insurance Act, 1990* – temporarily lists assessments and counseling by telephone or video, advice to patient representatives by telephone or video as insured services, and lists temporary sessional fee codes (effective March 14, 2020).	Hosted video visits and direct-to-patient video visits Professionals covered: all specialists, general practitioner-focused practice designated by physicians when providing services, primary care physicians who are in a patient enrollment model	Costs fully covered for OHIP patients	
PE	*The Health Services Act, R.S.P.E.I. 1988, Cap. H-1.6* – provides the regulatory and administrative framework that includes the creation of HealthPEI *The Health Services Payment Act* – governs payments to physicians and dentists for insured services	Telephone consultations and visits, email/fax communication, and video conferencing (limited) Professionals covered: general practitioners, specialists, and other practitioners who are registered to use the system	Costs are fully covered	Not payable on the same day as a visit or service fee by the same physician for the same patient Cannot bill for telephone calls initiated by the patient's family member Limitations per week unless there is prior approval from Health PEI.

Appendix B. Coverage in Alberta and Yukon

Jurisdiction	Service		
	Land ambulance services	Post-surgical rehabilitation & physiotherapy services*	Virtual physician visits
AB	**Who/what:** • Residents of Alberta. **Amount** (84)**:** • A charge of $250 if a patient is not transported and $385 if they are transported. • Non-residents of Alberta incur an additional fee of $200 whether transported or not. • Full coverage for interfacility transfers. **Exceptions/limits:** • Residents are not required to pay the co-payment fee if they are seniors, First Nations, or Albertans receiving income support. Some members of non-group supplementary insurance can avoid co-payment charges.	**Who/what:** • Residents of Alberta with a valid health card who were recently discharged from orthopaedic surgery may be eligible for coverage (85). • Assessment by clinic required. • The number of visits vary by health zone in Alberta (South, Calgary, Central, Edmonton, North)(86). **Amount:** • Unclear **Exceptions/limits:** • Coverage limits vary by health zone (South, Calgary, Central, Edmonton, North) in Alberta (86).	**Who/what:** • Residents of Alberta • Telephone, video, email, messaging and electronic medical record-enabled virtual tools (87). • New billing codes were created in March 2020 for medical advice, assessment, follow-up assessment, comprehensive consultations, comprehensive psychiatric consultations, psychotherapy and other psychiatric services (by a Psychiatrist, Generalist, GP or Pediatrician) (88). • Physicians must submit a Privacy Impact Assessment when using a new technology or process. During the COVID-19 pandemic, physicians may use the new technology or process while waiting for acceptance, provided that they notify the Commissioner (89). **Amount:** • Costs are fully covered for the patient. Patients are responsible for their own internet and cellular charges (90). **Exceptions/limits:** • Prior to the COVID-19 pandemic, limitations existed on some virtual billing codes, and physicians were only able to bill a maximum of 14 times per week for each of the following: telephone test results discussions, secure electronic communication, and videoconferencing (88,91).
YT	**Who/what:** • Residents of Yukon. **Amount:** • Ambulance services (ground and air) within Yukon are fully covered. • The Yukon Health Care Insurance Plan does not cover ambulance and related services incurred by residents while travelling outside Yukon. **Exceptions/limits:** • None listed	**Who/what:** • Persons with a valid health card who have been referred by a physician for physiotherapy or rehabilitative services. **Amount:** • Costs are fully covered. **Exceptions/limits:** • None listed	**Who/what:** • Residents of Yukon. • Physician services by phone or virtual health, using the doxy.me platform (92,93) • Telehealth services were available pre-COVID-19 with mobile telehealth services in several community health centres (94). **Amount:** • Costs are fully covered. **Exceptions/limits:** • None listed

Note. No information available for assistive reproduction technology in AB or YT.

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