POVERTY AND EMPLOYMENT PRECARITY IN SOUTHERN ONTARIO

WORKING PAPER 4: HOW TO PROVIDE EXTENDED HEALTH BENEFITS*†

1. Key challenge & overview

Those in precarious employment are less likely to have employer-sponsored benefits, including extended health benefits.

Most working-age adults have very limited access to prescription drug, vision, and dental care if they do not receive it through their employers.‡ This means that most people in precarious employment do not have access to either employer or government sponsored extended health benefits. They must either purchase these benefits out of pocket, or not get the healthcare they need. Thus, most policy options recommend either expanding coverage of employer-sponsored benefits or finding other ways to provide benefits outside of the employment relationship.

2. Evidence from PEPSO

PEPSO's *It's More than Poverty* report,§ explored who has access to extended health benefits and found that extended health benefits are a key challenge for those in precarious employment. Those in precarious employment were less likely to:

- Have an employer- sponsored benefit plan: only 9% of those in precarious employment had an employer-sponsored benefit plan, compared with 97% of those in secure and stable employment.
- Have family coverage: family members are less likely to be included in the coverage of those in the precarious group who do have health benefits.

Access to extended health coverage outside of the employment relationship for all working-age adults is uneven and limited. This means that individuals and families without employer-sponsored coverage are most likely to either pay out of pocket or not get the healthcare they require. A lack of benefits contributes to vulnerability, as paying for extended health, dental, and vision care out of pocket can compound financial vulnerability.

3. Context/current situation

The Ontario Health Insurance Plan (OHIP) covers medically necessary services provided by a physician, dental surgery performed in hospital and annual eye examinations for those under 20 and 65 and over,[1] and some eye care

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† This Policy Options Working Paper is one in a series of 16 working papers that explore the range of policy options that have been proposed to reduce or mitigate the impacts of precarious employment. Each of these papers must be read in tandem with the paper titled "PEPSO Policy Options Working Papers: Introduction". The full reference list is contained in a separate bibliography document.

‡ Those working-age adults on social assistance are the exception as they do have access to coverage.

§ PEPSO's *It's More than Poverty* report refers to the report that was published in February 2013 that was based on the main survey conducted by PEPSO. In these working papers this report will be called the PEPSO report or the PEPSO survey. This is only appropriate for these working papers as there are other PEPSO reports that will be published by the six case studies.

for residents aged 20-64 who have conditions that affect the eyes.[2] Prescription drugs, dental and vision care are frequently identified as medically necessary services not covered by OHIP.

3.1 Benefits inside the employment relationship

Employer-sponsored benefit plans are a form of non-wage compensation used to recruit and retain workers that often include extended health benefits. Employers are prohibited from discriminating on the basis of age, sex and marital status when they do offer benefit packages.[3] There is no employment standard, however, that prohibits employers from discriminating on the basis of employment status (e.g. discriminating on the basis of part-time or contract status). Workers in precarious employment are often not offered workplace benefit packages.

Employers are not mandated by employment standards to offer benefit plans.[4] Plans vary and can include a mix of extended health benefits, provisions for time off and pension / retirement benefits. Unless stipulated through a collective agreement, employers determine the type and degree of benefit coverage, as well as which workers receive them. Prescription drugs, vision and dental care are most often highlighted in the policy options, but it is worth noting that workplace benefit plans can offer a wide range of provisions, such as hospital care, assistive medical devices or paramedical services.

3.2 Benefits outside the employment relationship

In the absence of employer-sponsored health benefits, working-age adults have access to a limited range of extended healthcare services funded and administered by the province and municipalities.

Health care is in provincial and territorial jurisdiction. The federal government provides some funding to the provinces and territories for health care through the Canada Health Transfer (CHT).[5] The federal government also provides non-insured health benefits to registered First Nations and Inuit populations, including dental, drug and vision care benefits. The province is the primary provider of extended health benefits to those who do not have a workplace benefit plan. However, access to prescription drug, dental and vision care is limited and uneven for working-age adults. Programs often have eligibility requirements that target those on a very low-income or those in receipt of social assistance, and are less accessible to workers with low to middle-wage earnings. In 2014, the agreement that determines funding and service delivery through the CHT expires. The federal government will continue funding, however, it has imposed a new funding arrangement on the provinces without negotiations.[6]

The extended healthcare services administered by the provincial government are sometimes delivered by municipal public health departments, which have discretion over the programs that they provide. This can create inconsistent access to extended healthcare services across the province. Municipalities sometimes fund their own programs as well.

- Prescription drug coverage: The Government of Ontario funds and administers the Trillium Drug Program. It reimburses prescription drug costs when they exceed 4% of a household's total net annual income.[7] In addition, the Ontario Drug Benefit covers prescription drug expenses for seniors, those in long-term care or home care, and those in receipt of social assistance.[8] The City of Toronto has a Hardship Fund that helps city residents pay for medically necessary items and services, including some prescription drugs.
- Dental coverage: The Healthy Smiles Program[9] and Children in Need of Treatment Program[10] provides children (17 and under) from low-income families with free regular, or emergency dental care. These dental-care programs are delivered by municipal public health units and adults are not eligible to participate. The City of Toronto's Hardship Fund also helps pay for dental care. Toronto Public Health offers dental clinics for eligible parents enrolled in select perinatal or parenting programs and their Mobile Dental Clinic travels to select community agencies to provide free dental care to clients who experience barriers to service.[11] The City of Hamilton Public Health Services offers dental clinics for low-income residents who do not have

dental insurance and a Dental Health Bus provides free emergency dental services.[12] The City of Hamilton also provides funding for dental care for low-income residents.[13]

- Vision coverage: The City of Hamilton's Special Supports Program provides funding to help eligible residents pay for some prescription eyewear.[14] Social assistance recipients receive some coverage for eye care.[15]

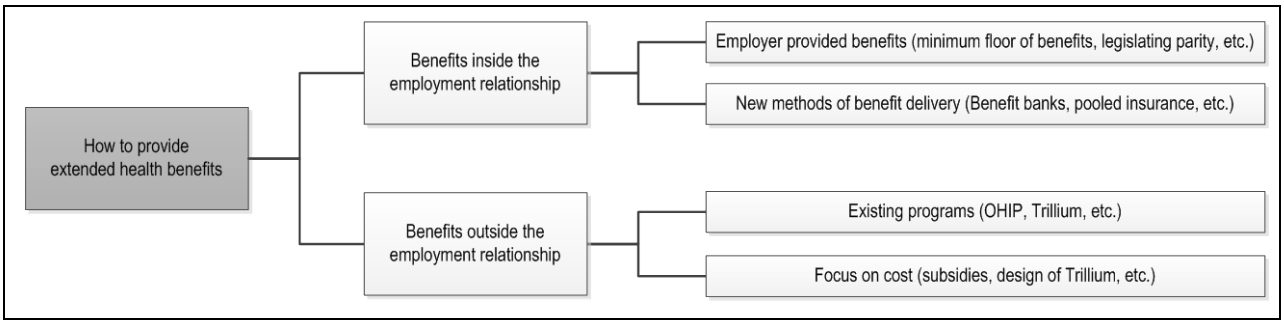
The provincial government also funds Ontario's two social-assistance programs. Recipients of Ontario Works and the Ontario Disability Support Program, and their dependents, may be eligible for a range extended health benefits. The loss of these benefits is a well-documented challenge for many social assistance recipients who try to move into the workforce.[16] However, ODSP does allow recipients to temporarily keep their benefits when they transition into employment.

Thus, working-age adults who do not have extended health coverage through an employer have very limited access to publicly funded prescription drug, dental and vision care. According to a report released by the City of Hamilton, 5% of Canadians have dental care covered through a government program, 60% are covered through an employer benefit package, and 35% are not covered by either.[17] For many individuals in precarious employment, the costs associated with these medically necessary services may put them out of reach, and these workers may not access prescription drugs, dental, and/ or vision care at all.

Employer-sponsored benefit plans are often not offered outside of a standard employment relationship.[18] Workers who do not have a workplace-sponsored benefit package are left with the option of paying for private insurance, paying at the point of service, or trying to access subsidized services through a limited range of government sponsored programs. Thus, coverage for extended health benefits is highly uneven and disadvantages adults in precarious employment, particularly those with low incomes.

4. Policy options

Policy solutions seek to improve access to extended health benefits or to improve their affordability. Some policy options focus on providing benefits through the employment relationship, while others look outside of it.



4.1 Benefits inside the employment relationship

One set of policy options explores a greater role for employers, or others in the workplace, in the provision of extended health benefits. They present ways to expand extended health benefit coverage to workers in precarious jobs. These include:

- Legislating parity to ensure that all workers, regardless of their employment status, have the same access to benefits.[19] In the European Union, legislation stipulates temp agency workers must be provided with the same workplace and employment conditions as other employees performing comparable work.[20] In the

U.S., the *Affordable Care Act* has stipulated that employers with more than 50 workers must provide health insurance.** [21]

- Introducing a minimum floor of benefits in order to reduce the cost incentive of hiring part-time over full-time workers.[22]
- Expanding the role of unions or workplace associations to include providing benefits,[23] which many unions already provide.
- Implementing tax measures that make it financially advantageous for employers to offer health insurance.†† [24] This proposal comes from the U.S and predates the *Affordable Care Act*.

Some policy options present ideas for new methods of benefit delivery that would extend coverage to workers in precarious jobs. They include:

- Developing benefit banks that offer coverage for employers, workers or anyone else looking for benefits to purchase.[25]
- Creating a benefit fund into which employers contribute health coverage payments and from which workers draw.[26]
- Offering low-cost, portable, pooled health insurance to mitigate the vulnerability that those in precarious employment experience.[27]

4.2 Benefits outside the employment relationship

Policy options that explore the provision of extended health benefits outside of the employment relationship largely focus on the role of government transfers and subsidies to increase accessibility and affordability of prescription drug, dental and vision care. Some options are broad in scope, proposing various degrees of universal coverage. Other recommendations target specific groups, or specific types of benefits.

Suggestions to address access to extended health benefits largely seek to improve existing programs to ensure wider coverage of prescription drug, dental and vision benefits by:

- Expanding OHIP to cover the cost of prescription drugs,[28] and dental care,[29] to ensure access for all residents with OHIP. Another proposal includes covering catastrophic prescription drug needs[30] and basic dental care[31] on a progressive universal basis. Some proposals target low-income households or low-wage workers for prescription drug,[32] dental[33] and vision[34] benefits.
- Extending the availability of prescription drug and dental care benefits to social assistance recipients in order to help them transition into the labour market,[35] including preventative dental care for social assistance recipients and their families,[36] which is currently in place for ODSP recipients to some extent.
- Including adults in provincially funded dental care programs to ensure that low-income working-age adults have access to dental care.[37]
- Expanding the Trillium Drug Program to increase participation in the program.[38]

Some policy options specifically seek to remove cost as a barrier to access. They include:

- Offering subsidies to help low-income households purchase health insurance.[39] This comes from the U.S., but may find a similar application for improving the affordability of extended health care in Canada.
- Changing the design of the Trillium Drug Program so that participants do not have to pay at the point of service for their prescriptions.[40]

** Early analysis indicates, however, that employers in the U.S. may be adjusting their hiring practices in order to remain below the threshold. (Washington Post, 2013b)

†† When employers offer health insurance in their compensation package, they pay for it with pre-tax money whereas salaries are paid after-tax. (Washington Post, 2013a)

5. Questions for discussion

1. Which policy options in this paper could have the most impact on the lives of those in precarious employment?
2. Which policy options in this paper can we realistically move forward on, given the current political, economic, and social climates?
3. Which policy options are missing from this paper, but require attention?

6. Endnotes

[1] Ontario Ministry of Health and Long-Term Care, 2014a
[2] Ontario Ministry of Health and Long-Term Care, 2013b
[3] Ontario Ministry of Labour, 2014a
[4] Ontario Ministry of Labour, 2014a
[5] Department of Finance Canada, 2011a
[6] Globe and Mail, 2014
[7] Ontario Ministry of Health and Long-Term Care, 2013a
[8] Ontario Ministry of Health and Long-Term Care, 2008
[9] Ontario Ministry of Health and Long-Term Care, 2014b
[10] City of Toronto, 2014a
[11] City of Toronto, 2014b
[12] City of Hamilton, 2013b
[13] City of Hamilton, 2013c
[14] City of Hamilton, 2013d
[15] Ontario Ministry of Community and Social Services, 2014
[16] Caledon Institute of Social Policy, 2008; Wellesley Institute, 2011b.
[17] City of Hamilton, 2013a citing Yalnizyan & Aslanyan, 2011
[18] PEPSO, 2013
[19] PEPSO, 2013; Workers' Action Centre & Employment Standards Work Group, 2005; Worker's Action Centre, 2007; NDP, 2013a; ILO, 2011
[20] Workers' Action Centre & Parkdale Community Legal Services, 2008
[21] Washington Post, 2013b
[22] Upjohn Institute, 2012
[23] Lewchuk, Clarke, & De Wolff, 2011; Canadian Policy Research Network, 2006a
[24] Washington Post, 2013a
[25] Arthurs (Human Resources and Skills Development Canada), 2006; Law Commission of Ontario, 2012; International Labour Organization, 2009
[26] Lewchuk, Clarke, & De Wolff, 2011
[27] CivicAction, 2011b; Wellesley Institute, 2011b; Kalleberg, 2009
[28] Institute for Competiveness & Prosperity, 2013; Canadian Doctors for Medicaid, 2011d; NDP, 2013; Ontario NDP, 2013; Canadian Policy Research Network, 2006a.
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[30] Canadian Policy Research Network, 2006a
[31] Canadian Policy Research Networks, 2006
[32] Social Planning Toronto, 2009; Access Alliance, 2011, Lankin & Sheikh, 2012; CivicAction, 2011c
[33] Lankin & Sheikh, 2012; PEPSO, 2013; MISWAA, 2006; Canadian Doctors for Medicaid, 2011d
[34] MISWAA, 2006; Social Planning Toronto, 2009; Wellesley Institute 2011b; Access Alliance, 2011
[35] MISWAA, 2006; Wellesley Institute, 2011b.
[36] Wellesley Institute, 2011b
[37] 25 in 5, 2010
[38] Social Planning Toronto, 2009
[39] Washington Post, 2013a
[40] MISWAA, 2006; Social Planning Toronto, 2009; CivicAction, 2011c