

Combined Insurance Company of America
www.combined.ca

AN IN DEPTH LOOK AT GROUP INSURANCE

The contents of this Module was prepared by Advocis, “The Financial Advisors Association of Canada” and is used with their permission

GROUP PLANS: AN OVERVIEW

The fundamental purpose of group insurance is to provide groups of individuals with insurance protection against various types of losses.

Types of groups

There are four main types of insurable groups within the marketplace:

1. SINGLE EMPLOYER GROUPS

Also known as employer/employee groups, this is the most prevalent type of group. Such a group covers the employees of one employer. The employer is the policyholder and the covered employees are the certificate holders.

2. ASSOCIATIONS

Consisting of individuals who share a common factor, but who are not all employees of the same employer. There are two types of association groups:

- **Associations of employers or franchisees:** The group plan covers the employees of several employers who are members of an association (for example, the Canadian Automobile Dealers Association). The association – sponsored plan operates like a series of employer/employee groups. This type of plan offers the individual groups more generous benefits and more competitive rates than they could obtain individually because of the greater volume of members compared to single-employer groups.
- **Association of individuals:** Individuals can enrol and receive similar benefits to those available from a standard group plan. Enrolment is voluntary and, as there is no employer, the members pay the entire premium. Rates and underwriting are more similar to those of individual plans rather than more traditional group plans. The most common plans are associations of individuals from the same profession, for example, engineers, accountants and physicians.

3. MULTI-EMPLOYER GROUPS

Normally a multi-employer group plan (MEP) is set up as a result of a collective bargaining process between a union and the employers of the union members. This type of plan works especially well in situations where the members move frequently among different employers. (For example, a plumber may work for several builders during the building season). It's common for an MEP to be established under a trustee arrangement, meaning that the administration of the plan is handled by an independent third party under a trust agreement.

4. CREDITOR GROUPS

A group contract is entered into between the insurance company and a financial institution in the business of making personal loans. The group plan insures, the loans, either through life or disability insurance. The borrower chooses to take the coverage and pays the premium as a portion of the regular loan payment. The financial institution is the policyholder and the individual borrower is the certificate holder. The proceeds of the insurance policy are normally made payable to the lender (the financial institution) to ensure that the borrower's obligation to the lender is discharged, in the event of disability or death. Coverage can be for any type of loan, including mortgages, personal loans, lines of credit or credit cards.

Definitions

Group Insurance: Provides mass protection against the financial hazards of death, accident and sickness. It is designed to insure classes of persons rather than specific individuals. The lives insured are not named or otherwise identified as individuals. They are simply defined as member of a "class."

Member: A person who is insured under the master contract. Group plans focus on the employees in a group as a whole and not on the individual. For example, coverage is the same for all employees of a class, regardless of their individual needs. The benefit schedule is the same for everyone within the class. A member receives a "certificate of insurance" on becoming covered under the group plan. The certificate indicates the member's name, class, beneficiary and date of eligibility. Members are also referred to as "certificate holders."

Policyholder: The employer or organization that sponsors the group contract. The policyholder signs the master contract, makes the decisions regarding the original contract and ongoing changes to the contract, and is required to pay all the premiums.

Waiver of premium: Long-term disability plans include a waiver of premium feature under which, when the disabled employee is approved for LTD benefits, the premium is waived while the employee is receiving benefits. Frequently, group life insurance plans include a waiver of premium provision that comes into effect when an employee is totally disabled. However, in most cases, the definition of disability that triggers the waiver of premium provision under group life insurance coverage may be different from the definition of disability applicable to the LTD benefit.

Employee benefits: Generally defined as compensation other than paid wages and government benefits. For example, group life and health plans, retirement plans, day care, reimbursement of training courses, stock option plan, matching charitable gifts, free parking, etc., are all forms of employee benefits.

A comprehensive benefits package can promote the overall well-being of employees, which, ultimately, positively affects efficiency, productivity and morale.

Advantages of group benefit programs

FOR EMPLOYERS	FOR EMPLOYEES
Expenditures toward group benefits are tax-deductible as a business expense.	Benefits received under the group plan may not be considered a taxable benefit.
Benefits attract and retain qualified employees.	No need to use after tax-money to purchase various types of insurance.
Benefits foster a healthy workforce and, consequently, improve employee morale, productivity and efficiency.	Does not usually require an individual to provide medical evidence of insurability.
Benefits can be provided in lieu of monetary compensation.	Insurance is less expensive to obtain under a group plan than for an individual policy.

Fundamental principles of group insurance

There are five fundamental principles that influence the formation of a typical group insurance policy:

1. Employees must be actively at work when they become eligible for group insurance. It is assumed that if the employee is actively at work, he or she must be relatively healthy and will represent a relatively low risk to the plan.

Example: Tom and Sue work for the same employer. Tom works 37.5 hours a week and is a member of the group plan. Sue only works four mornings a week, for four hours a morning, considerably less than the 24 hours a week required for inclusion as a full-time employee as defined under the plan. So, as a part-time employee, she does not qualify to join the group plan.

2. The choices and amounts of coverage must be restricted.

Example: The XYZ Manufacturing Co.'s employee group plan provides life insurance coverage equal to twice each employee's annual salary, with no options to buy additional coverage. All group members of the XYZ plan must have group life insurance coverage. Left to an individual's discretion, benefits selected would be those most beneficial to the individual and most likely to be utilized. This is known as "anti-selection" or "adverse selection" and is ultimately detrimental to the plan as a whole, as the claims experience for the plan would be much higher than for the population at large. More claims translate into higher group premiums. The insurance company protects itself from adverse selection by predetermining the benefits available to the group plan members.

3. If a plan is contributory (meaning that the employees pay a portion of the premiums), employee contributions must be deducted from the employee's pay. The employer or plan sponsor is responsible for submitting the total premium for the whole group plan in one single payment on or before the premium due date. This simplifies the administration process and keeps plan expenses to a minimum. The policyholder (employer) is contractually responsible for the premiums, regardless of whether the premiums are to be paid wholly by the employer or jointly by the employer and the employee.

4. The employer must pay a portion of the group insurance premium (many insurance companies insist on at least 50%). This indicates the employer's commitment to operate the plan along sound principles and to continue the plan for a number of years. Also, the more that employees have to pay for the group benefits, the more likely they are to file claims in order to "get their money's worth" out of the program. Thus, keeping the employee contributions low (by keeping the employer-contributions high) will ultimately reduced plan costs.
5. There must be a sufficient number of employees participating in the plan to spread the risk to even out the fluctuation as claims are incurred. To this end, the insurer will require a minimum number of participants (often 10) and a minimum percentage of employee participation (as low as 75% and commonly 100%), minimizing the opportunity for anti-selection.

Elements of a group insurance plan

The five elements of a group insurance plan are:

1. GROUP CONTRACT

The policy governs the group and is signed and sponsored by the policyholder and not the individual employees covered under the plan. The policyholder (employer) is responsible for the contract, makes decisions regarding changes, administers the plan and collects and remits the premiums.

2. ELIGIBILITY

The policy focuses on the members in a group, not on the individuals. The contract defines precisely who can be covered under the plan and when an employee becomes covered. There is usually a minimum 30-day waiting period after joining the employer before the employee is eligible to join the group plan, but this waiting period can be longer.

The eligibility requirements are the same for everyone in a class. A class might cover, for example, all hourly paid workers who work at least 35 hours a week after three months of employment.

3. UNDERWRITING REQUIREMENTS

These are not as stringent as for individual contracts. Because of the reduction of anti-selection and the spreading of the risk elements in the group contract, most of the basic benefits can be issued without evidence of insurability.

4. PREMIUM CALCULATION

The premiums for each benefit are calculated separately, taking into consideration the makeup of the group, the benefits and the claims experience. The rates are almost always recalculated each year to take into consideration the continuously changing makeup of the group.

5. PLAN ADMINISTRATION

The record keeping and clerical functions are most often handled by the policyholder (employer). These include:

- Adding and terminating employees.
- Paying monthly premiums.
- Collecting premiums from the employees (if applicable).
- Filling claim forms and submitting them to the insurance company.
- Notifying the insurance company of changes in employee status.

MEDICAL SERVICES GENERALLY COVERED BY PROVINCES AND TERRITORIES

Canada's health-care system operates on three levels:

- The universal public (government-funded) hospital and medical programs, which are the cornerstone of the system.
- Supplementary services provided through employer-sponsored benefit plans.
- Services covered under individual insurance contracts.

The Canada Health Act (1984) stipulates the conditions that an insured health-care program of a province or territory must meet in order to receive federal funding.

Referred to as the five basic principles of Canada's public health-care system, they are:

- 1. Public administration:** The provinces and territories' medicare system must be administered on a not-for-profit basis and by a public authority appointed by and accountable to the provincial or territorial government.
- 2. Comprehensiveness:** The provincial and territorial health insurance plans must provide coverage for all necessary hospital and medical services provided in hospitals.
- 3. Universally:** All eligible residents in a province or territory must be entitled to insured health-care services.
- 4. Portability:** An individual temporarily outside their home province or territory must have access to services in their host jurisdiction of residence at the host's rates. An individual becoming a new resident of a province or territory cannot be required to wait more than three months to be eligible for coverage in that province.

5. Accessibility: All residents must have the same type of access to insured services based on uniform conditions. Mechanisms, such as charges for services, cannot prevent an individual from having reasonable access. For insured services, physicians must be reasonably compensated and hospitals must be paid adequately. The act prohibits extra billing and users fees by physicians.

Basic services provided

The Canada Health Act ensures that all jurisdictions must provide generally the same basic services. These are defined as those that are medically required and provided by physicians, surgeons or other qualified health-care professionals. Some of the basic medical services include:

- Treatment in hospitals.
- Treatment by registered physicians.
- Ambulance services.
- Laboratory tests and X-rays.
- Treatment by health practitioners such as physiotherapists and podiatrists.
- Dental care.
- Drugs.
- Special nursing care services.
- Home care.
- Out-of-province/country coverage.

Additional benefits

While all jurisdictions must provide the basic services, some provinces and territories have expanded the spectrum of coverage beyond what is required. These additional benefits include:

PHARMACARE

All jurisdictions currently provide pharmacare programs for seniors. Drugs covered by the program are normally comprised of drugs in a list defined by each jurisdiction, called a formulary. Provinces are required recipients to pay a portion of the cost of the drugs in the form of a deductible (for example, a \$2 deductible per prescription in Ontario, to a maximum annual deduction of \$100).

DENTAL PROGRAMS

Certain types of oral and dental surgery medically required and performed in a hospital are covered in all jurisdictions. These include: surgery required as a result of trauma to the face from an accident, oral surgery or orthodontic care of a cleft palate, surgically removing impacted teeth. The range of additional or out-of-hospital dental provided to eligible residents varies among jurisdictions.

OUT-OF-PROVINCE AND OUT-OF-COUNTRY COVERAGE

The province or territory will cover only what the service would have cost had it been rendered at home. There is a trend not to cover any service provided outside the jurisdiction of residence unless it is as a result of an emergency. The jurisdiction of residence will pay the amount that the service would have been covered for in the province or territory of residence.

CHRONIC CARE AND LONG-TERM CARE

With the exception of Quebec, Newfoundland, Nova Scotia and P.E.I, all other jurisdictions provide some form of chronic care coverage. Chronic care means continuing care that is provided for individuals who are physically depended due to chronic illness with little chance of becoming independent. Care is provided in chronic care institutions.

ASSISTIVE DEVICES AND SUPPLIES

Individuals with long-term physical disabilities can receive help through the assistive devices program for the purchase of needed medical devices, equipment and supplies. For example, the plans may provide for: communication devices, diabetes supplies, internal feeding supplies, hearing aids, home oxygen, incontinence supplies, orthotic devices, ostomy supplies. Prosthetic devices, respiratory devices, visual devices and wheelchair, positioning and ambulation aids.

Provinces and territories, under budget pressures, have been delisting optional services previously covered under the plans. There is pressure on private health-care plans, group and individual, to pick up these costs. This has great implications on the pricing of group plans as they are being required to “pick up the slack” for delisted services previously provided under the provincial programs.

**THE BASIC PRINCIPLES OF GROUP AND
INDIVIDUAL INSURANCE CONTRACTS:
A COMPARISON**

	GROUP	INDIVIDUAL
Life Insurance		
Contract	<ul style="list-style-type: none"> • Contract in the name of the policyholder who is responsible for the policy. • Members are covered by class, not name in the contract. • Contract does not terminate when member terminates. 	<ul style="list-style-type: none"> • Contract in the individual name of the insured. • Contract terminates when individual terminates coverage.
Administration	<ul style="list-style-type: none"> • By the policyholder or designee. • Includes additions, terminations, premium payment, claims administration. 	<ul style="list-style-type: none"> • Individual responsible for premium payments, other changes such as address change, etc.
Underwriting	<ul style="list-style-type: none"> • Because of spread of risk and anti-selection rules, much, if not all, of coverage is sold without medical evidence. • Plan design allows streamlined underwriting, e.g., all benefits terminate at age 65. 	<ul style="list-style-type: none"> • Each contract is medically underwritten. • More stringent underwriting if policy is non-cancellable.
Choice	<ul style="list-style-type: none"> • Policyholder designs the plan, make changes and can terminate the plan. • Members who are covered do not have these choices. 	<ul style="list-style-type: none"> • Individual can make any choices available from the insurance company.

	GROUP	INDIVIDUAL
Life Insurance		
Amount of Coverage	By class, e.g. Senior Managers covered for 2X annual earnings.	Chosen by the individual, depends on need and affordability.
Premium	By group, e.g. all life insurance at \$0.09/\$1,000.	Rates per \$1,000 of coverage depend on the individual's age.
Termination of Coverage	On termination of contract, termination of employment, death.	When individual terminates contract, death.
Conversion Privilege	Has to be part of coverage, minimum conversion offered Term to 65.	Optional at an additional premium.
Beneficiary Designation	Same as individual.	As per legislative requirements.
Type of Plan	Yearly renewable term.	Complete choice by individual dependent on personal or business needs.
Short-term disability		
Amount of coverage	Many salary continuance plans link the benefit payable to the employee's tenure with the organization such as an increasing percentage of earnings depending on length of service.	Amount of coverage determined based on underwriting assessment of individual's needs.
Elimination period	Benefits may start from three to seven days or from day one if the disability is caused by an accident.	The elimination period is determined during underwriting and is a function of the occupation class and premium.
Premium	Standard rate for each employee class based on rating of group.	Determined based on the age of the insured, the amount of benefit, the benefit period and the elimination period.
Termination of coverage	When employment ceases or group plan terminates.	May be age 65 unless premium payment ceases earlier.
Definition of disability	The definition of an eligible disability under an STD benefit plan is usually tied to the employee's inability to perform any or all aspects of his/her normal occupation.	Depends on occupation class and other aspects of coverage applied for.

	GROUP	INDIVIDUAL
Long-term disability		
Amount of coverage	The monthly benefit is usually a percentage of the employee's pre-disability earnings.	Amount of coverage determined based on underwriting assessment of individual's needs.
Elimination period	The qualifying period for LTD benefits typically dovetails with the benefit period under the salary continuance or STD plan. Qualifying periods for LTD benefits generally range from four months, equivalent to the duration of the EI benefit, to 52 weeks.	The elimination period is determined during underwriting and is a function of the occupation class and premium.
Premium	Standard rate for each employee class based on rating of group.	Determined based on the age of the insured, the amount of benefit, the benefit period and the elimination period.
Termination of coverage	When employment ceases or group plan terminates.	May be age 65 unless premium payment cease earlier.
Definition of disability	May stipulate that the claimant is unable to perform the regular duties of his/her occupation and after the disability continues for a specified period of time, is unable to perform the duties of an occupation to which he or she is suited by reason of education, training or experience.	Depends on occupation class and other aspects of coverage applied for.
Extended health and dental		
Premium	Standard rate for each employee class based on rating of group and the benefits provided	Rates for the individual based on coverage and benefits requested
Amount of coverage	Based on benefits provided, deductible and coinsurance and reimbursement for claims submitted.	Based on benefits provided, deductibles and coinsurance and reimbursement for claims submitted.
Termination of coverage	When employment ceases or group plan terminates.	May be age 65 unless premium payment cease earlier.

GROUP PLAN FEATURES

Who pays the premiums?

The cost of group insurance (premiums) can be paid for either on a non-contributory (the employer pays all) or a contributory (both the employer and the group plan member pay part) basis.

NON-CONTRIBUTORY PLANS

The employer pays the entire cost of the group insurance plan. The members do not pay any premium towards the plan.

Advantages:

- Employees show greater appreciation for the benefits when all costs are paid by the employer.
- All employees are automatically included in the plan; there are no participation problems or conflicts over eligibility.
- Premiums are deductible as a business expense for the policyholder and are not generally considered taxable income to the employee.

Disadvantages:

- The employer bears the total cost of the plan.
- If the plan includes short- or long-term disability coverage, the benefits paid to the disabled employee are usually considered taxable income to the employee.
- Since the employee bears no financial responsibility, claims may be more open to abuse.

CONTRIBUTORY PLANS

The employee pays a portion of the premiums for the plan, most often 50%; the employer pays the balance.

Advantages:

- The larger total premium from both the employer and the employees is possible and makes more money available to provide a better benefit plan.
- Healthy employer/employee relations are promoted through the co-operative effort to manage the benefit plan.
- Employees have a greater interest in the operations of the plan when costs are shared.
- Sharing costs acts as a deterrent to excessive demands for benefits.

Disadvantages:

- The tendency for plan members who pay premiums to want to “get their money’s worth” by making claims at least equal to the total premiums that they have paid. In the case of semi-elective claims (such as eye care and dental care), there may be an incentive for a form of “anti-selection” in the amount and frequency of claims made by premium-paying plan members.

Premiums are split between employees and the employer differently, depending on the benefit. This is often dictated by tax legislation. These points will be covered more completely in future sections of this module dedicated to the different benefits available under these plans.

Deductibles and co-insurance

Deductibles are the expenses a covered member must pay before any reimbursement is payable in excess of that deductible.

Co-insurance is the percentage of eligible expenses split between the insurance company and the life insured.

These factors help:

- Share the risk.
- Keep claims down.
- Lower premiums.

DEDUCTIBLES

There are two types of deductibles:

Calendar year deductible

- The member pays, within the calendar year, a dollar amount against eligible expenses before being reimbursed. For example, a deductible of \$25 is paid by the member before the balance of the claims is reimbursed. If the claims were for \$175, then the member would receive \$150.
- There are single and family deductibles: the family deductible is usually twice the single deductible, so if a single deductible is \$25, a family deductible is \$50. The deductible for the whole family is \$50, but no more than \$25 for any one individual.

Example: Father, mother and daughter all wear eyeglasses and all bought new glasses in 2007. Father's group benefit plan has a \$50 annual individual deductible and \$100 family deductible for vision-care claims. When he bought his new glasses, he had to pay for the first \$50 or the cost himself. When mother next bought her new glasses, father had to pay the first \$50 of the cost of them as well. When daughter bought her new glasses, no deductible portion had to be paid since the \$100 annual family maximum deductible had already been reached for 2007.

- It is possible for the family deductible limit to have been met (and therefore the individual deductibles as well), even though the individual deductibles had not been satisfied for each claimant.

Example: If father and mother, above, had each made a \$40 claim, only \$20 of the family deductible would apply to daughter's claim and no deductibles would apply to any future claims in 2007.

- If the deductible has not been reached in any calendar year, then any claims incurred during the final three months of the year can be carried over to the following year to help fulfil the deductible for the year.

Per-prescription deductible

- Applies to pay-direct drug plans. A deductible applies to each prescription purchased. For example, a prescription costing \$47 with a per-prescription deductible of \$5 will reimburse the member \$42. Another kind of per-prescription deductible is for the employee to pay the pharmacist’s fee while the plan covers the balance.

CO-INSURANCE

Most group insurance plans do not provide for the plan to reimburse all of a member’s eligible health and dental expenses, over and above the deductible portion (if any). Rather, the plan usually covers only a percentage (75%, 90%, etc.) of the balance of the eligible expenses, with the plan member being responsible for the difference. The percentage of the expense covered by the plan is called the “co-insurance factor.” Thus, if the plan will cover 80% of the expense (and the member the other 20%), the plan is said to have an 80% co-insurance factor.

Example: Joan is covered for the cost of certain prescription drugs through her employer’s group health insurance plan. The plan has an annual deductible of \$25 and a co-insurance factor of 80%. Joan’s first claim for the current calendar year totals \$265. Responsibility for the drug expenses would be as follows:

Total eligible expenses incurred	\$265
Joan’s deductible	\$ 25
Net claim	\$240
Group plan’s co-insurance factor (80%)	\$192
Portion of net claim paid by Joan (20%)	\$ 48

Out of the total claim of \$265, the plan pays the co-insurance factor of \$192 (80%) and Joan pays the other \$73 herself (\$25 + \$48 = \$73).

Note that the co-insurance factor only applies to the net claim, that is net of the deductible payable by the plan member.

The more the employee pays toward a claim, the less that must be reimbursed from the group plan, therefore:

- Higher deductibles translate into lower requirements by the group plan and lower group plan premiums.
- Lower co-insurance factors translate into lower requirements by the group plan and lower group plan premiums.

Additionally, deductible and co-insurance factors tend to keep claims costs (and premiums) down by discouraging unnecessary claims. The plan member is more likely to consider the need for a claim if he or she is going to be responsible for a portion of its cost. Fewer claims result in fewer payouts for the plan and reduced administration costs. Of course, the deductible and co-insurance factors cannot be so high as to be punitive for the plan member; this would defeat the purpose of the plan in the first place.

Eligibility requirements

Group policies describe who is eligible for coverage. They define eligibility as those employees in a specified class. The classes must be defined by requirements that are related to conditions of employment (salary, occupation or length of employment, for example).

For example, a class could cover department managers who work full time.

The following provisions contain requirements that group members must meet in order to be eligible for coverage:

BE ACTIVELY AT WORK

To be eligible for coverage, an employee must be actively at work, not off work because of illness or on leave on the day that coverage is to take effect. Coverage will begin on the day the employee returns to work. It is assumed that if the employee is actively at work, he or she must be relatively healthy and represent a lower risk to the plan.

PASS AN ELIGIBILITY / PROBATIONARY PERIOD

The length of time a new group member must wait before becoming eligible to enrol in the group plan. Thirty-one days is usually the minimum period considered but can be longer. The higher the turnover of new employees, the longer the probationary period should be in order to minimize the administration work of constantly adding and terminating new members.

CALCULATING GROUP PREMIUM RATES

Insurance companies typically establish group insurance premium rates case by case: The rate for each group is individually established to be sufficient to pay the group's claims and administration costs, with a markup to provide for a profit margin for the insurer. Unlike individual insurance rates, the premium rates for group coverage are recalculated every year.

The rates charged to any given group are computed using one of three approaches:

- Manual rating.
- Experience rating.
- Blended rating (a combination of manual and experience rating).

Manual rating

Manual rates are premium rates established upon examination of an insurance company's claims experience for its entire block of business (the pool) and the average claim incurred for each grouping of age, sex, occupational class and area (geographical location) for a particular group insurance product. Manual rates are also established based on the group's own demographics, especially for life insurance and long-term disability benefit.

The pricing of group insurance products is a complex and highly technical process further complicated by the number of variables that can come into play. Pricing methods and techniques vary considerably by insurer, as do tables of base rates and adjustment factors used in the calculation of group manual rates and methods used to analyze the experience of a group.

Because there is no single pricing method common to all insurers, only basic concepts and general principles of pricing are considered. When pricing group insurance, the insurer must consider:

- How often a claim will occur.
- The cost of an incurred claim.

- The amount the insurer needs to cover the expenses it incur servicing the contract holder.
- The amount of anticipated profit from the group benefits plan.
- Applicable taxes.

The last three items are known entities. The insurer knows from its own experience the cost of doing business and sets its own profit targets for each line of business. The provincial and federal governments dictate the levels of premium tax and whether other tariffs, such as sales tax, are applicable to the various group insurance products. But how often a claim will occur and how much it will cost are largely unknown when a group benefits plan is being priced. The insurer will have to analyze the group and use a fixed set of assumptions to determine the expected claims experience. For each group insurance product, this fixed set of assumptions forms the basis for measuring the risk present in any group. This measurement of risk is called underwriting a process through which group insurance is priced.

The pricing of group insurance is wholly related to the frequency and amount of claims incurred. The net premium rate is a function of how often claims occur and how much claims cost. The gross premium rate includes the net premium rate plus administration expenses, risk charges, profit margins and premium taxes. Administration expenses are classified into two categories:

- **General administration:** These expenses typically include:
 - The commission paid to brokers and consultants.
 - The cost to produce the group contract.
 - The cost to print employee booklets, administration manuals and claim forms.
 - The cost to add the group to the administrative and claims-paying systems.
 - The cost to administer premiums on a monthly basis.
 - The cost to service the group on an ongoing basis.

- **Claims administration:** These expenses are related to the cost of paying claims. A risk charge is levied by the insurer to cover the losses of a group terminating coverage in a deficit position. Group insurance products earn profit in the form of a profit margin built into the expenses charged to the employer. The combination of some benefits and the applicable funding arrangements may allow the insurer to establish conservative claims assumptions that exceed actual claims experience, thereby generating a profit. However, group insurance exists in a very competitive marketplace, where all aspects of its cost are subject to scrutiny. Taxation affects the cost differently in every province and territory, which each charging premium tax applicable to all group insurance products. Ontario, Quebec and Newfoundland apply this premium tax to the claims and retention arising from uninsured administrative arrangements as well. Ontario and Quebec also apply the provincial sales taxes to insured and uninsured plans. There can be tremendous variations in the rates for any group insurance benefits.

Example: The Wiley Widget Manufacturing Co. has been in existence for 11 years. It is considering implementing a group life and health plan for its 83 full-time employees and has approached the Reliable Insurance Co. for a premium quote. Reliable is likely to establish premium rates for Wiley by using a manual premium rating method (using Reliable’s own data for similar-sized groups in the manufacturing field), since Wiley has no past claims or expense experience of its own on which to base assumptions regarding future claims.

Experience rating

Premium rate determination or renewal rating is the method of setting the premium rate at a level that will support the emerging claims experience and projected expenses of a specific benefit.

Rates can be determined on the basis of the actual claims experience of an individual group or employer, hence the term “experience rating.” Because past claims experience is used to project future rates, this method is sometimes referred to as “prospective ratings.”

Premium rates may also be determined on the basis of the collective experience of a group or pool of employers, in which case the benefit is said to be pooled.

The employer has to decide on the extent of the financial liability it is both willing to assume and capable of assuming and whether or not it wishes to share (assuming the insurer's criteria for financial participation are met) in the financial results of the group benefits plan.

The employer generally does not have a choice as to the method of premium rate determination since insurers establish their own guidelines for the renewal rating of benefits. However, assumption of risk by the employer may allow it the discretion to influence some of the variables that affect the calculation of renewal rates and hence, the renewal rates themselves.

PREMIUM RATE DETERMINATION

The most common methods available in the marketplace today are:

- Fully pooled,
- Prospective rating/experience rating,
- Refund (retention) accounting, and
- Administrative services only.

A fully pooled method of premium rate determination is the most appropriate arrangement for small groups. The pooled basis is also appropriate for those types of benefits where the incidence of a claim is low but the amount of claim is high, irrespective of the size of the group. Such is the case for life insurance, accidental death and dismemberment, and long-term disability benefits.

Because of the low incidence of claims against these types of benefits, it is more meaningful for insurance companies to analyze the experience for their entire block of business to determine the required premium rates.

A prospectively rated group is similar to a fully pooled group in all respects except for the renewal rating basis. Unlike pooled groups, premium rates for a prospectively rated group are determined in whole or in part on the group's own claims experience; hence, a plan that is rated on this basis is sometimes also referred to as an experience-rated plan. The term "prospectively rated" stems from the fact that renewal rates are applied prospectively, that is, to future contract or policy periods.

Example: If Wiley (above) had a group plan in place for the past eight of its 11 operating years, given the size of the group, Reliable would likely use experience rating to quote group insurance premiums for the company.

CREDIBILITY

The degree to which a group's experience can be used to determine its rate is called the credibility factor. By combining the claim experience of similar size groups into one pool, insurance companies are able to create a more meaningful basis to set premium rates and to apply credibility to that group's experience as a whole.

One distinguishing factor of the fully pooled rating approach is the fact that the past experience of a benefits plan itself does not affect its premium rates.

If a benefits plan's own experience has been unfavourable in one contract period but the majority of the groups in the pool has had favourable experience, it is likely that the benefits plan's premium rates will be decreased or at least maintained for the following contract period. Conversely, the group might be subject to an increase in premium rates if the pool as a whole has had unfavourable experience albeit an individual group itself did well in the same period. In other words, the rate for the group is based on the insurance company's manual rates.

Example: A short-term group disability insurance plan requires 250 employee-years of experience for the past experience to be considered to be 100% credible. One year of experience for a 250-life group or 10 years of experience for a 50-life group would each be fully credible. Three years of experience for a 50-life group would be 67% credible and so on.

Blended rating

Based on the size of group and the availability of historical claims experience, a group's experience may be used to determine only a portion of the renewal rate. The degree to which a group's experience can be used to determine a renewal rate is called the credibility factor. Insurers will use their own formula to determine this factor. For groups with a credibility factor less than 100%, the renewal rate will be a blended rate comprised of the manual rate and the experience rate.

Example: If Widget's claims experience data was only 60% credible, Reliable would probably set its rates using 60% experience rates and 40% manual (table) rates.

The decision of which rating system is used with a given group is a function of the characteristics of the group and the preference of the individual insurer.

FUNDING MECHANISMS

The way in which a group's claims and expenses are paid for is known as "funding" the group plan. There are a number of funding mechanisms available.

Non-refund accounting

A fully insured group plan is a plan for which the insurance company bears the total risk of paying claims. A fully insured plan is the traditional funding arrangement for group.

For example, even if the dollar amount of the claims submitted exceeds the dollar amount of the premiums collected, the insurer must pay the full claim. The client is not required to pay the difference to the insurer.

On the other hand, if the group experiences fewer claim expenses than anticipated, the insurer retains the surplus. No refund is paid to the client; therefore, "non-refund" accounting.

Refund (retention) accounting

A refund accounting group (also called retention accounting) may be said to be a prospectively rated group that chooses to share in its financial results. In terms of the renewal rating process, there is essentially no difference between a prospectively rated group and a refund accounting group. Premium rates for both plans are based in varying degrees (depending on plan credibility) on their own experience. The main difference between the two methods lies in the financial accounting process. A prospectively rated group, although rated on its own experience, is still pooled in that it does not share in the plan results, whereas a refund accounting group is rated on its own experience and shares in its experience results. The terminology tends to get a bit confusing at this point, because some insurers refer to a retention accounting group as an experience-rated group, since the plan's experience is used to determine any refunds. Others refer to this arrangement as a refund accounting group.

Refund accounting provides employers with a means of participating in the financial results of a group benefits plan. When a plan is performing well, an employer can benefit from the plan's good performance through refunds (also called dividends). Conversely, when a group benefits plan's experience is unfavourable, the insurance company is presented with an opportunity of recouping the shortfall through the renewal rating process.

Insurance companies normally have minimum requirements with respect to the size of the group and the premium generated by the group benefits plan. These requirements vary by line of benefit and are related to the volatility of the benefit – the more volatile or unpredictable the benefit, the higher the size and/or premium requirement for refund accounting arrangements.

Since health-care, dental-care and short-term disability claim amounts per occurrence are relatively small (in comparison to the life or long-term disability benefits) and the incidence of claims is high, insurance companies are in a better position to predict expected claims levels.

For these benefits, refund accounting is typically offered to groups of 150 lives or more, generating at least \$100,000 in annual premium. However, the criteria for refund accounting for the life and long-term disability benefits are much higher – typically, three times the minimum annual premium required for health and dental care, given the relatively higher claims amounts, lower incidence and greater liability involved. Insurers will be more flexible in offering refund accounting for life and long-term disability benefits when the average amount of insurance for the group is low, usually expressed as a flat amount per person.

PREMIUM RATE DETERMINATION

Premium or renewal rates are determined in the same manner as a prospectively rated group, that is premium rates are based on the group's own experience. However, a specific margin for deficit recovery, should the plan be in a deficit position, may be added to the renewal rates in recognition of the employer's agreement to address plan deficits as part of sharing in the experience results.

One method that insurance companies employ to address potential plan deficits for groups using refund accounting is the establishment of a claims fluctuation reserve. The claim fluctuation reserve or CFR (also referred to as the premium stabilization reserve/fund or rate stabilization reserve/fund) is a fund established by the insurance company from plan surplus for the primary purpose of offsetting a deficit.

A portion of, or the entire surplus generated by a plan in a favourable year is allocated towards funding the CFR. This provides the insurance company with some form of protection against shortfalls resulting from future unfavourable experience and the possibility of the plan terminating in a deficit.

LIABILITY OR RISK

In the course of sharing in the financial or experience results of the plan, the employer undertakes to address any deficits incurred while the plan is in force.

Because the employer has no legal or contractual liability for the deficit, it can terminate the plan and, in effect, walk away from the deficit. A refund accounting plan is still an insured plan regardless of the experience sharing and the insurer is ultimately at risk for claims incurred (and any terminal deficits) while the plan was in force.

Administrative services only plan

An administrative services only (ASO) plan is essentially a self-funded plan. The employer is exclusively liable for all financial (claims and related expenses) and legal aspects of the group benefits plan; hence, there is no insurance under an ASO plan. In a true self-funded plan, the employer would also be responsible for the administration of the plan; however, an employer generally does not have trained personnel to handle the claims adjudication and payment process and therefore, enters into an ASO agreement with an insurer to administer the plan. Nevertheless, there is still no element of insurance in this type of arrangement since the insurer simply acts as the administrator of the plan.

An ASO arrangement is typically offered on health care, dental care and short-term disability and less frequently on long-term disability and less frequently on long-term disability benefits. Because of the high degree of risk associated with the life benefit (high claim severity or large coverage amounts) and the taxability to the beneficiary of a death benefit in excess of \$10,000, it is rare for employers to provide life insurance on an ASO basis.

FUNDING METHODS

An ASO plan can be billed in advance through monthly deposit levels or billing rates common to a traditional insured plan. The advantage to the employer is that funding of the plan is level throughout the year, which is why plans funded in this manner are sometimes called budget ASO plans.

An ASO plan can also be funded through one of several billed-in-arrears arrangements. Because payments are based on actual paid claims and costs, the employer faces potential fluctuations in cash flow from periodic fluctuations in claims. Described briefly below are two billed-in-arrears arrangements:

- **Monthly billed in arrears (non-automatic fund transfers):** Claims and expenses are reimbursed through a cheque payment in the following month. There may or may not be an advance deposit or operating fund from which the administrator (insurer) can pay claims. Some administrators may insist on having an operating fund to facilitate claims payments.
- **Automatic fund transfers (AFT):** Billing in arrears can be done through automatic fund transfers from the employer's account on the basis of cheques issued (most common basis) and costs, or cheque cashed (rarely offered by insurers) and costs. Reimbursement is typically done on a daily or monthly basis. For plans that are billed in arrears on a cheques-issued basis, daily reimbursement can be done with or without a claims lag (typically two to five days). One advantage of an AFT cheques-issued arrangement on a daily reimbursement basis is the zero cash flow- hence the term zero-based accounting.

PREMIUM RATE DETERMINATION

A renewal rating is not necessary for ASO plans that are billed in arrears. For plans that are billed in advance through level monthly deposits or units rates, renewal rates are determined using the experience-rated approach. Insurers are more flexible in their renewal rate requirements for ASO plans because they are not at risk. However, although the insurer assumes no liability for the plan, potential losses from the employer's inability to repay and plan deficits can be minimized by setting deposits at a level that will support plan costs.

FINANCIAL ACCOUNTING

An ASO plan falls into the category of a refund or retention accounting plan in that an annual financial statement is prepared to reconcile deposits, claim payments, administrative expenses, applicable taxes and cash flow interest. There is a greater leeway in the treatment of plan surpluses or deficits because the insurer has no financial liability – the employer is fully liable for any plan deficits. Plan surpluses are credited with interest and may be refunded in full to the employer or carried forward as a positive balance into the next accounting period at the discretion of the employer. When an ASO plan (usually budget ASO or non-automatic fund transfer plans) is in a deficit position, the insurer faces a potential risk only in the event of bankruptcy of the employer.

This risk related to the inability to recover funds advanced by the insurer to pay claims and is not related to liability.

LIABILITY OR RISK

There is no element of insurance in an ASO arrangement since this type of plan is essentially self-funded or self-insured. The employer bears the full liability for all claims incurred under the group benefits plan and assumes the legal responsibility for claims litigation. Under an insured plan, any lawsuits would be directed against the insurer; under an ASO plan, lawsuits instigated by unsatisfied claimants would be directed at the employer.

CO-ORDINATION OF BENEFITS

The co-ordination of benefits (COB) provision was developed by the Canadian Life and Health Insurance Association (CLHIA).

The provision comes into play in circumstances where an individual is provided with group health or dental benefits under more than one plan. Typically, this would occur where an individual is covered under his or her own group plan and is also covered by a spouse's group plan. The COB guidelines ensure that the insurance companies involved in the group plans have a consistent and fair method of administering these claims and to ensure that the insured cannot collect benefits greater than 100% of the eligible claim.

The co-ordination of benefits guidelines provide that the primary carrier (determined to be the insurance company that will pay benefits under the claim first) shall be responsible for paying that portion of the claim provided for under its ordinary claims rules (allowing for deductible and co-insurance factors).

The secondary carrier (the carrier that is not determined to be the primary carrier) is required to pay the lesser of:

- The difference between the total claim and that portion of the claim covered by the primary carrier.
- The amount of the total claim that the secondary carrier would have paid had it been the primary carrier.

Example: John and Marsha are a married couple. John is a member of a group insurance plan (through his employer) that provides group dental coverage with a \$100 deductible and an 80% co-insurance factor. Marsha is a member of an association group dental plan that has a \$50 deductible and a 100% co-insurance factor. Marsha's plan also provides spousal coverage.

The couple's first dental claim for the year is a \$250 X-ray and cleaning bill for John.

John first submits his claim to his employer's plan, as primary carrier. The plan reimburses John \$120 of his dental expenses after allowing for the \$100 deductible (80% of \$150 = \$120). This leaves \$130 of the claim unpaid.

John then claims against Marsha's group plan (the secondary carrier). Before making a payment, Marsha's plan computes its liability using the formula above, the lesser of:

- the unpaid balance of \$130; and
- the amount the plan would have paid had it been the primary carrier. It would have paid \$200 of the claim (the \$250 claim, less the \$50 deductible, with a 100% of the \$250 dental expense (\$120 from his own plan and \$130 from Marsha's).

In circumstances where the first claim of the year does not exceed the deductible of one or both insurance plans, the whole claim may not be reimbursed and the deductibles for each plan are reduced accordingly.

Example: If John, above, had a first claim of only \$75, his plan would not have reimbursed any of the claim, but his remaining deductible would have been reduced from \$100 to \$25. The whole \$75 expense would have been carried over to Marsha's plan (as secondary carrier) and her plan would have reimbursed the couple in the amount of \$25 (after allowing for her plan's \$50 deductible). Her plan's remaining deductible would have been reduced to NIL"

If there had been a second claim later in the year for John of \$200, he would submit it to his carrier first. His carrier would pay \$140 of the claim (allowing for the \$25 remaining deductible and the 80% co-insurance factor on the net claim of \$175). The entire \$200 claim would then be submitted to Marsha's plan, which would pay the balance of the expenses of \$60 (the lesser of the \$200 that it would have paid had it been the primary carrier and the \$60 unpaid portion of the expense after allowing for John's claim).

In cases where an eligible health or dental expense is covered under two or more plans, priority of payment (determining the primary and the secondary carriers) is based on the following rules:

- Employee/claimant: The plan where the employee/claimant is an active member pays first.
- Spouse: the plan where the claimant is covered as a dependent spouse pays second.
- Dependent children: For claims made by or on behalf of a covered dependent child:

- The plan of the parent with the earliest birth date in the calendar year (month / day) – regardless of age – is the first payer.
- If both parent’s birthday fall on the same month and day, the plan of the parent whose first name begins with the earliest letter of the alphabet pays first (so, John’s plan would pay before Marsha’s).
- If the parents are separated or divorced, then the plans pay in the order that they appear below:
 - The plan of the parent with custody of the child.
 - The plan of the spouse of the parent with custody of the child.
 - The plan of the parent not having custody of the child.
 - The plan of the spouse of the parent not having custody of the child.

DENTAL ACCIDENTS

Health-care plans with accidental dental coverage pay first for accident-related dental treatment, before dental care plans.

Secondary insurers will require copies of the receipts and an explanation of the benefit from the first payer.

CASE STUDIES: THE CO-ORDINATION OF BENEFITS- DRUG PLAN

Case 1

Denis (birth date: March 2) is covered for drugs under his employer’s group plan. His plan also covers his spouse and dependent children.

Denis’ drug plan has a \$5 per prescription deductible, 90% co-insurance.

His spouse, Arlene (birth date: August 26), has similar benefits under her employer’s group plan.

Arlene’s plan has a \$25 a year deductible, 100% co-insurance.

Example A:

Arlene: Claims Submitted	Arlene: Her Group Plan Pays	Denis: His Group Plan Pays	Total Paid
\$47.00	\$22.00	\$25.00*	\$47.00
\$56.00	\$56.00		\$56.00
\$18.00	\$18.00		\$18.00
Total: \$121.00	Total: \$96.00	Total \$25.00	Total: \$121.00

*Denis's plan pays what Arlene's plan does not, the \$25 deductible; there is no extra co-insurance to pay.

Example B:

Claims Submitted	Arlene's Group Plan Pays	Denis' Group Plan Pays	
Arlene	\$68.00	\$43.00	\$25.00
Denis	\$44.00	\$ 8.90	\$35.10
Son	\$19.00	\$ 6.40**	\$12.60*

*Denis' plan pays first as his birth date is earliest in the year.

**Arlene's plan pays what Denis' plan does not cover, the \$5 per prescription deductible and the 10% of the co-insurance.

In both of the above cases, the COB guidelines serve the triple functions of providing clarity for priority of claim and ensuring that the claimant can be fully compensated for eligible expenses (by claiming against both plans), while capping the total compensation at 100% of the eligible expense. However, depending on circumstances, there may be a portion of the eligible expenses that are not reimbursed by either plan.

Case 2

Mike and Patricia (Pat) are married. Mike is a member of a group insurance plan (through his employer) that provides group dental coverage with a \$100 deductible and an 80% co-insurance factor. Pat is a member of an association group dental plan that has a \$50 deductible and a 50% co-insurance factor. Mike's plan also provides spousal coverage.

The couple's first claim for the year is a \$200 dental bill for Pat.

Pat first submits her claim to her group plan, as primary carrier. The plan reimburses Pat \$75 of her \$200 dental expenses after allowing for the \$50 deductible and the 50% co-insurance factor (50% of \$150 = 475). This leaves \$125 of the claim unpaid.

Pat then claims against Mike's group plan (the secondary carrier). Before making a payment, Mike's plan computes its liability using the formula above, the lesser of:

- The unpaid balance of \$125; and
- The amount the plan would have paid had it been the primary carrier. It would have paid \$80 of the claim (the \$200 claim, less the \$100 deductible, with an 80% co-insurance factor).

Mike's plan, then, would pay the lesser of the two amounts, \$80, and Pat would be reimbursed for \$155 of the \$200 dental expense (\$75 from her own plan and \$80 from Mike's).

In order to compute the total reimbursement, you must go through five steps:

1. Determine which plan is the primary carrier.
2. Calculate the portion of the claim that will be paid by the primary carrier.
3. Calculate the portion of the claim not paid by the primary carrier.
4. Calculate the portion of the claim that the secondary carrier would have paid had it been the primary carrier.
5. Compare the results of step 3 and 4 above. The lesser of the two amounts is the amount that the secondary carrier will pay.

INTRODUCTION – INTERMEDIARIES

There are three types of representatives who solicit group business from employers:

- **The agent:** Represents one insurance company in selling group plans and is compensated strictly by commissions. There are very few agents remaining in the Canadian market and they are no longer a factor in this field.
- **The broker:** Can represent any and all insurance companies in the group market and are compensated mostly through commissions and, to a lesser degree, by fee-for-service. The broker generally operates in one geographic area.
- **The consultant:** Can represent all insurance companies and is paid mostly through fee-for-service and, to a lesser extent, through commissions. Consultants can work regionally or nationally. They offer a wide range of services (such as marketing, administration, actuarial, communications, management consulting or any other services for which there is a need). The consultants control about 75% of the group business in Canada.

ACCOUNT EXECUTIVE

During the marketing, sales and ongoing service process, insurance companies are represented by account executives (also known as sales representatives, group representatives or employee benefit representatives). They are employees of the insurance company. Account executives assist the insurance companies, clients and ABCs in all presale and post-sale activities.

Presale activities

A typical group insurance sale begins with the insurance company representative identifying a potential client and developing a relationship. The prospect can require the rep to help it:

- **Remain up to date:** Employer should periodically review their group plans to ensure that they are up to date and adequate, given the changing needs of employees, the legislative climate and the marketplace. The current carrier should be compared to the market at least every five years.
- **Deal with problems with a current carrier:** This could include competitiveness of rates, local service, claims adjudication systems, benefits product line, flexibility and even compatibility with the insurers interacting with the employer and employees.
- **Find competitive rates:** The rep can check the current competitiveness of the group plan's rates but can also price alternative benefit or cost-cutting strategies.

Preparation of the request for proposal

The request for proposal is intended to be directed to life insurance companies who may be prepared to offer a group insurance plan. The following information must be collected from the prospect company:

DOCUMENTS

Get details of current benefits by getting a copy of an up-to-date contract and employee booklet along with all the amendments to the plan. This will allow you to get competitive quotes on the current plan and it will inform the quoting insurers exactly what benefits the experience information is based on.

EXPERIENCE INFORMATION

This includes premiums and claims for the past three years, the premium rates applicable to these periods and as much detailed claims information as is possible. The insurers release this information to the employers each year at renewal time.

EMPLOYEE DATA

This is the data on which the quotations will be based. You need, for each member: name or ID number, age or date of birth, sex dependent coverage election, occupation or class, earnings, coverage amount for each benefit, date of employment. This information is available in the monthly billing.

DETAILED OUTLINE OF BENEFITS TO BE QUOTED ON

These are the benefits that the insurers will be quoting on, so accuracy is paramount. This will include current benefits and alternate benefits.

SPECIFIC INFORMATION

This will include such things as expected commissions and bonus, letter of authority, special requests (such as personalized communications materials), specific service needs and any other items that the insurer should include in their response.

COVER LETTER

A covering letter should include any other items the quoting insurer should be aware of: date when quote should be returned, nature of the clients business, history of the client, proposed implementation date, reason for marketing plan, etc.

Points to remember when analyzing proposals

QUALITATIVE ANALYSIS

You should assess:

- The ability of the insurer to offer the requested benefits and services.
- The reputation of the insurer and its ability to underwrite the benefits as requested, based on the most recent rating of that insurer's claims-paying ability and general solvency according to rating agencies.
- Administration features, such as online, Internet access.
- The ability to produce reports and provide other services that are needed by the employer, including administration system and employee communication materials.
- The completeness of the proposal, including response to the questionnaire and quoted rates on both current and alternative plans.
- The promptness in submitting the proposal by the due date as specified in the cover letter.
- The quality of the proposal.

QUANTITATIVE ANALYSIS

You should review:

- The competitiveness of premium rates.
- The non-evidence and overall maximum quoted.
- The common basis of the comparison (“apples to apples”).

THE DECISION

In order to assist the employer in deciding on a new carrier, your report should include:

- **Introduction:** Reiterate the reason for marketing the group plan as well as the financial objectives in marketing the plan.
- **Commentary on current plan:** Identify gaps in the current plan design and how the marketing attempts to bridge those gaps.
- **Any limitations:** Such as the employer’s financial constraints, timing limitations or willingness to assume risk.
- **Market sources:** List the insurers invited to quote on the plan, why they were asked to participate and identify the ones who declined to participate.
- **Summary of the results of the qualitative and quantitative analysis:** Usually done on a spreadsheet format to facilitate the ranking of each insurer for each criterion.
- **Highlights of each proposal:** Identify in the commentary, for each insurer quoting, how they matched the RFQ and how each insurer stacks up.
- **Recommendations:** Based on the factors discussed in the report, specifying which insurer(s) will best serve the employer’s needs. Either recommend a shortlist or a firm recommendation as well as what benefits best suits the employer.

INSTALLATION AND ADMINISTRATION

You are responsible for:

- **Enrolment:** With the account executive, you hold employee enrolment meetings to enrol the employees in the new plan and to explain the new benefit plan.
- **Plan issue:** It is your responsibility to make sure the insurance company issues the new group accurately and as requested, including the contract, employee booklets and billing rates.
- **Administration:** The administration must be set up with the employer on time and the administrator must be comfortable with the process, including regular administration, claims submission, payroll deductions and premium billings.

ONGOING SERVICE

The installation of the group is only the beginning of the relationship between the employer, the representative and the insurer. The rep, with the aid of the account executive, will service and support the ongoing interaction among the employer, employees and the insurer.

One of the most important regular duties is overseeing the annual renewal. At this time the rates are recalculated. It is up to you to act on the client's behalf, to make sure that the rating process is fair to the client while at the same time supporting the insurer, to make sure it is receiving enough premium to support the plan. It is usual at renewal time for the rep to look at the whole plan to make sure the benefits are up to date and operating smoothly and to recommend changes.

It is obvious that agents, brokers and consultants, along with the insurer's account executives, play a crucial role in providing employee benefits. The activities involved in making an employer-sponsored benefits plan a reality can be fairly extensive and the process requires considerable knowledge and expertise. The key for representatives and insurers is to ensure that post-sale activities are as well addressed as presale activities. This is not only necessary to gain new clients but also to retain current ones. Employer dissatisfaction is one of major reasons why benefits plan are remarketed.

GROUP LIFE INSURANCE

Virtually all group plans contain a mandatory component of group life insurance. Plans also generally contain provisions for optional additional insurance on the life of the plan member and limited coverage on the member's family. The elements of group life insurance include:

Basic life insurance

Basic group life insurance is provided by the group contract and, in almost every case, it is in the form of yearly renewable term. This requires that the group contract be automatically renewed on an annual basis.

A group term insurance contract pays a death benefit only, with no build-up of cash values.

Basic group life insurance plans can be either non-contributory or contributory, in which case the employee pays for all or part of their premiums through payroll deduction.

Schedule of benefits

The amount of group life insurance coverage for which an employee is eligible can vary depending on the method of benefits calculation chosen by the employer.

A schedule of benefits is used to designate eligible employees under various employment classes and to determine the amount of life insurance that will be provided to the members of each class.

A benefit schedule, however, is subject to human rights legislation dealing with anti-discrimination. Class descriptions must be fairly broad and must be relevant to the plan member's status as employees, using descriptions such as occupation, length of service or earnings.

Earnings schedule

The most common method of determining the amount of an employee's insurance coverage is to base that amount on earnings, expressed as a multiple of annual earnings.

Example: Fred a department manager, is covered for two times annual earnings; if Fred earns \$44,500. then his group life insurance coverage would be \$89,000.

It is important to note that an employee's earnings include base salary only, excluding other compensation, such as bonuses, dividends or profit sharing.

Flat benefit schedules are commonly used among union groups covering hourly paid employees. They are also preferred by employers who wish to provide only a minimum amount of life insurance to all employees. Generally, the benefit is relatively small, such as \$10,000 or \$25,000.

Benefit maximums

There is always a limit to the amount of life insurance coverage issued to a member in order to control the insurer's risk in relation to the size of the group plan. The maximum amount of insurance reflects the number of employees covered by a group contract and the average benefit amount per employee. Limits are placed on the benefit amount that high-earning employees can receive to reduce the possibility of adverse selection.

Most group contracts do not require evidence of insurability from individual plan members. But an eligible employee must provide such evidence under certain situations, such as when:

- The amount of coverage is in excess of the predetermined non-evidence limit.
- The insurance is not applied for within 31 days of the member becoming eligible.
- An employee drops coverage and later wishes to rejoin the plan.

The type of medical evidence required is at the discretion of the insurance company and is based on the employee's age, the amount of insurance applied for and any existing history that would indicate more information may be required.

Example: An employee is eligible for \$245,000 and the non-evidence limit is \$150,000, under her group plan. The employee submits evidence for the amounts of coverage over \$150,000. If she is deemed to be uninsurable, she would receive the \$150,000 of coverage, but not the requested amount above \$150,000.

Reduction rule

To address the higher cost of providing life insurance coverage to older employees, a common specification in schedules of insurance benefits calls for a reduction in the benefit amount. Reduction provisions are generally applied at the earlier of retirement or attainment of a certain age, typically 65.

Benefit reductions of life insurance coverage can be carried out in three ways:

- Coverage can be reduced by a set percentage at a certain age. (Life insurance coverage is reduced by 50% at age 65).
- The amount of insurance can be limited to a flat amount at a certain age. (The benefit is reduced to \$25,000 at age 65).
- Benefits can be reduced gradually. (Coverage reduces by 20% a year beginning at age 65, and each year thereafter, terminating at age 70).

Premium rates

The monthly premium rate for basic life insurance is expressed as an average rate per \$1,000 of insurance for the entire group of employees, based on the group's average age.

The employer is responsible for submitting the total amount of premium payments for the entire employee group on a monthly basis. The premium rate is determined at the beginning of each year and is guaranteed for that year only. At renewal, a rate adjustment may be imposed, to reflect any changes that occurred in the group. Any rate adjustment will not reflect the claims experience of the group, as life insurance is funded on a manual rate, or non-refund, basis.

Dependant life insurance

Group plans often provide life insurance coverage for the dependants of insured employees.

Under dependant life insurance coverage, a dependant is typically defined as:

- An employee's married spouse or common-law partner.

- Unmarried children (including stepchildren and adopted children) between specified ages, usually 14 days to 21 years of age, or to 25 years of age if a full-time student who is dependent on the employee for financial support. Dependents can be covered beyond these ages if they continue to be solely supported by the employee as a result of mental or physical disability.

BENEFIT AMOUNT

The benefit amount is generally a modest flat dollar amount. The spouse is covered for a flat amount and each dependent is covered for half that amount. For example, the spouse is covered for \$5,000 and each dependent child, \$2,500 may cost the employee a flat \$3 a month.

Survivor income benefit

Some group life insurance plans offer a survivor income benefit (SIB) in addition to a lump-sum death benefit. This benefit has three attributes:

- The employee does not name a beneficiary, since only a spouse or dependent children are eligible to receive the benefit.
- It is payable in the form of a monthly benefit to the beneficiaries (an annuity).
- Benefits are paid only if at least one beneficiary survives the employee.

BENEFIT AMOUNT

Benefits are defined as a flat amount or a percentage of the earnings of an insured employee at the time of death, typically between 10% and 40% for the spousal benefit and a lesser amount for the dependent children. Both amounts are subject to a maximum limit. Plans may make benefits payable separately to the surviving spouse and dependent children.

Optional life insurance

An employer may offer optional life insurance coverage in addition to basic coverage. The group contract of an optional plan provides the same term life insurance provided by that of a basic group plan, except:

- The amount of coverage is elected by the individual.
- Evidence of insurability is required.
- The optional plan is almost funded by the employee contributions.

BENEFIT AMOUNT

The coverage is usually offered in units such as \$5,000 or \$10,000. The employee chooses the number of units that gives him or her the amount of coverage required. So if units are \$10,000 and the employee wants \$100,000 of optional life insurance, then the employee would buy 10 units. There is always a limit on the number of units that an employee may purchase.

PREMIUM RATES

Optional life rates are step-rated to reflect the age of the purchaser. Because the benefit is voluntary, the participation, the ages of participants or the amounts are not known in advance. The rates would be expressed per month, per unit of coverage. The age steps would look something like: up to age 35, 36 to 45, 46 to 50, 51 to 55, 56 to 60 and each year thereafter. Optional groups also break down rate by sex and smoker/non-smoker status.

Accidental death and dismemberment

AD&D is offered by many groups to provide benefits in addition to basic life insurance coverage, in the event that an employee was to die in an accident or suffer specified injuries or losses. It is also referred to as “double indemnity coverage.”

Below is a sample table of AD&D losses:

For loss of:	Benefit amount:
Life	Principal sum
Both hands or both feet	Principal sum
Sight of both eyes	Principal sum
One hand and sight of one eye	Principal sum
One foot and sight of one eye	Principal sum
One foot and one hand	Principal sum
Speech and hearing	Principal sum
One arm or one leg	Three-quarters of the principal sum
One hand or one foot	Two-thirds of the principal sum
Speech or hearing	Two-thirds of the principal sum
Sight of one eye	Two-thirds of the principal sum
Thumb and index finger	One-third of the principal sum of the same hand
Loss of four fingers	One-third of the principle sum
Hearing in one ear	One-quarter of the principle sum
All toes of one foot	One-eighth of the principle sum
For loss of use of:	
Both arms or both hands	Principal sum
Both arms and both legs (quadriplegia)	Principal sum
Both legs (paraplegia)	Principal sum
One arm and one leg on the same side of the body (hemiplegia)	Principal sum
On arm or one leg	Three-quarters of the principal sum
One hand	Two-thirds of the principal sum

EXCLUSIONS

Under the term of a typical AD&D contract, a benefit is payable for death or injury that is a direct result of the accident and that ensues within a certain period of time, usually 365 days following the date of the accident.

On the death of an employee, the death benefit amount is payable to the beneficiary. For injuries, the benefit is paid to the employee.

Most group contracts specify that benefits are not payable for any loss caused by or resulting from:

- Intentionally self-inflicted injuries, attempted suicide or suicide, whether sane or insane.
- Declared or undeclared war or any act of war.
- Fully-time active duty in the armed forces of any country or international authority.
- Flying as a pilot or crewmember of any aircraft.

PREMIUM RATE

The monthly premium rate for AD&D coverage is a single rate per \$1,000 of insurance that is applied to all employees, without differentiating for age or sex.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT PLANS

“Voluntary” AD&D insurance coverage is similar in most respects to the basic AD&D coverage. Employees have the option to select this additional benefit and employees usually pay all of the premium for this coverage.

Generally speaking, an employee may select any benefit amount in units of \$10,000 or \$25,000, up to a maximum. Unlike optional life insurance, because benefits are payable only in the event of an accident, evidence of insurability is not required. Similarly, minimum participation is usually not required as there is virtually no concern for adverse selection. A contractual overall limit on total basic and optional benefits payable (referred to as the combined maximum) is commonly imposed when voluntary coverage is available. This is necessitated by the fact that benefit amounts are selected by the employees and catastrophic claims may be incurred in one accident.

Example: Debbie Jones, an executive of SOS Finances Inc., has basic AD&D coverage for a principal sum of two times her annual \$100,000 salary (\$200,000). She also purchased an additional five times her annual earnings under the voluntary coverage (\$500,000), for a total coverage of \$700,000. Debbie got into a serious car accident, resulting in the paralysis of one side of her body. Because of the total and permanent loss of the use of her arm and leg, she is eligible for twice the principal sum under both the basic and voluntary coverage (hemiplegia is payable at two times the principal sum). However, two times \$700,000 exceeds the combined maximum of \$1,000,000. The amount payable by the insurance company to Debbie is therefore limited to \$1,000,000.

Another provision sometimes included in AD&D group contracts is the aggregate limit. This provision limits the amount payable as a result of claims that may arise from more than one employee all involved in the same accident. For example, a group of employees of ABC Ltd. may be travelling to a convention on board the same airplane and that plane crashes. Without an aggregate limit, XYZ Insurance Co. would have to pay the full principal sum for each employee who died as a result of the accident. With an aggregate limit that stipulates a maximum of, say, \$3,000,000, total claims payable are limited to that amount.

Finally, voluntary plans also offer AD&D coverage for an employee's dependant's. Like dependant life insurance coverage, the benefit amount for the dependant is relatively lower than the benefit amount for the insured employee. The amount of spousal coverage varies, usually 40%, 50% or 60% of the employee's coverage, and dependent children are covered for typically 10%, 15% or 20%.

If the plan does not offer coverage to an employee's dependants or if it provides spousal benefits without child coverage, independent of the employee benefit amount, it may be referred to as an "optional" instead of "voluntary" AD&D benefit.

Key group life provisions under CLHIA rules

BENEFICIARY DESIGNATION

The provisions allowing an insured member to designate the beneficiary are a fundamental part of a group contract that pays out benefits provided by group life insurance plans. The contract must provide an employee with the right to name the beneficiary who will receive the death benefit when a claim is made on the death of the life insured, which is the plan member or an insured member of his or her family.

Certain types of life insurance, however, places restrictions on who can be designated as a beneficiary. For example, only the employee can be named the beneficiary under dependant life insurance.

The employee is allowed to change the beneficiary at any time, except in the rare situations where the beneficiary designation is made irrevocable. In Quebec, designation of a spouse as beneficiary is automatically considered irrevocable, unless otherwise stated.

CONVERSION PRIVILEGE (LIFE INSURANCE)

An insured person has 31 days after termination of employment or after ceasing to be a member of the group to apply for conversion of the benefit under the group contract to an individual policy regularly issued by the insurance company at that time. The conversion can be exercised without submitting any evidence of insurability. This may be in the form of term to age 65 or a one-year convertible term policy, but not any other type of term insurance. For this policy, the individual pays a standard applicable rate charged by the insurance company for individual policies based on age and level of protection.

The level of coverage provided by an individual policy cannot be greater than the amount of life insurance the employee was covered for under the group plan at the time of termination or \$200,000, whichever is less.

The conversion option is rarely exercised. It may simply stem from the fact that many terminated employees receive new group coverage when they find new employment. Others balk at the higher premium cost of the individual insurance policy relative to that of group life. The insurers have not encouraged the conversion privilege, since employees who exercise this privilege do not submit evidence of insurability and are potentially poorer risks.

NOTE: Some group plans also offer the conversion privilege for group long-term disability coverage.

MISSTATEMENT OF AGE

If, for any reason, there is a misstatement of the age of an employee, the benefit amount to which the employee is entitled is changed to correspond to the benefit amount stipulated in the schedule of insurance for the actual age. The premium will also be adjusted accordingly.

Whether the plan is contributory or not, the contract holder (the employer), not the individual employee whose age was misstated, is responsible for making up the shortfall in premium where the age is understated. If the age is overstated, the employer has the right to a refund.

SETTLEMENT OPTIONS

Group contracts generally stipulate that the death benefit is payable in a lump sum, unless an alternative method is chosen. If an employee did not elect a benefit settlement method prior to his or her death, the beneficiary then has a choice among any number of options made available through the insurer.

Apart from the lump-sum method, other options in settling a life insurance claim are provided by insurance companies to beneficiaries, including:

- The death benefit amount can be left on deposit with the insurance company and will earn interest, based on rates available at the time. It must be made clear that the funds however, may be withdrawn in full at any time by the beneficiary without penalty.
- The death benefit amount can be paid in instalments over a specified period.
- Periodic instalments can be calculated and paid as part of a life income option, where the benefits are paid over the lifetime of the beneficiary. A guarantee provides for continued payment of benefits to a secondary beneficiary or an estate, should the beneficiary die before collecting the full death benefit sum.

Tax treatment for group life insurance

Premiums paid by the employer:

- Are a tax deductible expense for the employer.
- Are considered a taxable benefit for the employee.
- Are paid with personal after-tax income, so are not tax deductible. But death benefits are tax-free to the named beneficiary.

Group creditor insurance

Group creditor insurance is contained in a contract between an insurance company and a financial institution in the business of making personal loans. The insured individual is the borrower who has elected to pay for the coverage. This is considered a group contract because the financial institution is the policyholder and the borrower who chooses to buy the insurance is the member.

In addition:

- The benefit, at any time during the coverage period, is the insured borrower's outstanding debt to the financial institution. The plan beneficiary is always the financial institution.
- Benefits are payable due to the borrower's death or disability and, in the case of some credit cards and personal loans, unemployment.
- Coverage can be for any personal loan including mortgages, personal loans, line of credit or credit cards.
- The individual chooses whether to be covered for life, disability or unemployment.
- The premiums are included in the regular loan repayments.

For disability, benefits are payable during the period of disability only. Outstanding indebtedness remaining after recovery again becomes the responsibility of the borrower. Similarly, benefits for unemployment are only payable during periods of unemployment up to a specified duration.

Application for creditor group insurance is fairly simple and is marketed by the financial institution at the time the loan is procured.

The premium rates for creditor group insurance are not comparable to group insurance under employer/employee plans as the amount of creditor insurance decreases the longer the borrower remains insured.

For disability claims, the duration of the coverage may be limited to the period of time for which the loans interest rate is guaranteed, not the entire term of the loan. This is a critical point for borrowers who renew their mortgages every few years.

GROUP DISABILITY PLAN

Group disability coverage dates back to the 1920s in Canada, but had limited growth until after the Second World War. Spurred by the influence of a trade unions and the introduction of a long-term disability plan in the early 1960s for the federal civil service, group disability has grown over the past five decades to the point that there are now more people covered under group disability plans than under individual contracts.

Contributing to this growth has been the expansion of government disability benefits included in the Worker's Compensation, Employment Insurance and Canada/Quebec Pension Plan programs. The growth of group disability plans has made employees, unions and employers more aware of the gaps in the government– sponsored plans.

Elements of a group disability plan

Every group disability insurance plan has it core a series of common components.

THE DEFINITION OF DISABILITY

There are two basic definitions of disability and both relate to the individual's ability to work.

Any occupation

Refers to the individual's ability to perform any occupation as a result of his or her disability. The specific wording of the "any occupation" definition typically is as follows:

"An employee is considered to be totally disabled if a medically determined physical or mental impairment due to injury or sickness prevents them from performing the regular duties of any occupation for which they are, or may reasonably become, suited to perform, based on education, training or experience."

Own occupation

Is linked directly to the individual's ability to perform the major duties of his or her regular occupation and typically contains the following wording:

“An employee is considered to be totally disabled if a medically determinable physical or mental impairment due to injury or sickness prevents him or her from performing the regular duties of his or her occupation.”

Most group long-term disability contracts include a two-year “own occupation” clause for the early years of a disability with the remainder of the disability covered under the “any occupation” clause.

Example: Under the terms of one plan, individuals would receive the benefit if they were unable to perform the regular duties of their own occupation during the first 24 months of disability. In order to continue to receive LTD benefits after 24 months, they would have to be unable to perform the substantial aspects of any occupation for which they may be qualified by reason of training, education or experience.

From the insurance company's perspective, the “own occupation” definition period is the period during which it can effectively manage and rehabilitate the individual back to their regular occupation. The “any occupation” definition requires the insurance company to perform an assessment of the individual's ability to perform an alternative occupation that may be available, either with their current employer or elsewhere.

Example: A fully qualified tool-and-die maker is in an accident and sustains muscle damage to one of his arms, developing a noticeable and uncontrollable shake. He can no longer work on the equipment especially the metal lathe, so he can no longer perform the key element of his job. For the first two years, he will be considered totally disabled under the two-year “own occupation” clause. After the two years have elapsed, he may no longer be considered totally disabled under the “any occupation” clause. He could for example, be rehabilitated to work training other tool-and-die makers. This is an occupation he is capable of doing and he would earn about as much as his previous occupation.

The definition of an eligible disability under a short-term disability plan is tied to the employee's inability to perform any or all aspects of their occupation, an "own occupation" definition. Some negotiated STD plans will include the definition of disability as an "any occupation" definition. Because of the shorter benefit period under STD, only one definition of disability will apply.

ELIMINATION PERIOD

The plan design for STD or LTD benefits incorporates a qualifying period, or elimination period, during which the eligibility of the disabled employee can be determined and after which the benefits commence.

SHORT-TERM DISABILITY

The elimination period for STD benefits is primarily intended to reduce administration on those claims that are of very short duration, such as a one-day absence from work due to such illness as a 24-hour flu. Most STD plans provide for payment after seven days of a sickness or on the first day if the disability results in hospitalization or is due to an accident.

LONG-TERM DISABILITY

The elimination period for LTD is usually co-ordinated with the STD plan so that the LTD elimination period ends when STD benefits ends and LTD benefits begin. For example, a very common LTD elimination period is 120 days, as this coincides with the Employment Insurance disability benefit.

For both short-term and long-term disability benefits, the length of the elimination period has a direct impact on the costs or premiums charged by the insurance company. The longer the elimination period, the lower the risk to the insurance company, since there is a greater probability that the disabled employee will return to work before becoming eligible for disability benefits. Also, the longer the elimination period, the longer until the insurer will have to begin paying benefits. Therefore, the longer the eligibility period, the lower the premium rate.

Features and coverages

PARTIAL DISABILITY BENEFITS

Many insurance companies provide a partial disability benefit to enable disabled employees to receive benefits provided they are motivated to actively pursue reemployment. The partial disability benefit provides protection for an employee who is able to work in a reduced capacity.

The essential features of the partial benefit include:

- An employee who qualifies for total disability benefit and is able to work in a reduced capacity can apply for partial benefits.
- Benefits are payable if, due to reduced earnings capacity, the employee's loss of income exceeds a specified percentage (usually 15% or 20%) of the employee's indexed pre-disability earnings.
- Common partial benefit allows the claimant's total income (disability benefit and partial earnings) to equal 75% of pre-disability earnings, after which the employee can keep 50% of partial earnings and reduce the disability benefit by 50% until total earnings reach 100% of pre-disability earnings.

Example:

• Pre-disability monthly earnings:	\$3,000
• LTD monthly benefit, 66.67%	\$2,000
• Part-time partial monthly earnings	\$ 750
• 75% of pre-disability earnings	\$2,250
○ LTD benefit	\$2,000
○ Partial up to 75% of pre-disability earnings	\$ 250
○ 50% of balance of partial earnings	\$ 250
○ Total earnings under partial benefits	\$2,500

The partial disability benefit gives an incentive for the disabled employee to get back to work as soon as possible. The sooner the employee returns to some form of productive work, the greater the chance of a full recovery.

RECURRENT DISABILITY

Insurance companies support an individual's effort to return to the workplace. Therefore, most group disability plans include a provision for tracking a recurrent disability.

If an individual returns to work on a full-time basis following a period of total disability for which benefits were payable and again becomes totally disabled due to the same or a related cause, the individual will be considered to have been continuously disabled for the purposes of the qualifying period. The typical recurrent period for STD is 14 days and for LTD is six months.

Example: Henry works in the shipping department in a large warehouse. His LTD plan has an elimination period of 120 days and a benefit period to age 65. Henry was receiving LTD benefits because of a severe lower back strain. He returned to work, but after two months he re-injured his back and had to go off on disability again. As he is within the recurrent period of six months, Henry can receive benefits again and does not have to go through the qualifying elimination period.

On the other hand, because the second claim is considered a continuation of the initial claim under the recurrent disability clause, the total maximum benefits payable will be reduced by the benefits paid under the initial claim.

COST-OF-LIVING ADJUSTMENT

Disability benefit plans are designed to provide disabled employees with a percentage of pre-disability earnings to enable them to sustain a reasonable standard of living. The impact of inflation can effectively diminish the value of a disability benefit. To prevent this from happening, insurance companies introduced the concept of a cost-of-living adjustment (COLA) option in LTD plans. COLA is considered unnecessary in STD plans because of the short duration of the claim.

A COLA option typically provides an indexing of the disability benefit based on the lesser of:

- An adjustment based on the consumer price index, not to exceed a state maximum, such as 3 to 5%.

- A fixed stated adjustment, usually 3 to 5%.

The COLA maximum is kept relatively low because if the cost for every 1% COLA adjustment, the premium cost will increase from 5% to 7%. For example, a 3% COLA will increase the LTD premiums to 21% from 15%.

The indexing of benefits usually does not start until a claim actually commences, although some plans available in the market index the potential benefit payable starting with the initiation of the coverage.

DIRECT AND INDIRECT OFFSETS

Other sources of income payable to the disabled employee are stipulated in the group contract as “offsets” and used to reduce the benefit payable under the LTD benefit plan. These offsets are defined under two distinct categories: direct and indirect.

Direct offsets

Direct offsets (also called primary offsets) usually cover benefits payable under government-sponsored programs, including: Canada/Quebec Pension Plan and Workers’ Compensation benefits.

In some instances, the insurance company will also include, as a direct offset, benefits payable under automobile insurance (especially in those provinces where there is a government-sponsored automobile insurance plan, such as in Saskatchewan or Quebec) and CPP/QPP spousal and children’s benefit payable to the employee.

When the employee receives payment from these sources, the insurance company takes the position of the second payer. So when a claim occurs, insurance companies insist that the disabled employee apply for CPP/QPP benefits and, if the disability is the result of a work-related injury, for Workers’ Compensation as well. Any benefits received by the employee from these two sources is then used to reduce the amount of the benefit payable under the LTD benefit plan.

Since the adjudication process under CPP/QPP may delay the actual payment of the benefits, its common practice for an insurance company to pay the LTD benefit and require the disabled employee to sign a reimbursement agreement to repay the insurance company if a benefit is paid under CPP/QPP.

It is also common for insurance companies to ask claimants to sign an assignment of CPP/QPP benefits form, allowing the insurer to collect directly from CPP/QPP amounts already paid to claimants, by which the LTD benefits would have been reduced had the CPP/QPP decision been known at the time.

Indirect offsets

LTD benefits plans usually also have indirect (or full) offsets, which can include:

- Benefits payable under an association or other group disability program.
- Any income as a result of any job or business for remuneration or profit excluding severance or vacation pay, except under an approved rehabilitation program.
- CPP/QPP disability pension benefit payable to the employee on behalf of his/her dependants.
- Disability benefits payable under a motor vehicle insurance plan.
- Any retirement benefits related to any employment.

These offsets are used to further reduce the LTD benefit. All of these offsets are taken into consideration when the insurance company is establishing the rates for the LTD benefits plan.

CONTINUATION OF BENEFITS

Disability benefits are unique in that they are maintained even though the group contract may be altered or terminated by the employer. Once an employee is on short- or long-term disability, the insurance company is obliged to maintain the payment of benefits. Even if the employer cancels the group contract or changes the plan design, after the benefit payments have commenced employees will be paid until the benefits would have been terminated under the terms of the group contract.

TERMINATION OF BENEFITS

STD and LTD benefits cease on the earliest of the date that the employee:

- Recovers from the disability.
- Dies.
- Attains age 65.
- Reaches the end of the benefit period.
- Fails to submit required proof of ongoing disability.
- Fails to report for a required medical examination.
- Ceases to receive generally accepted professional treatment for the condition being treated.

WAIVER OF PREMIUM

LTD plans include a waiver of premium feature. The premium for the LTD benefit is waived while the employee is receiving the benefits. STD plans do not have a waiver of premium feature because of the number of short duration claims. The waiver of premium begins with the payment of benefits after the elimination period and is not backdated to the beginning of the disability.

PRE-EXISTING CONDITIONS

A standard provision in LTD plans is the exclusion and/or restriction for pre-existing conditions. This provision is designated to protect the plan from the negative cost impact of the high claims that could result when an employee with a pre-existing condition joins the employee benefits program.

Benefits are not payable for a total disability that commences during the first 12 months of an employee's coverage, if the disability results from any sickness or injury for which the employee was treated or attended by a physician, or for which prescribed drugs were taken, within 90 days prior to the effective date of the employee's insurance.

STANDARD EXCLUSIONS AND LIMITATIONS

The purpose of a disability benefit plan is to provide active employees with financial protection if they become unable to work due to disability. Most plans stipulate exclusions under both STD and LTD coverage, which specifies those benefits, will not be paid:

- For any period during which the employee is not under the care of a physician.
- If the employee engages in any occupation for remuneration or profit, except as approved by the insurer under partial disability or rehabilitation provision.
- For the period an employee is entitled to pregnancy or parental leave allowed by law or agreed to with the employer.
- If the employee refuses or fails to participate in an approved partial disability or rehabilitation program as required by the insurer.
- For any period during which the employee is confined in a penal institution or house of correction.

There are other standard exclusions in STD and LTD plans that stipulate that no benefits will be paid for disabilities resulting from:

- An intentionally self-inflicted injury or attempted suicide while sane or insane.
- War, whether declared or undeclared.
- Participation in the commission of, or attempt to commit a criminal offence.

STD registration under the EI plan

An employer can “register” its STD plan with Human Resources Development Canada (HRDC) and obtain a premium reduction for Employment Insurance. Provided the benefits plan is equivalent to or better than the EI benefit, it will be accepted for registration. The employer’s contribution for EI will be reduced from 1.4 times the employee’s contribution to an amount announced each year to reflect the claims experience of the EI disability benefits. The reduced employer EI contribution is usually around 1.28 to 1.3.

The employer must submit its application for premium reduction on or before Sept. 30 in the year before the year for which the reduction is sought. A plan must be in effect on or before Jan. 15 of the year in which the application is being made to be eligible for the maximum premium reduction. The plans effective after Jan. 15 and prior to Sept. 16 can apply for a prorated premium reduction for that year. Full reduction will apply in the subsequent year. EI requires that at least 5/12 of the premium reduction be passed on to the employees in some form, such as cash or enhanced benefits.

Taxation of group disability plans

If the employees and the employer are sharing the cost of the group benefits plan, how best to share the costs? One consideration is whether the employees should pay all the premiums for the group disability plans.

The tax implications are as follows:

- Any premiums paid by the employer for either the STD or the LTD plan is a tax-deductible expense to the employer and generally not a taxable benefit to the employee.
- If the employer pays any portion of the disability premiums for either the short- or long-term plan, the disability benefits received by the employee in excess of the total employee premiums paid (if any) are considered taxable income to the employee.
- Any premiums paid by the employee are paid for with after-tax dollars.
- If the employee pays 100% of the disability premiums, the benefits are received tax-free.

The government wants to collect the taxes either on the premium or the benefits received. If the benefits are to be set up on a tax-free basis, then 100% of the premium has to be paid by each employee, including provincial sales tax.

Note: If the goal of the LTD plan is for the disabled employee to take home approximately 67% of pre-disability take-home pay and the plan is taxable, then the employee should be covered for about 70% of gross pay, as this will be taxed. If the plan is non-taxable, then 55% would suffice as 55% tax-free would at least equal 67% of pre-disability take-home pay. The lower volume of coverage would cost proportionately less, which is important, since the employees are paying 100% of the premiums for the non-taxable plan.

Co-ordination of benefits and third-party subrogation

ALL SOURCES MAXIMUM

All sources maximums are included in a LTD plan design to account for income from sources other than the group LTD plan. The purpose of all sources maximum is to prevent situations in which an employee's total income while disabled comes too close to pre-disability earnings, effectively eliminating the financial incentive to return to work.

Under the all sources maximum definition, income from other sources listed in the group contract are added to the LTD benefit payable and direct offsets are deducted to determine what the actual benefit payout should be. If the total income received exceeds the all sources maximum, the benefit payable is reduced by the excess amount.

If the benefit is taxable when received by the employee, then the all sources maximum is based on a percentage (80% to 85%) of pre-disability pre-tax earnings. If the benefit is received tax-free by the employee, then the all source maximum is based on a percentage (80% to 85%) of pre-disability post-tax income. The all sources maximum is based on such income as group and individual disability insurance plans, government disability plans, and any other earnings.

THIRD-PARTY SUBROGATION

A disabled employee may potentially file a claim for compensation for loss of earnings against a third party for causing them to become totally disabled. If the employee is awarded compensation, he or she must return to the insurance company any benefits received under the LTD benefit plan, up to the amount representing the reimbursement for the loss of earnings from the third party. The recovery of these amounts is known as third-party subrogation of claims and is a common provision in LTD plans.

Under the subrogation provision, the insurance company will most likely oblige the insured who has suffered a loss caused by a third party to inform the insurance company and to participate in any lawsuit against the third party. The insured will also be obliged to reimburse the insurance company for some or all of the claim amounts it has paid if the insured does receive compensation from the third party.

Example: A disability results from a car accident and, as a result of settlement a payment is made to the disabled employee from the other driver's insurance company. If the settlement is based on the disabled employee's loss of earnings, then the amount of the settlement can be recovered by the insurance company in repayment for LTD benefits previously paid to the disabled employee.

GROUP ACCIDENT AND SICKNESS

Medical services available

Group health-care plans share a role with government in ensuring that Canadians receive adequate health care, by building on the minimum universal standard care already provided by provincial health insurance plans. Provincial health insurance plans cover basic hospital, physicians' care and other medical services, leaving private health-care plans to cover those medical products and services not covered by provincial health insurance plans.

As governments reduce and eliminate coverage of services not mandated by the Canada Health Act, they are, in effect, cost shifting – moving a greater portion of the responsibility for funding these gaps in coverage to employer-sponsored plans.

HOSPITAL CARE

Provincial health insurance plans cover most of the basic hospital and surgical expenses that any Canadian resident incurs during a period of hospital confinement, including accommodation at the ward level, the services of physicians and surgeons, diagnostic procedures and drugs.

Therefore, employer-sponsored hospital plans cover only the additional cost of preferred accommodation – semi-private and private rooms.

Coverage is for confinement in an active treatment hospital, which is defined as an institution that:

- Is a licensed hospital,
- Operates with a staff of physicians at all times.
- Is always open.
- Offers in-patient accommodation, and
- Provides continuous 24-hour nursing services.

AMBULANCE SERVICES

Health-care plans supplement government benefits by covering charges in excess of the amount payable under the provincial health insurance plan for services provided by professional licensed ambulance companies. Coverage includes ambulance services to transport the covered person:

- From the place where the emergency sickness or injury occurred to the nearest institution where essential treatment is available.
- From the first institution where treatment is provided to the nearest alternative institution for required specialized treatment.
- From a basic hospital to a convalescent hospital.

DRUG CARE

Prescription drugs form the largest item of an employer's total health-care plan, accounting for from well over half, to as much as 75% of the total costs. Drug benefits may be underwritten on a stand-alone basis under a separate plan, particularly in the pay-direct plan design. Most drug benefit plans are commonly included under one group contract covering all eligible health-care expenses and are subject to deductibles and co-insurance features.

All drug benefit plans will cover only drugs and medicines that:

- Are medically necessary.
- Are prescribed by a physician or dentist.
- Have a drug identification number.
- Are dispensed by a registered pharmacist.

Plan design

There are two common variations of drug benefits plan design:

- **Prescription-only drug plans:** Provide coverage only for drugs and medicines that can only be purchased with the written prescription of a physician or dentist. Individuals are responsible for paying for any other drugs that can be purchased over-the counter, even if the physician prescribes the medication.
- **Any prescription drug plans:** Cover all drugs and medicines, including over-the-counter drugs provided they are prescribed by a physician or dentist. These plans are more expensive due to the increased scope of the coverage.

Method of payment

There are two methods by which claims for drug expenses are paid:

- **Reimbursement plan:** Drug benefit plans were originally designed on an employee reimbursement basis. Under such a plan, the employee pays the pharmacist for the prescription at the time the prescription is filled. The employee then submits a completed claim form, including the prescription receipt, to the insurance company or third-party administrator (TPA) or reimbursement as set out in the group contract. Approximately 40% of all individuals covered under group drug plans claim through a reimbursement plan.
- **Pay-direct plan:** Part of the evolution of drug plans is the introduction of pay-direct drug cards. With this card, the insurance company pays the participating pharmacist directly for the eligible cost of the drug. A covered person (either an eligible employee or dependent) presents a drug identification card to any participating pharmacist and pays for any out-of-pocket expenses at the point of sale as per the plan design, such as a deductible and/or a co-insurance payment. The pharmacist then charges the provider directly for the balance of the cost of the prescription. With the advancement of technology and electronic claims adjudication, a pay-direct drug plan claim can be adjudicated online in real time, at the point of sale between the pharmacist and the pay-direct drug plan provider.

Compendium

The compendium is the list of drugs that require a prescription that are approved for sale in each province. Most plans cover the entire compendium and change when the compendium changes.

Drug formularies

No other health-care benefit has experienced the kind of ballooning costs that prescription drug benefits have experienced, registering annual increases in costs much greater than the consumer price index (CPI) general inflation rate.

Providers and employers often use drug codes outlined in the drug compendium in designing drug benefit plans. The listing of drugs and medicines covered under a drug plan is referred to as a “formulary”. Providers offer a variety of options to employers, each with different cost implications.

- **Fixed formulary:** Cover only those drugs selected by the employer at the time the formulary is adopted. Often, this formulary will mirror the eligible drugs covered under the provincial health insurance plan. Any new drug that has entered the market after the formulary is in force would not be immediately covered, added only when the cost/benefit of the new drug is established.
- **Generic equivalent:** Under a generic equivalent drug plan, insurers will reimburse drug expenses only up to the generic equivalent drug cost, if brand named drugs are purchased and there is a generic substitute available. A generic equivalent drug is a drug with the same active ingredients at the same doses as the brand name original of the drug, but normally available at a lower cost. Certain restrictions and exceptions may exist. For example, if a generic equivalent is not available or the brand name drug cannot be substituted as prescribed by the physician, then the brand name cost would be eligible for reimbursement.

Pharmacy benefit management has emerged, with the advent of sophisticated technology and electronic claims adjudication, to facilitate better controls for today's pay-direct plans. "Pharmacy benefit management" is the term used to describe the combination of new technology and process management that has significantly improved the effectiveness of pay-direct drug plans. Other features of a drug plan can be controlled at the point of sale, such as the enforcement of plan requirements and the co-ordination of benefits coverage under different plans.

PRIVATE DUTY NURSING

Most group health plans offer benefits for private duty nursing care that is provided on the recommendation of a physician, to a covered employee who is not confined in a hospital.

Coverage is permitted only for nursing care that can be performed by a registered nurse (RN) who is not related to the covered person and does not live in that person's home.

The maximum amount for this benefit generally takes two forms: \$10,000 a year or \$25,000 every three years. While the incidence of this type of expense is relatively low, usage for this benefit is increasing as the provincial health-care plans are shortening hospital stays and sending recovering patients home earlier. When benefits are incurred, the costs can be astronomical. For this reason, the traditional requirement of a RN has been liberalized to include care by a licensed or registered practical nurse or a registered nursing assistant.

For a pre-care assessment, the employee's attending physician may be required to submit written information that provides:

- A description of the covered employee's medical condition and prognosis.
- A list of the nursing services required.
- A description of the level of skill or qualifications of the nurse necessary to perform the required services.
- The number of hours of care required on a daily or weekly basis.
- An estimate of the length of time that nursing care will be required.

PARAMEDICAL PRACTITIONERS

Health-care plans cover the charges for treatments provided by paramedical practitioners. The types of practitioners covered include:

- Physiotherapists.
- Chiropractors.
- Osteopaths.
- Naturopaths.
- Podiatrists.
- Chiropodists.
- Psychologists.
- Speech therapists.
- Massage therapists.
- Acupuncturists.
- Christian Science healers.

Coverage of treatment by certain paramedical practitioners is contingent on the treatment being medically necessary and requires the recommendation or approval of a physician. Coverage of some of these practitioners is included in the group health-care plans to give an array of benefits to those who seek alternative or supplementary medical care. Benefits are limited to a maximum dollar amount annually per practitioner.

A number of provinces provide coverage for some of these paramedical practitioners. Some allow insurance plans to top up their coverage, allowing extra billing. Others will not allow extra billing but will allow the private plans to insure the benefits after the provincial health-care plan reaches its maximum. The insurance companies provide the option of either insuring the extra billing (the more expensive option) or insuring after the provincial plan reaches its maximum.

OUT-OF-PROVINCE/OUT-OF-COUNTRY BENEFITS

Charges incurred for medical care and other related expenses while travelling outside the home province are covered under the out-of-province/country benefits in claimant's group health-care plan.

Out-of-province emergency health-care services provided under provincial health insurance plans have been subject to cuts. Many health-care plans have absorbed higher costs for out-of-province/country benefits by topping up existing provincial health insurance coverage.

Virtually all health-care plans include a provision that pays benefits for out-of-province/country emergency medical expenses if:

- Treatment is required due to a medical emergency that occurred while the covered person was travelling.
- The covered person is a resident under the provincial health insurance plan.

Coverage will include:

- Treatment provided by a physician.
- Diagnostic X-rays and laboratory test.
- Hospital accommodation.
- Medical and paramedical supplies and services provided during hospitalization.
- Hospital and nursing services and medical supplies provided on an outpatient basis.

If a covered person could return to Canada but does not, benefits will be paid for the amount it would have cost for comparable treatment in Canada.

Coverage for emergency medical services in a province other than the person's province of residence will be paid for through one of the reciprocal agreements among the provinces.

REASONABLE AND CUSTOMARY CHARGES

Group health-care plans commonly pay for eligible health-care services on the basis that a treatment or procedure is provided at a reasonable and customary charge. What is considered a "reasonable and customary charge" for a specified treatment is normally left to the insurance company's discretion. Reasonable and customary charges fall within the range of fees normally charged in a geographic location for a given service, treatment or procedure and performed by eligible health-care professionals who have suitable education and experience.

Insurance companies usually define a reasonable and customary charge to be the lowest of:

- A price that is common in the area where the treatment was provided.
- A price published in a fee guide for a given professional association.
- The maximum price established by law.

TRAVEL ASSISTANCE

Under a travel assistant program, a covered person travels with a service provider's identification card, which lists a contact phone number. In the event of an illness or injury, the person contacts the service provider, whose representative assesses the person's medical condition and then arranges for the appropriate treatment.

Many health-care plans include a travel assistance program through a provider network that offers the following services:

- A 24-hour emergency telephone line, listed on the provider's card.
- Assistance in locating the most appropriate medical facility.
- Guaranteed deposit/payment for emergency medical treatment.
- Arrangement for admission to a hospital.
- Contact with the person's physician to elicit advice and recommendations.
- Assistance in co-ordinating a necessary emergency medical evaluation.
- Arrangement of a return trip home for the covered person and/or dependent children left unattended on the trip.
- Arrangement for a family member to visit a covered person travelling alone and hospitalized for a minimum period of time.
- Meals and accommodation for the visiting family member, to a maximum, for example \$150 a day up to seven days.
- Repatriation of the remains of a covered person who dies while away from home, to a maximum of \$3,000.
- Return of a vehicle either back to a rental agency or back to the province of residence, to a maximum cost of \$500.

VISION CARE

The expense usually covered by vision-care benefits are those for eyeglasses, which includes frames and lenses and contact lenses. Safety glasses and prescription sunglasses are sometimes included.

The benefit amount payable is limited to a specified maximum ranging from \$150 to \$350 and up. Frequency of use is limited to a stated period of time, typically 24 months. Since these limits effectively control claims costs, vision-care benefits are not subject to the deductible or co-insurance feature.

HEARING AIDS

Unlike other benefits under the health-care plan, this is one where the benefit maximum is imposed over a longer period of time, usually five years. The dollar maximum (typically \$500) covers only one set of hearing aids over that period.

ACCIDENTAL DENTAL

Health-care plans also provide coverage of the expenses for dental treatment when an employee's healthy, natural teeth have been injured in an accident. The plan will provide more generous coverage for accidental dental benefits than is provided under the dental-care plan.

Accidental dental coverage will pay expenses for treatment required due to an accident and provided by a dentist in his or her dental office and if:

- The accident occurred while the employee is covered under the plan.
- Barring any medical conditions that postpone treatment, treatment starts within a specified period after the accident, usually 12 months.
- Treatment is applied to an injured tooth or teeth that did not require any restoration treatment before the accident.

If dental treatment is required after the accident, but does not meet these requirements, then it would be considered for payment under the provisions of the employee's dental-care plan, if one exists.

MEDICAL SUPPLIES AND SERVICES

Group health-care plans provide benefits for medical supplies and services to assist covered persons recovering from and living with an illness or sickness. Similar to vision care, benefits for equipment and devices are often limited to a maximum amount payable per covered person for a limited period. For example, a maximum benefit amount of \$200 for orthopedic shoes is payable once in every period of 12 consecutive months.

Items covered are often contingent on the recommendation and approval of an attending physician and may include the purchase or rental of:

- Orthopedic equipment such as orthopaedic shoes that are custom built to correct a physical impairment, splints, braces and cervical collars.
- Mobility aids such as canes, walkers crutches, trusses and wheelchairs.
- Respiratory equipment such as oxygen and the equipment needed for its administration.
- Kidney dialysis equipment.
- Prosthetic equipment including artificial eyes, standard artificial limbs external breast prosthesis.
- Other medical supplies, such as hospital beds, catheters, hypodermic needles or a wig required for permanent hair loss as a result of any injury or disease or for temporary hair loss as a result of medical treatment for any disease.
- Oxygen blood, blood products and their transfusion.

It is also important to note that the type of device eligible for coverage is normally limited as well. For example, special wheelchairs, versus standard wheelchairs, may be covered by a plan, if the special wheelchair is necessary to enable a covered employee to function independently in daily living. However, special wheelchairs that are required primarily for participation in sports would not be covered. Equipment for personal comfort, convenience, exercise, safety, self-help or environmental control items, or items used for reasons other than medical, are excluded. For this reason, insurance companies recommend that covered persons contact them prior to purchasing or renting any medical equipment or supplies, in order to determine whether or not such items are covered under the plan.

Deductibles and co-insurance

The deductible and co-insurance features in the group health-care plan are very common as employers attempt to share costs with employees. These features also aim to inhibit unnecessary use of plan benefits and the submission of claims for very small amounts.

DEDUCTIBLES

A deductible is an amount of eligible health-care expenses a covered person must incur before any reimbursement is payable for the eligible expenses in excess of that deductible.

The deductible comes in two forms:

- A calendar year deductible.
- A per prescription deductible.

CO-INSURANCE

Co-insurance is the percentage of eligible expenses above the deductible that is eligible for reimbursement.

MAXIMUMS

Health-care plans will pay a specified maximum amount of benefits for an eligible employee and each of their dependants. Benefit maximums define the maximum amount of benefits that may be paid on behalf of any one eligible person covered by the plan.

There are two types of benefit maximums:

- **Overall:** All plans have an overall maximum, even if the stated maximum is “unlimited.” Overall maximums of \$5,000,000 are common but some old contracts may still have an overall maximum of \$1,000,000.
- **Internal:** Internal limits are benefits maximums that may be applicable annually, or every two years, or that may be applicable over the eligible person’s lifetime, depending on the type of expense. Each internal limit is applied separately to a specific benefit. These are designed to protect the health-care plan by discouraging abuse of use or disregard for the cost of benefits. For example, vision-care benefits are normally subject to a two-year maximum, out-of-country coverage is subject to a lifetime maximum and hearing aids are subject to a five-year maximum.

Limitations and exclusions

Group health-care plans are integrated with hospitalization and other medical services and supplies covered under provincial health-care plans and do not pay for benefits relating to claims covered under Workers’ Compensation.

While the situations in which benefits are not payable vary from one health plan to another, such plans typically incorporate exclusions stipulating that no benefit will be paid:

- If any such payment is prohibited by law.
- For any services or supplies that a covered person may obtain as a benefit under any provincial health insurance plan.
- For any services or supplies for which no charge would have been levied in the absence of coverage.
- For any services and supplies associated with a covered item but not specifically listed as eligible for coverage in the contract.
- For services and supplies received outside of Canada, except for those that are covered and provided under the out-of-country provision included in the group contract.
- For expenses resulting from intentional self-inflicted injury.
- For expenses resulting from the commission of a criminal act by the covered individual.
- For expenses resulting from voluntary participation in a war, insurrection or riot.
- For expenses resulting from injuries suffered while serving in the armed forces.
- For experimental drugs and medical procedures or treatments.

PRE-EXISTING CONDITION

A pre-existing condition clause may exclude or limit any amount payable relating to a condition that existed prior to the start of the coverage.

Example: The insured received medical treatment, consultation, care or services including diagnostic measures; or took prescribed drugs or medicine in the three months just prior to the effective date of coverage; or had symptoms for which an ordinarily prudent person would have consulted a health-care provider in the three months just prior to the effective date of coverage; and the disability begins in the first 12 months after the effective date of coverage.

Dental plans will have a list of covered expenses and those that are not covered. As well certain treatments may be covered to a maximum amount only. For example a dental plan might not cover the installation of crowns or it might limit the amount the plan will pay for any procedure in which the dentist installs a crown.

DENTAL CARE

Although dental health has significantly improved, dental-care costs continue to escalate. Some of the increase is attributable to inflation, but increased use and the introduction of new services are factors that have contributed significantly to the total increase.

Features of group dental plans

The type and scope of dental-care service covered under a dental-care plan vary somewhat from one plan to the next; however, dental-care services are generally grouped into three major categories:

- **Basic services:** Encompasses coverage for diagnostic and preventive treatments, such as cleanings, fillings and tooth extractions.
- **Major restorative services:** Provides coverage for diagnostic and preventive treatments, such as cleanings, fillings and tooth extractions.
- **Orthodontic services:** Provides coverage for procedures and appliances, such as braces required to straighten teeth and correct other defects.

COVERED DENTAL EXPENSES

Basic services:

- Diagnostic procedures:
 - Dental exams to evaluate a patient's condition as well as to determine any necessary future treatment, such as a complete oral examination or a limited oral examination (commonly known as a "recall exam").
 - X-rays.
 - Laboratory reports.
- Preventive procedures:
 - Cleaning, including polishing and light scaling of the teeth.
 - Topical application of fluoride and sealants on the teeth.
 - Oral hygiene instruction and other preventive procedures.

- Dental surgery required for reasons other than an accidental injury (if covered in the group health-care plan) including the surgical removal of impacted teeth.
- Minor restorative treatment designed to restore the functional use of natural teeth with the use of such artificial appliances as silver and tooth-coloured amalgams (fillings).
- Repair to natural teeth required due to damage from causes such as wear and decay.
- Periodontic services to treat bones and gum around the tooth, including deep scaling of the tooth and periodontal appliance, such as night guards to control the clenching and grinding of teeth at night.
- Endodontic services to treat the root and nerve (known as the dental pulp) of the natural tooth, such as root canal therapy.
- In some group contracts, relining, rebasing and repairing of dentures, crown or bridgework.

Major restorative services

- Major restorative procedures to restore the normal functioning of the natural tooth with such artificial appliances as gold or porcelain crowns and inlays and onlays.
- Prosthodontic services designed to replace missing teeth and structure with:
 - Removable appliances such as full or partial dentures.
 - Non-removal or fixed appliances such as bridgework, crowns (caps) and veneers.

Orthodontic services

- Orthodontic procedures required for the prevention, diagnosis and correction of dental and oral irregularities and defects of the jaws through the use of corrective devices, such as wires, tooth bonding, braces, space maintainers or other mechanical aids used to reposition teeth, commonly known as straightening of the teeth.

BENEFIT LIMITS

Dental care benefits are subject to limits. Some standard limitations within dental-care plans are:

Benefit maximums

The majority of dental-care plans include overall benefit maximums that limit the amount that the plan pays for each covered person. The maximum can range up to:

- Unlimited, for basic services.
- \$2,000 a year, for major restorative services.
- \$2,000 a lifetime, for orthodontic services.

Age limitations

The standard orthodontic plan covers dependants up to age 19. Adult orthodontic plans are growing in popularity as many adults are taking advantage of orthodontic services that were unavailable to them as children. Because of the added exposure to claims by covering adults, adult orthodontic plans are more expensive than strictly dependant coverage. Plans also limit the eligibility for certain services, such as topical application of fluoride and pit and fissure sealants to dependent children under a specified age, usually 19. These limits are based on studies that have shown these dental-care procedures to be effective only up to certain ages.

Frequency limitations

Recall exams and the services associated with routine checkups, cleaning, scaling and X-rays have historically been eligible for coverage under a dental-care plan once every six months. However, the current trend is to extend the required minimum interval between recall exams to nine or 12 months.

Replacement limitations

Major restorative services are expensive and, as such, employers tend to impose limitations on the replacement frequency of specific prosthodontics in an attempt to control costs. For example, existing dentures, crowns or bridgework may not be replaced unless they are at least five years old or beyond repair. Furthermore, replacement of temporary dentures with permanent dentures is covered only if done within a specified period of time, such as one year.

DEDUCTIBLES AND CO-INSURANCE

Deductibles and co-insurance provisions are traditional cost-containment tools utilizing the concept of cost sharing between the employer and the employees.

Most dental-care plans have a deductible in the form of a calendar year deductible, which is a fixed dollar amount of covered expenses that the covered person must pay each year before the plan pays any benefits. The deductible for single coverage often represents a minimal amount, such as \$25. Similar to group health-care plans, family limits apply that limit the amount of deductibles that must be satisfied per person if the family has more than one dependant. In our example of a \$25 per person deductible, there is a family limit of two times the deductible, or \$50 per family.

It is common for dental-care plans to have different levels of coverage, or co-insurance, for the three levels of benefits:

- Basic services 80% to 100%
- Major restorative 50% to 80%
- Orthodontic 50%

FEE GUIDES

The benefit amount a dental-care plan pays for a given procedure can be determined based on the fee guide in effect in the jurisdiction in which the covered person resides. The dental-care plan will reimburse and expense for a given procedure based on the fee commonly charged for the procedure by eligible dental-care practitioners within a given geographical region.

The maximum amount that will be payable for a given procedure is the amount listed in the suggested fee guide for the applicable year. Fees for specialists are generally 10% to 20% higher than fees charged for the same procedures by general practitioners.

The use of provincial fee guides in dental-care plans can be categorized into three general bases:

- **Current fee guide:** Plans base any reimbursement on the fee guide of the current year, or the current fee guide. Reimbursement on this basis is automatically updated annually as the new fee guides are released by the provinces.
- **Fixed fee guide:** Plans base reimbursement on a fee guide of a particular year, so that reimbursement remains the same annually, until the employer chooses to amend the plan. For example, all dental fees will be paid at the 2007 fee guide level until the fee guide is changed by the employer.

- **Year lag basis:** Plans provide a level of reimbursement for services in a given year that lags behind current fee guides by a year or two – the one/two year lag basis. For example, a plan may provide benefit amounts based on a one-year lag basis so that reimbursement in 2007 is based on the 2006 fee guide.

PREDETERMINATION OF BENEFITS

Dental care plans in general include a provision that provides for a pre-treatment review by the insurer of any dental-care expenses likely to cost more than a predetermined dollar amount. This provision allows the insurer to review, assess and validate the necessity of the proposed dental treatment prior to the dental-care procedures being performed. Use of the provision also ensures that the employee know prior to undergoing the treatment just how much of the cost will be reimbursed by the plan and how much out-of-pocket expense will be required.

A predetermination of benefits provision is recommended for costly non-emergency treatment expected to exceed a specified amount, usually \$300 to \$500.

ALTERNATIVE BENEFIT

The alternative benefit provision allows insurers to substitute the cost of more expensive services with less expensive services, if they feel that the latter can produce a professionally adequate result. For example, some dental consultants feel that white fillings do not possess the same abrasion, compressive tensile and strength as amalgam and are more expensive. In some plans, if an employee chooses to have white fillings on molars, reimbursement may be cut to the cost of amalgam fillings, in accordance with the alternative benefit provision.

EXCLUSIONS

Many of the exclusions contained in health-care plans are also contained in dental-care plans. The following are some of the most common exclusions:

- Services or supplies that are primarily for cosmetic purposes, unless required due to an accident occurring while an employee or dependant was covered.
- Services or supplies that are not provided by a legally qualified dentist or denturist acting within the scope of their licenses, with the exception of X-rays ordered from such individuals by a dentist or services or supplies furnished by a dental hygienist under the supervision of a dentist.

- Services or supplies that are required as a result of an accidental injury to natural teeth and fully covered under a group health-care plan.
- Experimental dental treatments.
- Replacement of lost or stolen prosthodontic artificial appliances and devices such as dentures and duplicate appliances.
- Certain services relating to treatment that began prior to the date that coverage for an individual became effective for example, implanting teeth to an existing partial bridgework is not covered if the implant replaces a tooth removed before the employee was covered under the plan.
- Any service or supplies covered by any government sponsored benefits program, such as Workers' Compensation
- Services or supplies for implantology, which can include tooth implantation, tooth transplantation and fabricated implants surgically inserted.
- Dental exams required by a third party.
- Miscellaneous items such as travel, counselling, communication costs, broken appointments and the completion of forms.

A typical group health and dental plan

The employer, as the policyholder, makes the final decisions in designing the group health and dental plan. In doing so, it works with two partners: the broker (who advises the employer) and the insurer (who provides the benefits and outlines the parameters of the benefits that it will underwrite). There are a number of areas to consider in designing such a plan and decisions to be made in each area as to what best suits the employee group and what can be afforded.

The main areas to be considered and common choices many employers would select:

GROUP HEALTH BENEFITS PLAN

Area of choice	Typical group plan choices
Drug plan	<ul style="list-style-type: none"> • Pay-direct drug card • \$5 deductible per-prescription • Generic drug option
Hospitalization	<ul style="list-style-type: none"> • Semi-private • No deductible • Maximum \$150 a day, 90 days hospitalization
Extended benefits	<ul style="list-style-type: none"> • Deductible: Single \$25, Family \$50 • Co-insurance: 90%
Paramedical benefits	\$300/year maximum per practitioner
Vision care	Maximum \$250/ two years

GROUP DENTAL BENEFITS PLAN

Area of choice	Typical group plan choices
Dental care plan	Deductible: Single \$25, Family \$50
Basic services	<ul style="list-style-type: none"> • Co-insurance: 100% • Maximum: Unlimited • Includes periodontal and endodontic services
Major restorative	<ul style="list-style-type: none"> • Co-insurance: 60% • Maximum: \$1,500/year
Orthodontic	<ul style="list-style-type: none"> • Co-insurance: 50%
<ul style="list-style-type: none"> • Maximum: \$2,000 lifetime 	

EMPLOYEE ASSISTANCE PROGRAMS

The increasing professional and personal demands of modern-day living have given rise to non-traditional employee benefits, such as “employee assistance” and “wellness” programs, designed to address employee health and well-being. The concept behind both is that a happier and healthier employee is more productive and less likely to use disability and health-care benefits.

At any given moment, about one in five employees in an organization suffers from too much stress in dealing with personal problems, which can affect job performance – unless some sort of intervention takes place. One such means of intervention is the employee assistance program (EAP).

There are many employers who still restrict their benefits plans to traditional group benefits. However, in a recent survey on employee benefits costs in Canada, it was found that approximately 34% of employees and their family members were provided with access to EAPs.

Troubled employees are prone to increased absenteeism and reduced productivity and they also have more serious on-the-job accidents. This, in turn, drives up the costs of health and disability benefits, lowers employee morale since co-workers are forced to pick up the slack and increase staff turnover, which has a negative impact on the employer’s bottom line.

Alternatively, an employee who uses an EAP may be able to bring job performance back into line. In addition, use of an EAP prevents a covered person’s physical and mental condition from deteriorating to the point where they have to claim for health-care benefits and short-term or long-term disability benefits. An EAP is no longer viewed as a fringe benefit, but has become a major component within a comprehensive program to control benefit expenditures and to improve employee health. Confidence in the efficacy of EAPs is so strong that some insurance companies offer discounted long-term disability rates to employers who offer EAPs.

Fundamentals of an EAP

An EAP is a program of systematic interventions in the workplace designed to:

- Promote health in the workplace, using a wide range of health promotion strategies aimed at employees who have little risk of personal problems affecting their job performance.
- Provide covered persons who are just beginning to experience personal difficulties with some means to voluntarily access needed care or assistance.
- Provide employers with an alternate option to the organization's normal disciplinary procedures for dealing with employees whose job performance is at an unacceptable level due to a serious problem and who may be unwilling, or unable, to take advantage of preventive resources.

EAPs assist the employer, the employee and the employee's dependants. They can be accessed voluntarily by the employees dealing with problems that have not yet affected job performance. As well, an EAP provides employers with an alternative to solving job performance problems and could save otherwise productive and talented employees.

As the following statistics illustrate, it makes good business sense to provide EAPs:

- An estimated 10% to 20% of Canadian workers abuse alcohol and drugs, which creates problems that cost business between one billion and three billion dollars each year.
- Emotional problems account for 20% to 30% of employee absenteeism and up to 50% of industrial accidents.

An EAP can be provided in one of two ways:

- Large employers may develop their own EAP, providing an on-site program through its human resources or occupational health and safety department.
- Other employers consider it more cost-effective to implement an off-site EAP. With the specialty providers and health-care networks developing EAPs, off-site programs can adequately service employers by offering access to a wide range of services without the employer having to absorb start up and overhead costs.

Wellness programs

An increasingly popular addition to EAPs are wellness programs that aim to educate workers about controllable lifestyle health risks and to promote health and fitness through programs focusing on fitness and exercise, nutrition and weight management, smoking cessation and stress management.

Plan design

Four basic types of services should be included in an EAP:

- Crisis intervention, which includes 24-hour toll free hotlines 365 days a year and telephone counselling services, drop-in centres and self-help groups, such as Alcoholics Anonymous.
- Outpatient services, which include assessment, diagnosis, information, education and ongoing treatment for a variety of problems most likely to arise in a particular workplace. Services include counselling on marital and mental health problems and alcohol and drug dependencies.
- In-patient services, which provide intensive treatment for employees with sever problems. Treatment is provided to stabilize the problem until long-term help can be put into place.
- Self-help groups, which each focus on a specific problem and which are set up and operated by individuals who have overcome a similar problem to provide ongoing support in coping with problems such as alcoholism an divorce. Self-help groups should not replace needed professional treatment.

There are a broad number of categories of problems that are open to treatment under an EAP, such as:

- Marital problems
- Mental health problems
- Alcohol and drug dependency
- Personal and emotional concerns
- Single-parent issues
- Elder-care issues
- Stress and anxiety
- Poor personal or work relationships
- Financial issues
- Legal issues
- Trauma response services

Formalizing and publishing policies and procedures are essential for the success of an EAP as they clarify both the responsibilities of the employees and the employer. A comprehensive document should include:

- **Mission statement:** At the very inception of an EAP, it should be well communicated that the program is designed to assist employees with problems affecting their job performance, but that the employee is still responsible to perform at an acceptable level. Employees must understand that the use of an EAP will not shield them from disciplinary action, where required, nor will use of an EAP hurt their job security or chances for promotion.
- **Statement of confidentiality:** This is essential at every stage in the use of an EAP. No one other than those involved with the assisting the employee should be made aware of the employee's problem.
- **Referral provisions:** Most EAPs are based on either voluntary referrals, where the employee contacts the EAP on their own, or on "assisted referrals," where a colleague, supervisor or other concerned individual encourages the employee to use the EAP.
- **Explanation of services:** This is required in order to clarify what the employees may expect in terms of services available under the program.

When an insurer underwrites an EAP, the program's services are paid for by monthly premium payments that are usually experience-rated, in which the premium rate is based on the utilization of the plan. The premium rate is adjusted on a yearly basis, depending on whether the program's use is above or below expected levels. This type of EAP can be administered by the insurer itself, the employer, but is most often supplied by a specialty provider.

CONFIDENTIALITY

Perhaps, the most important feature of an EAP is confidentiality. Not even the most comprehensive EAP will attract employees if there is any indication that an employee's problems and the services they will use will not be kept confidential. Few employees, if any, will use an EAP if there is fear of reprisals or an invasion of privacy. Without confidentiality, the EAP will lose credibility and will not be viable. It must be clear that:

- The names of employees are not released to the employer.
- Every aspect of the referral process is conducted by professionals bound by confidentiality rules.
- Any information about the employee's progress under treatment is governed by legislation protecting an individual's right to privacy and that allows release of information only with the employee's consent.
- Information that is released to an employer is strictly statistical program utilization data, such as the age of plan users, the services used, the frequency of usage, the number of cases resolved and the types of personal problems for which assistance is sought.

Effective programs formalize their policies and publish them, communicate them to employees, while demanding that the EAP staffs strictly follow confidentiality procedures.

The delivery of the key components of EAP is instrumental in the success of any program. These are:

- Confidentiality
- Availability (24-7-365).
- Accessibility (toll-free-service).