Manion Magazine

VOLUME 1 ISSUE 3
JULY 2014

Inside This Issue

Canada's Anti-Spam Legislation Guidelines

With the passing of Canada Day comes Canada's new anti-spam legislation (CASL). This new law will impact how we communicate with potential and existing clients and outlines the requirements relating to commercial electronic messages (CEMs).

If the CEM includes any component that offers to purchase or sell a product, advertises services or products, or advises of a business or investment opportunity, it has a commercial component and is affected by this law.

Every CEM must include an option for the recipient to "unsubscribe" to future CEMs from the sender.

There are certain exemptions under CASL. For example, the following messages are not subject to CASL even if they include a commercial component:

- Messages in response to a request, an inquiry or that were solicited;
- Messages between employees of two organizations that have a relationship (if the emails concern the business of the recipient organization);
- Messages sent to satisfy a legal obligation;
- Messages sent by individuals to individuals with whom they have a personal or family relationship as defined by CASL

Penalties for non-compliance can be quite significant and we encourage all our clients to familiarize themselves with the law. Further information can be found a www.fightspam.ca.

MANION

Expanded GST/HST Exemptions for Certain Services and Supplies

Included in the 2014 Federal Budget were a number of measures relevant to benefit plans, including the expansion of GST/HST exemptions for the following items:

- Training Services designed to help individuals cope with a disability or disorder
- Professional Services provided by naturopathic doctors and acupuncturists
- Specialized Eyewear, if prescribed by specified health professionals (including physicians) that is designed to electronically enhance the vision of those with visual impairments.

These exemptions are likely to ease private benefit plan costs slightly. The above noted changes will apply to services provided or products made after February 11, 2014.

Voluntary Benefits – Demand in Canada is Growing

There has always been a larger demand for voluntary benefits in the U.S. but this demand is growing in Canada. Voluntary benefits are additional insurance that an employer can offer that are paid for by the employees. Typically, these would include *optional life*, *critical illness*, *travel insurance* and *healthcare spending accounts*. The increasing interest is due in part to the fact that employees value benefits tailored to their unique needs.

With the launch of our Personal Financial Consulting department as well as the anticipated launch of **Manion's** new Health Spending Account offering in the fall of 2014, we are positioned well to satisfy this growing demand. **Manion** is now in the testing phase for their new Health Spending Account offering. This option provides huge advantages to both the provider and the insured by drastically reducing the incidence of fraud and providing flexibility for the insured's healthcare requirements.

Medical Marijuana…What is the Potential Impact on Benefit Plans?

The use of medical marijuana has exploded since 2001 when Canadians were first able to legally acquire it for HIV/AIDS and a handful of other conditions. As of 2014 the number of users of medical marijuana has grown to approximately 40,000. According to Health Canada, this is expected to increase tenfold in the next decade. While plan sponsors have not paid much attention to this in the past, with the anticipated growth in usage, consideration should be given to the potential impact on their benefit plans.

- Will medical marijuana be covered at all under third party plans if prescribed by a licensed physician? If so, for what disease states/uses, or will there be any controls over what it's allowed to be used to treat?
- Since medical marijuana will not have a drug identification number (DIN) because the product cannot be regulated and controlled by Health Canada, how will it be handled in private plans? Will plan administrators issue product identification numbers (PINs)?
- Will PINs be issued for all licensed growers or just those who have been validated by various third-party payers?

- Will PINs be issued for all strains produced by a licensed grower or just specific strains?
- Will healthcare spending accounts cover medical marijuana from any licensed grower?
- Will plans cap what they will pay? Will there be a step-therapy process or prior authorization protocol implemented?

How Much is Enough to Cover Health Care Bills in Retirement?

Many Canadians forget to consider how much it will cost to cover their health care expenses when they are saving for retirement. The so-called "replacement ratio" that has been bandied about is not realistic in many instances. To retire comfortably financial advisors will recommend saving enough so you can have an income between 50 and 70 per cent or more of your pre-retirement income.

It's common knowledge that we are living longer however not necessarily are we living healthier. Many of us spend little on health care costs during our working years particularly if we have a benefits program through our employer. However, only about half of employers in Canada provide a retirement health plan to their employees with many requiring the retiree to self-pay for that coverage.

Health issues often become more prevalent as we age and consideration should be given to how much we can expect to pay for health care once retired. According to Ellen Whelan, an actuary and principal at *Eckler Ltd*., the cost could be between $1,500 and $3,000 per person per year. Multiply this by the number of years in retirement – say 30 years – and you're looking at $90,000 on average.

Add that amount to the so-called 50 to 70 per cent and a more reasonable number to consider is 75 to 80 per cent.

Old Age Security Pension and Benefits – Increase July to September 2014

OAS benefit amounts are reviewed quarterly and revised to reflect increases in the cost of living, as measured by the consumer price index (CPI) set by Statistics Canada. The *Old Age Security Act* guarantees that OAS benefits do not go down even if there is a decrease in the CPI.

The quarterly benefit amounts for OAS for July to September 2014 will be increasing from $551.54 per month to $558.71 per month.

Quebec's Publicly Funded Drug Plan Leads in Access

Results of a recent study done by the Canadian Health Policy Institute, shows that Quebec's publicly funded drug plan provides the best access to new drugs among all public drug plans in Canada. Researchers found that the quality of insured access to new drugs varies significantly between the various provincial public drug plans. Quebec and Ontario had the best coverage rates (publicly insuring the highest number of available new drugs). Manitoba, Alberta, BC and the federal National Indian Health Board (NIHB) had the lowest coverage rates for new drugs.

Quebec also had the shortest delays to listing new drugs for reimbursement on its public drug plan, while New Brunswick, PEI and Ontario had the longest delay.

Manion Responds to Ontario Pension Regulatory Proposal

On April 25, 2014, the Government of Ontario released four proposals in respect of proposed amendments to Regulation 909 under the Pension Benefits Act (PBA) and sought comments from interested pension plan sponsors, unions as well as other stakeholders.

The proposals relate to PBA reforms introduced and announced by the Government of Ontario over the past four years. The proposals included the following:

- Requiring periodic statements to be provided to former members and retired members;
- New rules regarding Statements of Investment Policies and Procedures (SIPPs);
- Permitting variable benefits to be paid directly from Defined Contribution (DC) plans; and
- Updating references to Accounting Standards in the regulations.

Requiring periodic statements to be provided to former members and retired members

On June 16, 2014, **Manion** submitted our commentary to the Government of Ontario concerning the initial implementation schedule and specifics required for disclosures for marriage breakdown liabilities on the statements.

We believe there may be some practical difficulties in providing some of the required information to former members and retired members. Hopefully the regulations will be amenable so that where this information is not readily available the plan administrator will not be in contravention of the PBA for not including it on the annual statements.

New rules regarding Statements of Investment Policies and Procedures (SIPPs)

The Investment Consultants and Investment Managers have sent their commentary and to date, we have not been advised of any concerns regarding changes in the regulations related to the SIPP as tabled by the Financial Services Commission of Ontario (FSCO).

Permitting variable benefits to be paid directly from Defined Contribution (DC) plans

Having reviewed this proposal, we have no concern with respect to the terms of the proposal. However, if it were approved, we would not suggest this change to our current DC clients. Currently, the DC plans provide benefits through transfers to registered retirement vehicles including LIFs and annuity purchases. If a DC client was to amend their plan text to provide retirement income from the trust fund on an ongoing basis, administration, audit and custodial costs would increase as a payroll system would have to be developed and additional accounting and financial reporting would be required year over year. The DC clients who want to provide this flexibility can amend their pension plan to provide the LIF option at retirement.

Updating references to Accounting Standards in the regulations

The Trust Fund auditors have already incorporated the majority of the changes and have voiced no concerns regarding this proposal.

A Word On Health Care Fraud

Fraud really does matter. Canadian businesses lose billions of dollars annually to healthcare fraud and abuse. Fraud and abuse results in not only higher insurance premiums and reduced benefits but can ultimately impact the health of plan members and their dependents. Most medical and dental providers are honest and work hard to improve their patients' health. However, a few are only looking for financial gains and any opportunity to increase revenue.

Billing Fraud

There is extensive "User" fraud associated with:

- *Forging receipts which can sometimes be accessed from a Provider Office or created electronically. With today's technology it is fairly simple to produce a "fraudulent document"*
- *Changing the dollar value on existing receipts*
- *Submitting duplicate claims that often get reprocessed through the system*
- *Allowing ineligible individuals (family/friends) to use their drug card as the user is not policed at the pharmacy level*

Plan sponsors need to preserve their Benefit Plans from "Providers" who:

- *Provide and Bill for services that are not medically necessary*
- *Receive "kickbacks" from the manufacturer*
- *Consistently invoice "inappropriately" for the services provided to patients*
- *Submit codes for more enhanced services than those actually provided to the patient*

Insurers incur the costs of professional training for staff, updating their system to identify suspicious trends and subscribing to associations that keep them abreast of industry tracking on fraud. Additional expenses are often incurred related to maintaining claims turnaround times while assessing the claims for potential fraudulent activity. Time requirements are also increased by the need to check provider watch lists and review claims for potential "altering" of the receipts as well as identifying claimants' changing claims patterns; an increase in a particular area of claims or in claims originating from a specific provider or clinic. This requires additional time commitments and investigation by the adjudicator. All these processes need to be factored in to the cost of doing business.

Employers/Benefit Providers must take on the role of educator when it comes to employees and their benefits.

Plan Design can help an Employer and their Employees to better manage their benefits. The Employee has more control over the types of treatment they can access and the providers they can use. By utilizing some of the following measures, they often realize plan savings and increased plan viability.

- Combined Maximums for such things as paramedical providers
    - Per person or per family

- Implementation of a Health Spending Account
    - This places the responsibility for benefit spending in the hands of the employee who will be informed of his remaining balance after each claim is paid
    - Allows more flexibility in the ways an employee wishes to use their benefit dollars

False Referrals

In today's environment, most people trust their practitioner to give them good advice and most do. There are however some who, in collusion with other providers of medical equipment, services or devices, are prescribing unnecessary equipment/supplies.

In many cases, Employees are oblivious to the impact of these costs to their Employer's bottom line. It is important that Clients clearly explain to their employees how increased benefit costs impact the Company's costs and hence the Company's profitability. This in turn can result in reduced benefits and/or increased payroll deductions. The Employee needs to feel some ownership for their benefit package and the costs that are incurred.

Pre-Signed Claim Forms

Your employees/members should never pre-sign claim forms for a provider to hold for future appointments. When a claim form is signed it should be completely filled out with the date of service, a description of the services provided and the cost for each service. The insured should feel comfortable asking for clarification of any information it contains. After the appointment if they are still unclear and have questions that the medical/dental provider cannot answer, your insurance provider might also be a resource for this information. Your member/employees should always review their healthcare insurance claims history from time to time. Most providers offer an online service where members can view their individual and dependent's claim activity as well as monitor direct deposits and payments to service providers. Members should be reminded to keep personal information confidential and never share drug card, ID or certificate numbers.

Valuable or Free Rewards

Getting something for free is a great motivator for where you do your shopping. A free pair of shoes with your orthotics or some free massage therapy sessions would be attractive to many individuals.

Your members should be aware of these get rich quick schemes and valuable or free reward offers. If there is pressure to make a big purchase decision immediately, it is likely too good to be true. The service being provided must be medically necessary and not purchased solely for the free item or reward associated with it. Because the claimant is somewhat removed from the employer/plan sponsor on these transactions, they do not take on the responsibility for any wrongdoing.

To be clear, when a plan is abused the ultimate costs to the employer go up and in turn the member will see increased monthly premiums and payroll deductions and/or a reduction in actual benefit coverage. It is in the employer's best interest to clearly explain this to employees.

Non-insured Services

Be aware that beauty treatments, running shoes and non-prescription sunglasses are not covered by health insurance plans and substitution of these products or services for receipts for services that are covered by your plan is fraudulent activity. The beauty industry is very competitive. Service providers will offer to "massage" receipts in order to cover pricey treatments otherwise not insurable. In these situations it is almost impossible for insurers

to detect fraudulent activity. For all intents and purposes the receipts appear legitimate. In these situations the insurers rely on the tips received through associations such the Canadian Health Care Anti-fraud Association (www.chcaa.org) or the Insurance Bureau of Canada (www.ibc.ca).

As a consumer your responsibility is to be aware of what is being billed to the insurance provider and that you have received and paid for the covered service or treatment being billed. *Always report fraudulent activity*.

What Can We Do?

Part of the solution is to foster employee engagement and understanding of their plan. Providing education and information relative to their coverage and the implications of claim misuse can lead to a feeling of ownership versus entitlement for their benefits and how they are used. The penalties associated with fraudulent claim activity should be clearly defined and supported by the Plan Sponsor/Employer. Don't ignore tips provided by employees/members and don't hesitate to make an example of the employee whose fraudulent claims are detected and confirmed.

It's challenging to engage employees in these tough economic times. However, the reality is most employees would prefer to pay higher premiums to maintain their benefits versus facing cutbacks or reductions. Involve your employees in the management of the health plan dollars; an example would be the implementation of a Healthcare Spending Account. This provides the employees with a specified amount which they can use for medical expenses as allowed under the CRA medical expense guidelines. It can be a plan that supplements an existing defined Benefit Plan or a standalone Healthcare Spending Account for a specified amount.

Your insurance provider should be able to supply you with some educational material to share with your employees. You may want to encourage the option of an "employee committee" to participate in a project to review the design and costs associated with their Plan. Such a committee helps to create overall awareness and buy in regarding the importance of maintaining a viable benefits plan.

Kimberley Keeler, Manager, Claims Department

Susan Brown, V. P., Claims and Member Services

Manion Wilkins & Associates Ltd.