Benefit Plan Management

Information on 2014 Health and Dental Trend Factors

The trend factors used by insurers for programs renewing in 2014 have not changed from the factors of a year ago, according to an informal survey of various insurance carriers conducted by GroupNews.

Trend factors assume that claims will increase each year due to inflation in the cost of medical goods and services, as well as utilization, erosion of deductibles, and the impact of newer and more expensive drugs and procedures. The double-digit trend for health care goods and services – led by drug claims as the biggest contributing factor – is the largest single factor affecting most group benefit programs. Overall trend factors for dental continue to be lower, as they reflect utilization and generally lower annual increases in dental fee guides.

The annual trend factors depend on plan design. The survey indicates that the range is currently 11.5%-13% per annum for health care and 5%-9% per annum for dental care. If an organization has a demonstrated lower credible annual trend, this could be taken into account in the setting of renewal rates. Although insurance companies seldom change their standard factors, concessions can be made on a case by case basis.

Update on 2014 Employment Insurance (EI) and Quebec Parental Insurance Plan (QPIP) Maximums

Further to the information provided in the September edition of GroupNews, the Canada Revenue Agency (CRA) has released the 2014 maximum employer and employee contributions for employers and employees outside and inside Quebec. The amounts for Quebec differ from those in the rest of Canada because of QPIP – the province’s own maternity, parental and adoption benefit plan. On December 3, 2013, Emploi et Solidarité sociale Québec released the final 2014 QPIP premiums and maximum insurable earnings.

The full 2014 EI and QPIP rate information is provided in the table below.

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Insurable Earnings</td>
<td>$47,400.00</td>
<td>$48,600.00</td>
</tr>
<tr>
<td>Premium Rate (per $100 of insurable earnings) – outside Quebec</td>
<td>$1.88</td>
<td>$1.88</td>
</tr>
<tr>
<td>• Maximum Contribution - Employers</td>
<td>$1,248.00</td>
<td>$1,279.15</td>
</tr>
<tr>
<td>• Maximum Contribution - Employees</td>
<td>$891.00</td>
<td>$913.68</td>
</tr>
<tr>
<td>Premium Rate (per $100 of insurable earnings) – in Quebec</td>
<td>$1.52</td>
<td>$1.53</td>
</tr>
<tr>
<td>• Maximum Contribution - Employers</td>
<td>$1,009.00</td>
<td>$1,041.01</td>
</tr>
<tr>
<td>• Maximum Contribution - Employees</td>
<td>$720.00</td>
<td>$743.58</td>
</tr>
</tbody>
</table>
New Brunswick: Catastrophic Drug Program Introduced

On December 10, 2013, the Prescription and Catastrophic Drug Insurance Act (Bill 27) was introduced in the New Brunswick Legislative Assembly. If Bill 27 is passed:

- Effective May 1, 2014, provincial residents will be able to access the New Brunswick Drug Plan (NBDP), a new, government-sponsored drug insurance plan funded by participants and the provincial government. The NBDP will not be subject to either medical underwriting or a waiting period. Additional information about the NBDP is provided below.
- Effective April 1, 2015, all provincial residents must be a member of either the NBDP or another plan providing comparable benefits. Private plans will be required to meet certain minimum coverage standards as of this date, including covering all drugs listed on the NBDP formulary.

The NBDP will be available to all provincial residents who have a valid New Brunswick Medicare card and who either:

- Do not have a prescription drug plan; or
- Have a prescription drug plan and have:
  a) reached their annual or lifetime drug coverage maximum, or
  b) need a specific drug that is on the NBDP formulary but not on their drug plan formulary (in these cases, coverage will only be provided for the specific drug).

The NBDP will have a 30% co-payment, to a maximum of $30 per prescription for all plan participants. Annual plan premiums will range between $800 and $2,000 per adult, depending on individual or family income, as shown in the table below.

<table>
<thead>
<tr>
<th>Gross Income Level</th>
<th>Annual Premium (Per Adult)</th>
<th>Monthly Premium (Per Adult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• $26,360 or less</td>
<td>$800.00</td>
<td>$67.00</td>
</tr>
<tr>
<td>• $26,361 to $50,000</td>
<td>$1,400.00</td>
<td>$117.00</td>
</tr>
<tr>
<td>• $50,001 to $75,000</td>
<td>$1,600.00</td>
<td>$133.00</td>
</tr>
<tr>
<td>• Over $75,000</td>
<td>$2,000.00</td>
<td>$167.00</td>
</tr>
<tr>
<td>Single with Children or Couple with or without Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• $49,389 or less</td>
<td>$800.00</td>
<td>$67.00</td>
</tr>
<tr>
<td>• $49,390 to $75,000</td>
<td>$1,400.00</td>
<td>$117.00</td>
</tr>
<tr>
<td>• $75,001 to $100,000</td>
<td>$1,600.00</td>
<td>$133.00</td>
</tr>
<tr>
<td>• Over $100,000</td>
<td>$2,000.00</td>
<td>$167.00</td>
</tr>
</tbody>
</table>

Bill 27 prohibits private plans from amending or cancelling their prescription drug coverage between December 10, 2013 and March 31, 2015, if the primary purpose of the cancellation is to transfer costs to the NBDP.

We will continue to follow the introduction of the NBDP closely to determine the impact on private plans, and will report on new developments in future editions of GroupNews.
Ontario: Supreme Court of Canada (SCC) Rules Ontario Pharmacies Cannot Sell Private Label Generics

On November 22, 2013, the SCC released its ruling in Katz Group Canada Inc. v. Ontario (Health and Long-Term Care). In a unanimous decision, the SCC upheld regulations issued by the Ontario government in 2010 preventing pharmacies from selling their own “private label” generic drugs.

The Ontario government has been attempting to combat the high cost of prescription drugs, including generics, for many years. Under the Drug Interchangeability and Dispensing Fee Act (DIDFA), the Ministry of Health and Long-Term Care can designate a generic drug as “interchangeable” with a brand-name drug. If such a designation is made, pharmacists will then fill prescriptions using the cheaper generic drug, unless the prescribing physician states that no substitutions can be made. The DIDFA also limits the dispensing fees charged by pharmacies. The Ontario Drug Benefit Act (ODBA) is another statute used to help control drug prices in the province. It provides that the government will reimburse pharmacies for prescription drugs dispensed to persons covered by the Ontario Drug Benefit Program (ODBP), at a prescribed rate, if the drugs are listed in the ODBP formulary.

In 2006, amendments were made to the DIDFA and the ODBA to eliminate the rebates paid to pharmacies by drug manufacturers as an incentive to stock their products (the price of these rebates was reflected in the drug price paid by consumers and the government). In 2010, these two statutes were further amended to prevent pharmacies from controlling manufacturers who sell generic drugs under their own name, but do not manufacture them. The amendments provide that such drugs, known as “private label products” cannot be designated as interchangeable under the DIDFA or listed on the formulary. The amendments also eliminated the payment of “professional allowances,” which had been used by pharmacies and drug manufacturers in place of the banned rebate system.

Katz Group Canada Inc., Shoppers Drug Mart, Pharmx Rexall Drug Stores Ltd. and Pharma Plus Drug Marts Ltd. all operate pharmacies in Ontario and had taken steps to set up their own private label generic drug producers. In 2010, Sanis Health Inc. (Shoppers’ drug producer) had its application to list several of its generic drugs as interchangeable rejected on the basis that the drugs were private label products. Shoppers and Katz challenged the 2010 regulatory amendments, claiming that they were outside of the scope of the statutes. While their challenge was initially successful in Divisional Court, that ruling was overturned by the Ontario Court of Appeal in 2011.

The SCC found that the original legislative intent of the DIDFA and the ODBA was to control the cost of prescription drugs in Ontario without compromising safety. The 2010 regulations were designed to promote transparent drug pricing and prevent the use of private label generics as a way to circumvent the ban on rebates. As a result, the SCC found that the 2010 regulations were not outside the scope of the DIDFA and the ODBA, and were within the government’s power to make.

OPEB Corner

Sustainability of the Canadian Health Care System

A September 2013 report sponsored by the Society of Actuaries and Canadian Institute of Actuaries examined the sustainability of the Canadian health care system and the impact of the 2014 revision to the Canadian Health Transfer (CHT). CHT cash transfers represent federal funding support to provinces/territories. Historically, these transfers have been calculated on an equal per-capita basis, and have grown at a fixed annual nominal rate of 6%. The federal government is proposing to eliminate the fixed annual increase rate of 6%, starting with fiscal year 2017-2018, and to instead link the growth of these transfers to the gross domestic product, subject to a minimum increase of 3% annually. As provinces will not be able to rely on increased funding from the federal government for health care, they will need to increase revenues elsewhere or shift costs away from their coverage.

In 2012, the private sector paid approximately 30% of Canada’s total healthcare expenditures. However, the report estimates that between 2012 and 2037, in the absence of policies to control health care costs, total health care costs incurred by the private sector are expected to grow at an annualized real rate of 3.7%. For plan sponsors who sponsor post-employment plans, increases in health care costs each year will increase plan costs, and losses will need to be recognized immediately in the income statement, as per the new accounting standards.
The report also estimates that provincial and territorial spending on healthcare will increase by 5.1% annually, from 44% of total provincial revenue today to 103% by 2037, meaning all provincial government spending would go towards healthcare. With such an unsustainable increase, the report suggests the private sector may see more costs shifting from the provincial and territorial governments to plan sponsors. As a result, in addition to real growth in healthcare expenditures, plan sponsors could find themselves responsible for a larger share of Canada’s healthcare expenditures. For example, the Ontario Drug Benefit Program currently pays for approximately 60-70% of drug-related expenses for members over the age of 65. If, however, this percentage decreases in the government’s attempt to save money, plan sponsors may be required to cover the difference, and could see a dramatic increase in their post-retirement drug costs.

It is important for plan sponsors to review their plan wording, especially for those plans that are coordinated with government programs, to ensure that sponsors understand what benefits they are offering their employees, and more importantly, what would happen if the government benefit programs were to change and not automatically pick up any transferred costs.

GroupNews will continue to monitor the proposed changes to the Canada Health Transfer. Future editions will comment on whether action needs to be taken in anticipation of future changes to government health programs.

Legal & Legislative Update

**British Columbia: Province to Subsidize Food Costs for Patients with Rare Genetic Disorders**

On November 28, 2013, the British Columbia Ministry of Health announced that it will provide a monthly food subsidy for patients diagnosed with phenylketonuria (PKU) and other rare genetic disorders. Starting January 1, 2014, a monthly subsidy of up to $250 per eligible patient will be available to pay for low-protein foods for those being treated with a metabolic disorder in the province. The province will continue to supply the metabolic formula that PKU patients require for proper body development.

**Manitoba: Competitive Drug Pricing Legislation Receives Royal Assent (Bill 45)**

Bill 45, *The Competitive Drug Pricing Act*, received Royal Assent on December 5, 2013. It amends *The Pharmaceutical Act* (both the current and new unproclaimed versions) and *The Prescription Drug Cost Assistance Act (PDCAA)* to enhance the government’s ability to negotiate lower drug prices and to implement the Pan-Canadian Competitive Value Price Initiative for Generic Drugs (Initiative) in the province. The Initiative is an agreement between a number of provincial and territorial governments to negotiate lower prices for generic drugs. Additional information about the initiative can be found in the *March 2013 edition* of GroupNews.

The Bill provides for the removal of a drug from the interchangeability formulary under *The Pharmaceutical Act* as well as to the drug-listing provisions of the PDCAA. When a prescription drug is removed from either or both lists, the government must provide notice in accordance with any agreement it may have with a drug manufacturer or distributor regarding the price or supply of the drug. If a drug is covered by an agreement that was entered into before September 30, 2013, the agreement can be terminated with 30 days’ notice. The provisions of Bill 45 took effect on December 5, 2013.

**New Brunswick: Legislation Introduced Adding New Categories of Job-Protected Leaves (Bill 22)**

On December 3, 2013, the Government of New Brunswick introduced *An Act to Amend the Employment Standards Act* (Bill 22), which provides two new unpaid leaves of absence for employees whose child is critically ill or who has disappeared or died as the result of a crime.

- **Critically Ill Child Care Leave:** Up to 37 weeks of leave are available to an employee to provide care to a critically ill child. A qualified medical practitioner must issue a certificate stating that the child is critically ill and requires the support of one or more parents, and the period during which the child requires care. If both parents of a critically ill child work for the same employer, the parents may share the 37 weeks of leave.
• **Crime-Related Death or Disappearance Leave:** Up to 37 weeks of unpaid leave are available to an employee whose child has died or disappeared as a probable result of a crime. If the child is found dead during the 37-week period and it is probable that the child died as a result of a crime, the leave of absence ends 37 weeks after the day on which the child is found.

The provisions of Bill 22 are similar to legislation recently introduced or enacted in other jurisdictions, including Newfoundland and Labrador, Nova Scotia and Yukon. For information on these pieces of legislation, please refer to the November 2013 and August 2013 editions of GroupNews. Once passed, Bill 22 will come into force on a date to be named by proclamation.

**Newfoundland & Labrador: Update on Job-Protected Leaves Legislation (Bill 17)**

Two new categories of job-protected leave are now available to employees in Newfoundland & Labrador. Bill 17, *An Act to Amend the Labour Standards Act*, adds unpaid leaves of absence for employees whose child has disappeared or died as a result of a crime, and for employees whose child is critically ill. More information is available in the November 2013 issue of GroupNews.

**Ontario: Legislation Introduced to Amend Employment-Related Statutes (Bill 146)**

Bill 146, the *Stronger Workplaces for a Stronger Economy Act*, was introduced on December 4, 2013. The Bill contains amendments to the following employment-related statutes:

- The Employment Protections for Foreign Nationals Act (Live-in Caregivers and Others), 2009;
- The Employment Standards Act, 2000 (ESA);
- The Labour Relations Act, 1995 (LRA);
- The Occupational Health and Safety Act (OHSA); and

Bill 146 proposed the following amendments to the above statutes:

- Removing the $10,000 cap on the recovery of unpaid wages owed through a Ministry of Labour order in the ESA, and extending the ESA’s time limit to recover wages from between six and 12 months to two years;
- Reducing the LRA’s open period, the time during which a trade union may apply to the Labour Relations Board for certification as a bargaining agent, from three months to two months in the construction industry;
- Adding a new definition of “worker” to the OHSA that includes trainees, co-op students and other individuals who work without pay; and
- Adding a definition of “temporary help agency” to the WSIA, along with provisions specifying that an injury suffered by an employee of such an agency will affect the experience rating of the agency client where the injury occurred, not of the agency itself.

**Ontario: Employer Health Tax (EHT) Exemption to Increase Effective January 1, 2014 (Bill 105)**

Bill 105, *Supporting Small Business Act, 2013*, increases the EHT exemption threshold for Ontario employers. Effective January 1, 2014, employers with an annual payroll of less than $450,000 will not have to pay EHT, up from the current level of $400,000.

**Prince Edward Island: Changes to the Workers Compensation Act (Bill 23)**

A number of amendments have been made to the province’s *Workers Compensation Act* (Act) following recommendations released earlier this year in the Report of the 2012 Legislative Review Advisory Committee on the Workers Compensation Act of PEI. The amendments are contained in Bill 23, *An Act to Amend the Workers Compensation Act*, which comes into force on January 1, 2014. The changes made to the Act by Bill 23 include:

- Reducing the wait time for claims from three days to two;
- Increasing wage loss benefits to 85% of net earnings;
- Increasing benefit indexation from 75% to 80% of the Consumer Price Index, effective July 1, 2014; and
- Ensuring full funding of the Workers Compensation Board and requiring the implementation of a plan to maintain full funding status.
Drug News

Health Canada Approves Generic Form of Oxycodone

Health Canada recently approved a generic non crush-resistant form of oxycodone manufactured by Ranbaxy Laboratories. Most provinces have deleted generic forms of oxycodone from their formularies and now only cover prescriptions for OxyNEO, the tamper-resistant form of the drug. The United States Food and Drug Administration had previously announced that it will not approve any new generic forms of the original formulation of oxycodone due to the ease in which that form of the drug can be tampered with.

Health Canada Approves New Treatment for Rheumatoid Arthritis

On December 2, 2013, Janssen Inc. announced that Health Canada had approved SIMPONI® I.V. (golimumab) for the treatment of rheumatoid arthritis (RA). Golimumab is approved for use by adult patients with moderately to severely active RA, in combination with methotrexate.

Miscellaneous

The Holiday Season … By the Numbers

As the year draws to a close, and with the holiday season in full swing, we thought we would end the last GroupNews of 2013 with some interesting holiday statistics, courtesy of Statistics Canada’s Christmas... By the Numbers 2013.

• Season’s eatings! Canadians spent $4.4 billion on food and beverages at large retailers in December 2012, up 14% from average monthly sales of $3.8 billion in 2012 and up 13% from November 2012.
• Some eggnog with that? 9.9 million litres of eggnog were sold in Canada in November and December 2012.
• Looking to burn off all those calories? Large Canadian retailers sold $28.9 million worth of exercise and fitness equipment in December 2012 and another $33.3 million in January 2013.
• Ringing in the New Year? 21.9 million litres of sparkling wines were sold in Canada in 2011/2012, up 7.9% from 2010/2011.
• A final reminder – please don’t drink and drive! Both the number and rate of alcohol-impaired driving decreased in 2012 after generally rising over the previous five years. However, the number of drug-impaired driving incidents continues to climb, reaching nearly 2,000 in 2012. There were 84,483 impaired driving incidents reported by police in 2012, down from 89,607 in 2011. Unfortunately, the number of incidents of impaired driving causing death increased from 130 in 2011 to 138 in 2012.