

# 9.1 The Insurer Files

# Benefacts

NEWS FROM HEATH BENEFITS CONSULTING

## Special Notes

● **Heath Group.** Our UK parent has announced that, subject to acceptance of a share offer, it is merging with Lambert Fenchurch PLC, a publicly traded British insurance broker. If the acquisition is successful, Heath will become the sixth largest broker in the world. On the benefits side of things, Lambert Fenchurch owns the Kooper Group of New York City and various other benefits offices internationally. We in Canada have been associated with the Kooper Group for several years, and this relationship has resulted in seamless cross-border services for several of our clients.

● **Sun Life.** Has announced that its demutualization vote will be held on December 15, 1999. The proposal will require support of two-thirds of eligible voters, which, based on the votes at **Clarica, Manulife and Canada Life**, should not be a problem.

● **Maritime/Aetna Merger.** As integration activities proceed, Maritime and Aetna have issued several announcements. They indicate that final approval of the transaction by the Office of the Superintendent of Financial Institutions is expected early in 2000. Head office will continue to be in Halifax. Their focus for group insurance purposes will be on clients of from 50 – 5000 lives, and on trustee groups and association groups. Similar to other insurer mergers, Maritime has recognized that their focus will be inward for some time, as they integrate operations. They may, therefore, be less likely to quote for new business, in the short term.

● **Rx Plus.** Is not an insurer, but, like **Assure** and **ESI**, a provider of electronic point of sale claims processing services. As such, they contract with insurers, third-party administrators, or employers directly. Rx Plus has announced that they, in partnership with Aptek communications, have launched a fully automated on-line dental adjudication system, using the latest CDA technology protocols. Apparently this system will be fully functional in January, and we shall monitor its success.

**Over the next month, we are all going to be deluged with commentary from many perspectives about the end of the year, decade, century and millennium. With that in mind, this message will be brief.**

As in other years, we wish you a happy and safe holiday season. Heath has adopted a practice of making a charitable donation in lieu of sending greeting cards to clients or suppliers. Last year we donated to THE HEART AND STROKE FOUNDATION and will do so again this year. Our wishes are sincere, and it appears that there is support from you for expressing them this way.

Last year we delayed our December issue in order to include our annual Quick Facts, with the key information on federal programmes. This year, we have decided to make that a separate mailing in January. So, it will be in your hands and on our web site, in just a few weeks.

It is rather amusing that with all the technology, information and knowledge developed this century, we ring in the millennium spending unprecedented amounts of money because we failed to account for two digits. It will be interesting to see how history looks back at this massive fauxpas; our great grandchildren thinking what a bunch of morons we must have been..

*That said look at what we have accomplished.....*

Only a hundred years ago, most of the western world was both celebrating and cursing the impact of the industrial revolution. The lot of the working person was very much at the whim of the few owners of the engines of power. This was the period before the worst of the labour conflicts – it was the time when ‘jobs’ as we know them today were just evolving. Unions were beginning to emerge in response to the worst workplace abuses.

There was no such thing as CPP, EI, Workers’ Compensation, or state-provided medicare. Of course, there was no income tax either.

There were no ‘benefits’ as we now understand them for employers to provide or for employees to seek. Nobody argued about dental fee guides or vision care maxima. People were more independent then, more concerned with looking after themselves and those – immediate and extended family members – who depended upon them.

We’ve come a long way in this century. Arguably, in the western world, the quality of life and the standard of living are both at the highest levels in recorded history. And many would say that Canada leads most countries. For all our challenges, we have muddled our way to an incredibly advanced lifestyle. We have found a way to knit private and public programmes to the general good of all. And we have kept enough flexibility so that the fabric of our society can evolve with changing times.

Therein may lie the benefits challenge for the future. Maintaining the appropriate balance of public and private arrangements to stimulate innovation and development, to reward intelligence and risk-taking, to care for those who cannot care for themselves, and to protect and develop the best aspects of being Canadian. The people at Heath look forward to contributing meaningfully to this process, on your behalf.

Best Wishes

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## 9.2 Product Developments

### Viagra Update.

Talk about expanding a market. In the month before Viagra's introduction, according to Hylton Benefit News, there were 15,500 erectile dysfunction prescriptions filled, for a cost of \$933,000. The month after, that rose to 65,700 and \$4,700,000! And this, without inclusion of coverage in most group contracts. Laurentian-Imperial, for instance, reports that it gave its group clients the option to add the coverage [at extra cost], and only 1% of them accepted.

### Celebrex

This is a newly approved drug which relieves pain, particularly arthritic pain, without the side effects normally associated with such medications. As such, unlike Viagra, it is included in most insurance drug formularies. In its first three months in the United States, there were 428,400 prescriptions issued, at a cost of \$20.7 million. No figures have been seen on how much of this usage was replacing earlier, less expensive medications.

### Xenical

This new anti-obesity drug, which was mentioned in our edition 7, is also commonly covered on insurance drug formularies, and is quickly moving up the bestseller lists. Assure Health reports over 22,000 prescriptions per week in the US, with Canadian data expected shortly.

### The Benefit of Benefits

Ever wonder how well your staff appreciate group insurance? An Angus Reid survey, sponsored by Hoechst, a pharmaceutical company, produced these findings:

- 73% think their medical benefits meet their needs well
- they rank benefits in order of importance as: drugs, dental, disability, life insurance.
- 39% said they had no idea of what benefits cost employers. Of the rest, only 14% said more than \$1,200. This would be a low number for virtually all plans.
- 78% rated provincial medicare as good or very good.

- more than half the respondents felt that they should contribute to the rising cost of medicare through co-payments and user fees, rather than increased taxes or cutbacks.

- dealing with services delisted by medicare, 40% said they expected to pick up that cost themselves, and 17% said they felt the cost should be shared between them and their employers. [if only you had known.]

- as to covering the increasing cost of group insurance, 50% are ready to pay the premium increase themselves, 16% feel coverage should be reduced to hold down costs, and 31% would prefer point of service charges like deductibles and co-payments.

### Multi-National Pooling

This is an underwriting arrangement especially developed to respond to the needs of multi-national employers. Presently, about 12 consortia of insurers offer the arrangement on somewhat similar terms. Essentially, multi-national pooling involves global pooling of premiums and claims onto one financial statement, with a single refundable surplus or deficit declared. Preferred expense charges and interest factors can be negotiated. Employers also benefit from insurance limits and provisions which reflect the global purchasing power, which is especially helpful for start-up operations. Historically, highly competitive markets like Canada and the US have not been ideal candidates for pooling, because of the likelihood that they would contribute deficits internationally. Now, as the concept matures and evolves, new techniques and hardening rates are changing this thinking. It's still not right for everyone, but it is now of appeal to more employers than ever. If you have substantial operations around the world, you may find that an international pool could be of real interest. *Ask us.*

## 9.3 News from Here & There



### Federal

#### Pay Equity Settled At Last.

Finally, the government has accepted to begin paying civil servants the \$3.6 billion they are owed under pay equity rulings. Amazing as it may seem, the government that made the original rules, used every source of appeal available to them, to tie up the federations in 13 years of debate and appeals, all of which the government lost.

**Medicare Cutbacks Cost Plenty.** The Canadian Institute for Health Information has published data on the impact of reductions in provincial medicare schemes.

- The total health care tab in 1998 was \$80 billion, up 3.9% from 1997. Of that total, \$55.8 billion came from public funds, primarily provincial medicare programmes.
- The balance, \$24.3 billion, came from insurers and individuals.
- Public funding is at a modern-era low, at 69.7% of the total expense. It was 72.8% in 1993, when Jean Chretien came to power, and 76.4% in 1975.



Happy Holidays



## Alberta

**Speaking of Privatization.** Both Ralph Klein, the premier of Alberta, and Keith Martin, the health critic for the Reform Party, are promoting what might be called 'twin-track' health care. From material published so far, this appears to be most like the British system, which is also very comparable to public vs. private education. In principle, all taxpayers continue to support public health services and facilities, and government continues to ensure that the system meets public needs. But, for those who wish, private systems exist on a standalone financial basis. Both Klein and Martin maintain that this is a plus for the current public system, because it will have just as much money as ever, but fewer demands on it. As well, the private facilities can represent a safety valve when the public system is overcrowded.

It might be argued that this would be better than the current scenario, particularly in Ontario and Quebec, where patients are shipped to the United States, when local facilities are not available. It is estimated that Canada exports over \$2 billion worth of healthcare annually to the US.

All of the above has happened over the past 15 years in the UK, with mixed results. The private track is certainly seen as elitist, and is certainly accessed mostly by higher income people. Participation in the private system, by means of insurances, has become a perquisite of senior management. The public track has developed some available capacity. But, perhaps not unexpectedly, the quality of publicly provided care has not been seen to have increased. In Britain's case, this appears to be primarily a case of underfunding the public system. Other European countries, all of which have two tier healthcare systems, do not appear to have many of the same problems Britain has. They do spend more per capita on public healthcare than Britain does.

It has long been our perception that Canada already has a twin track health care system. It is, however, the only industrialized country in the world that does not have a 'formal second tier'. There is the domestic, publicly funded system, which is egalitarian, and which, relative to virtually all other jurisdictions, worked quite well until the cost-cutting of the past 5 years. And, for those of wealth and influence, there is the access, through connections, to the best domestic medical care providers, in the best facilities with the best equipment. And where that is not enough, a quick trip across the border is easily arranged for those who can afford it.

This will be an interesting debate. Naturally, from the perspective of the benefits consultant, moves in this direction would be seen as opening up new areas for insurances to be developed.

**New Dental Fee Guide.** It is recalled that the Alberta Dental Association did not publish a dental fee guide in 1998 or 1999. In response, insurers reimbursed claims according to the 1997 guide, leaving, in some cases, portions unpaid. The CLHIA has announced that it has reviewed the situation and determined that, with effect from January 1, 2000, claims will be reimbursed to a maximum of the 1997 guide plus 2.7%. For plan sponsors, this means essentially an automatic premium increase in respect of Alberta employees, unless you choose to fix your fee guide at, say, the 1997 level.



## Quebec

RAMQ, the provincial medicare authority, has issued a bulletin announcing changes to the rules of eligibility for its universal drug plan. The bulletin states that dependents of employees and retirees residing in Quebec will no longer be eligible for drug coverage under a group insurance contract after the death of the employee/retiree. Instead, the dependents will have to enroll with the Quebec drug insurance plan, or participate in a group plan of their own. The group plan may supplement the state drug plan, as well as provide other coverages. More details are expected.



## British Columbia

**The Healthiest Canadians.** According to Maclean's magazine, British Columbians are the healthiest Canadians. Some key findings:

- most physically active [27%]
- fewest smokers [24%]
- least overweight [27%]
- highest male life expectancy [76.6 years]
- highest female life expectancy [82.1 years]
- lowest mortality rates in all cancers and all circulatory diseases

### The Highest Health Insurance Cost Increases.

Adjustments for 'trend' in B.C. are now the highest in the country; with most carriers adjusting EHC rates at levels in around 20%. While some part of that may be related to the prior item, by far the vast majority is attributable to delisting of products and services from provincial medicare. BC is just about the last province to have really started slashing their programme, and, as was found elsewhere, most of the cutting has been picked up by the group insurance schemes. If you don't want to participate in this form of subsidy, ask your Health consultant for plan alternatives to limit your exposure.



## Newfoundland

Is following the lead of other provinces in moving to formalize certification and standardization of midwife services. Legislation is expected to provide a framework in which midwives may work in their professional capacity. The bulletin does not indicate whether such services would be covered by provincial medicare.

*News from  
Here & There*  
continued on Back Page



## New Brunswick

Has announced that its provincial medicare programme will cover the cost of Hepatitis A and B injections for those infected with Hepatitis C. This is a preventive measure for people in a high risk category.

The injections are administered over a period of several weeks.



## Nova Scotia

Senior's Pharmacare coverage update. Further to prior reports, Nova Scotia has issued the following clarifications. The issue is the provision of 1st dollar coverage for retirees.

- The revised effective date is October 1, 1999
- the legislation only applies to 'national' employers, that is, those with covered retirees in Nova Scotia and any other province or territory
- when a national employer provides first dollar coverage to a retiree in another province [most likely to be New Brunswick, Newfoundland or Yukon], it must provide the same first dollar coverage to its retirees in Nova Scotia.

If your company's retiree plan is affected by this situation, contact your Heath consultant to discuss your alternatives.

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## 9.4 goodstuff@thenet

For a quick reference, here are the web sites for all the Workers Compensation offices across the country:

British Columbia	<a href="http://www.worksafebc.com">www.worksafebc.com</a>
Alberta	<a href="http://www.wcb.ab.ca">www.wcb.ab.ca</a>
Saskatchewan	<a href="http://www.wcb.sask.com">www.wcb.sask.com</a>
Manitoba	<a href="http://www.wcb.mb.ca">www.wcb.mb.ca</a>
Ontario [WSIB]	<a href="http://www.wcb.on.ca">www.wcb.on.ca</a>
Quebec	<a href="http://www.csst.qc.ca">www.csst.qc.ca</a>
New Brunswick	<a href="http://www.whscc.nb.ca">www.whscc.nb.ca</a>
Nova Scotia	<a href="http://www.wcb.ns.ca">www.wcb.ns.ca</a>
Newfoundland	<a href="http://www.whscc.nf.ca">www.whscc.nf.ca</a>
Prince Edward Island	<a href="http://www.wcb.pe.ca">www.wcb.pe.ca</a>
Yukon	<a href="http://www.wcb.yk.ca">www.wcb.yk.ca</a>
NWT/Nunavut	867-920-3888

[www.healthandproductivity.com](http://www.healthandproductivity.com) Here's a site that's chock-a-block full of good information. It's full of useful and timely content on many aspects of human resources.

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