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The Administrator's Corner

The nuts and bolts of beneficiary designations

Plan administrators act as primary points of contact for the insurer and plan members. As such, they often have to deal with information requests or questions about beneficiary designations.

In this first **Administrator's Corner**, we are pleased to bring you some Q&As on beneficiary designations. We hope these will help you answer basic questions from plan members, and reduce the time spent on information requests.

Q. What is a beneficiary?

A beneficiary is an individual, group of individuals or entity, designated by the plan member on his/her enrolment or latest modification form, that is entitled to the group life insurance benefit upon the member's death. For the benefit to be payable, the member's insurance must be in effect, and a claim must be submitted to the insurer along with proof of the member's death.

Q. Can members name separate beneficiaries for Life Insurance, Optional Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance?

Since all of the member's benefits fall under one group policy, designated beneficiaries are entitled to all life insurance benefits payable upon the member's death. They're also entitled to AD&D benefits, when available, if death is accidental and not subject to any of the exclusions specified for this benefit.

Q. The insurer has rejected a member's beneficiary designation and is asking for a new designation. Why?

Insurers must follow strict rules and procedures to ensure the legality of beneficiary designations. Beneficiary designations must meet the following criteria.

- The designation must be an original, written in ink, and signed by the member.
- The designation must not show unapproved corrections (to approve a correction, the member has to put his or her initials next to the correction).

- When percentages are specified for two or more beneficiaries, they must total 100% (if no percentages are specified, the life benefit will be split evenly among the beneficiaries).

- The beneficiary's revocable or irrevocable status must not be ambiguous.

Until the member sends in a new designation, the beneficiary designation will be the "legal heirs" or "rightful claimants", referring to the legal succession process. This designation is always revocable.

Q. What is the difference between a "revocable" and an "irrevocable" beneficiary?

A revocable beneficiary may be removed or modified at any time. An irrevocable beneficiary's rights cannot be removed or reduced without his or her written consent. However, consent is not necessary when the member wishes to increase the irrevocable beneficiary's benefit percentage (provided it doesn't reduce or remove the rights of another irrevocable beneficiary).

Q. I have heard that an irrevocable beneficiary's benefit is better protected against the deceased member's creditors in case of insolvency at the time of death. Is this true?

Only the "capital build-up" or "cash surrender value" of a life insurance policy can be considered among the assets of a deceased insured. Since group life insurance doesn't include such components for members, it makes no difference whether the beneficiary is revocable or irrevocable. Creditors cannot claim portions of the designated beneficiary or beneficiaries' benefit as repayment for the deceased member's debt.

The only exception happens when the designation is "legal heirs" or "rightful claimants", either because no specific beneficiaries were designated or for some other reason. The life insurance benefit then becomes part of the deceased member's succession and creditors can claim a portion or the totality of the benefit as debt repayment.

The nuts and bolts of beneficiary designations

Q. Can a member name underage children as irrevocable beneficiaries?

Yes, but such a designation often leads to complications and issues. Since minors cannot give legal consent until they reach majority, it follows that an underage irrevocable beneficiary cannot legally consent to designation changes. The result is that changes cannot be made.

For this reason, it is recommended to avoid designating underage children as irrevocable beneficiaries for group life insurance benefits.

Q. A member names two beneficiaries. One is irrevocable, the other revocable. Is the irrevocable beneficiary's written consent necessary to remove or make changes to the revocable beneficiary?

No. As long as the rights of the irrevocable beneficiary are not removed or reduced, the member can make changes to any revocable beneficiary.

Q. The insurer has rejected a designation change for a Quebec member who had previously named his legal spouse as beneficiary, stating that the spouse's status is irrevocable. The member showed me a copy of the previous designation, and neither "revocable" or "irrevocable" were checked.

Under Quebec law, if a legal spouse is named as beneficiary and the status (revocable or irrevocable) is not specified, the default status is irrevocable. This applies only to the legal spouse. For all other designations, the default status is revocable. To change the designation, the member will need the legal spouse's written consent.

Q. A member had designated his/her married spouse as irrevocable but is now going through divorce proceedings. The spouse refuses to consent to a change of designation. Can he or she do anything about it?

Unfortunately, the only option is to wait for the divorce proceedings to be concluded. The member can then send a modified beneficiary designation, along with a copy of the official divorce papers. If the insurer finds the request to be in order, the beneficiary designation will be modified.

In all other cases, the irrevocable beneficiary's written consent is necessary.

Q. What are the resources at our disposal if we have more questions about beneficiaries?

Administrators and plan members can contact Industrial Alliance Customer Service to get support. They can also refer to a lawyer or a barrister for complex situations.

File

Plan cost management

Several studies show that a majority of employers consider rising group insurance plan costs to be their most pressing human resource challenge.

In an effort to address this issue, we are pleased to provide you with a series of articles on proactive plan cost management. In them, we will tell you more about what is being done, and what can be done, to help employers successfully meet this challenge.

PART 1 MEETING THE RISING COST OF PRESCRIPTION DRUGS

Over the last decade, the rising cost of prescription drugs has had a major impact on group insurance premiums. An aging population and the costly process of developing new drugs are some of the underlying causes of this phenomenon.

Employers are faced with a dilemma. On the one hand, they need to offer a competitive benefit package to retain employees. On the other hand, controlling costs is a necessary condition to a healthy bottom line, not to mention that high premiums can lead to employee dissatisfaction.

Insurers, advisors and employers are aware of this issue, and here are some of the ways they pool their resources to address it.

Promoting Generic Substitution

Generic substitution, whenever possible, is one way to help keep drug costs down. Most plans that encourage generic substitution offer a higher reimbursement percentage for generic drugs. When supported by a good communication plan, such a measure gives employees an incentive to request generic drugs from their pharmacist. Employees save money on their prescription, while contributing to a reduction in overall plan costs.

Proactive Drug Cost Management From the Insurer's Side

Insurers have implemented several cost control measures to better support employers and advisors' initiatives. Many of them specifically target prescription drugs.

- Manual treatment of exception drugs: whenever a drug claim falls into the "exception" category, it requires authorization before being paid. An authorization form has to be filled out by the claimant and his or her consulting physician. The claim is reviewed by an analyst and, if needed, by a consulting pharmacist. When the claim is accepted, the authorization extends for a specific time period, after which it has to be renewed;

Plan cost management

- Proactive management of high-volume claimants: high-volume claimants are given closer attention, to ensure that prescribed medications fit the declared medical condition, and to prevent any abuse or misuse of medications;
- Manual treatment of expensive drugs: claims for expensive drugs are subject to deeper analysis. Once a claimed drug reaches the cost threshold, the claim must be manually reviewed and validated by an analyst.

Reports and Information Resources

Employers can also put the information and reports they get from the insurer to good use. For confidentiality reasons, these reports don't show any information that could lead to the identification of specific claimants. But they do list the most commonly purchased drugs, along with volumes, percentages and dollar figures. This information can help employers identify specific issues and take preventive action.

Expert Resources and Services

To ensure that their methods and processes remain geared towards helping clients manage their plan costs, insurers must also rely on expertise. Industrial Alliance can count on the following resources and services, among others.

- Consulting Pharmacist: the consulting pharmacist supports the team of analysts by keeping a list of exception drugs, determining in advance when and in what quantity new drugs should be prescribed, and maintaining a list of medical conditions and their appropriate treatment. The consulting pharmacist also investigates drug claims that fall out of the norm;

- Audit Department: the Audit Department's mission is to protect our clients' investment. To achieve that purpose, they play an active role in investigating and monitoring abnormal claims situations within specific group plans. When required, they can work in partnership with an employer to address a situation and take action. However, their scope of action is not restricted to group plans. They also closely monitor Industrial Alliance internal controls and processes, to ensure both compliance and maximum effectiveness.

As prescription drugs keep on putting upward pressure on overall plan costs, Industrial Alliance will continue to work in partnership with employers and advisors to develop cost management initiatives and tools.

In the next issue of the Info Bulletin, we will continue this series and take a closer look at other cost control measures. If you have questions about the contents of this article, please contact your Industrial Alliance Group Account Executive.

Legislation

Ontario's Bill 102

TRANSPARENT DRUG SYSTEM FOR PATIENTS ACT

Introduced in April 2006, the *Transparent Drug System for Patients Act* received Royal Assent on June 20, 2006, with most sections of the Act becoming effective on October 1, 2006. The Act introduces numerous reforms to the Ontario drug system and is seen as an integral part of the Government of Ontario's plan to reform the provincial drug system.

The purpose of the reforms, as expressed by the government, is to:

- Improve patient access to drugs under the provincial drug system
- Promote the appropriate use of medication
- Strengthen the government's position as a customer to secure value-for-money
- Reward innovative health system research
- Strengthen transparency and accountability in the provincial drug system

The reforms introduced by the Act that could impact group drug plans are as follows.

1. Interchangeability of off-formulary generic drugs will be allowed. This means that a brand name drug will not have to be listed on the Ontario Drug Benefit (ODB) formulary for a pharmacist to substitute a generic brand without the physician's consent. Also, interchangeability will be allowed for drugs that not only have the same active ingredients in the same dosage forms but also where they have similar active ingredients in a similar dosage form.

This reform allowing for the interchangeability of off-formulary generic drugs will not take effect October 1, 2006, but on April 1, 2007.

Once implemented, the reform will have the most impact on group drug plans which provide for mandatory generic substitutions or which provide a lower level of reimbursement for brand name drugs. It should also impact group drug plans in general since a pharmacist should be able to substitute a generic drug for a brand name drug in almost all situations where a generic drug exists.

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TRANSPARENT DRUG SYSTEM FOR PATIENTS ACT

2. The current set-up of the ODB formulary with its general formulary listing, limited use drugs and Section 8 drugs will be reformed.

A rapid review process for breakthrough drugs will be introduced to expediate their review in order to have them available faster for those patients who are in need of them. In addition, the limited use and Section 8 processes will be eliminated and replaced by a process which will allow for drugs to be added to a conditional listing with approval based on the patient satisfying pre-certified clinical criteria.

Once the process is implemented, it could have a positive impact on group drug plans covering active members or retirees aged 65 and older as drugs could be added more quickly to the ODB formulary or those awaiting a formal review decision could be added to the conditional listing. This will result in the drugs being paid for by the ODB and not submitted to a group drug plan for reimbursement.

3. The allowable price mark-up by pharmacists on the cost of drug ingredients will be reduced from 10% to 8%. The government had originally announced that it intended to cap the mark-up at \$25 but the government subsequently decided not to proceed with this change.

As this reform only applies to drugs paid by the ODB, pharmacists are not required to respect the limit on the mark-up with respect to group drug plans. In addition, this reform could impact group drug plans as the reduction in the mark-up costs for ODB formulary drugs could lead to increased dispensing fees for non-ODB formulary drugs.

4. The allowable dispensing fee for drugs covered by the ODB will increase from \$6.54 to \$7.00.

This reform will have no impact on group drug plans as individuals will continue to only be responsible for the per prescription fee of \$6.11.

5. The introduction of a fee schedule for specific pharmacy services related to the pharmacist's role in patient counselling.

This reform will not have an immediate impact on group drug plans as professional services are generally ineligible for reimbursement. However, plan sponsors could feel pressure to provide coverage for these services by their members. In addition, depending on the services provided, plan sponsors may find that they support workplace wellness strategies and as a result, will undertake to cover them.

6. Rebates received by pharmacists from generic drug manufacturers in exchange for buying their medications will now be limited in the public system. Pharmacists will now be allowed to receive defined professional allowances, subject to 20% of the generic cost in the public system. However, pharmacy rebates in the private sector will continue to be allowed on an unlimited basis.

The Government of Ontario had originally intended to discontinue the practice of rebates in its entirety; however, they subsequently softened their stance.

The impact of this reform on group drug plans could be twofold. First, the loss of pharmacy revenue from generic rebates could result in pharmacists increasing their dispensing fees to fill prescriptions for non-ODB formulary drugs. Secondly, the continuation of pharmacy rebates in the private sector will likely maintain the relatively high cost of generic drugs in the Ontario market in comparison to international prices.

7. The ODB will become second payer for working seniors with private insurance coverage.

This reform is not included in the Act or its regulations. Instead, the Government of Ontario intends to introduce it as a policy change. At the current time, there is no proposed date for the implementation of the policy change.

The impact of this reform on group drug plans will vary based on the demographics of the group. Plans with employees aged 65 and over will be negatively impacted as they will become responsible for reimbursing drug claims which were previously paid by the ODB.

Other reforms introduced by the Act which are of interest but will not directly impact group drug plans include:

- A Shared Care Network which will provide prescribing guidelines to promote appropriate drug use.
- An "All drugs, all peoples" model to provide access to an electronic drug history for all residents.
- A "Rewarding Innovation Fund" that can be accessed by any group that can provide better drug management.
- A new position (Executive Officer, Drug Programs) to assist in making the public system more efficient.

For more information on the *Transparent Drug System for Patients Act* and its possible impact on your group drug plan, please contact your Industrial Alliance Group Account Executive.

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Industrial Alliance is among the most solid financial institutions in the country and is a leader in insurance and financial services. With offices from coast to coast, Industrial Alliance insures more than 2 million Canadians and has over

\$39 billion in assets under management and under administration, making it the 5th largest life and health insurance provider in Canada.

This INFO Bulletin is also available on our website at www.inalco.com/groupinsurance under the Administrator Services section.