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Disability Management

With the growing incidence and cost of disabilities in the workplace, employers need to begin to take a different approach to managing their employees' disabilities.

- Statistics Canada has indicated that in 2001, the average number of work days lost per employee to disability was 7.0 days compared to 6.2 days in 1997, an increase of approximately 13%.
- The Ontario Workplace Safety Insurance Board (WSIB) indicated that the average workplace injury in Ontario costs employers over \$59,000.
- A recent study on disabilities and the workplace has shown that employers now spend approximately 7.1% of payroll on the direct costs of disabilities.
- Indirect costs associated with disabilities (cost of replacement workers, lost productivity, overtime, etc.) can represent 2 to 3 times that of the direct costs.

Employers can no longer take a wait and see approach to disabilities, but must implement a proactive disability management program that not only provides assistance to their disabled employees in their rehabilitation and return to work efforts, but also provides services that help to reduce or prevent the occurrence of disabilities in the first place.

The most common services available to employers to help in the prevention or reduction of disabilities in the workplace are:

- Employee Assistance Programs (EAPs), which help employees deal with the increasing stresses and strains of the

workplace and home-life before they result in disabilities due to mental and nervous conditions.

- Ergonomics, which is a tool for employers to deal with the growing problem of repetitive strain injuries associated with the changing work environment, specifically the increasing use of computers in the workplace.
- Health and Wellness Programs, which aim to change employee lifestyles so as to prevent or reduce the occurrence of disabilities related to such lifestyles. Common programs deal with stress management, smoking cessation and weight loss, all of which are related to disability causing lifestyles (mental and nervous disorders, cancer, and obesity).

Once an employee becomes disabled, the employer's disability management program must be proactive in promoting the early return to work of their disabled employees through a strong early intervention program. Studies show that the chance of returning a disabled employee to work is related to the timeliness of intervention with the employee. After 3 months, the ability of returning a disabled employee to work becomes much more difficult due to such issues as: the disabling condition becoming chronic; the employee developing a "disability mentality"; and the employee learning to live on a reduced salary.

If an employer's disability benefits (short and long-term) are provided by an insurer, the contract should be designed to promote the early return to work of a disabled employee.

The short-term and long-term benefits should work together to support the employee's early return to work efforts and not act as a deterrent to such efforts.

If the employer manages its own short-term disability plan (e.g. salary continuance plan), it should include an early intervention program. The early intervention program should itself include an assessment of each disabled employee for return to work potential from the onset of the claim to identify the employee's abilities as soon as possible after the disability occurs. For an early intervention program to be successful, the program should be managed by a knowledgeable disability management specialist who will be able to work with the employee, employer, employee's physician and other possible healthcare providers who need to be involved for the successful return to work of the disabled employee.

With a properly designed disability management program incorporating both prevention and early return to work programs, employers can look to reduce the frequency and length of the disabilities occurring in the workplace and thereby help to control and reduce disability costs.

For information regarding the disability management programs and services available from the IAG Group of Companies, please contact your benefits advisor or your IAG Group sales representative.

Health Spending Accounts

The principle of the Health Spending Account (HSA) originated in the United States, where it is generally called a "Flexible Spending Account" and was developed following the implementation of flexible benefit plans. The concept was imported to Canada in the late 80s when Revenue Canada adopted various rules with respect to its tax treatment.

The popularity of HSAs has increased during the past couple of years as employers have seen them as efficient tools to control the increasing cost of private health plans while offering employees an attractive option. In addition, if the HSA is properly designed, benefits will be non-taxable to the participant, except in Quebec where they are subject to provincial taxes.



What is a Health Spending Account?

An HSA allows for reimbursement of eligible medical and dental expenses which otherwise would have been payable by the individual.

An HSA resembles a personal bank account in that it works with debits and credits. As long as the account balance is positive, the individual may obtain reimbursement for eligible medical and dental expenses and his or her account will be debited by the paid amount. The amount deposited in each account must be used within a specified period (1 or 2 years), after which the unused balance will be forfeited. This is known as the "use it or lose it" principle, necessary in order to maintain a reasonable element of risk in the benefit plan, and required by Revenue Canada for the HSA to qualify as a private health services plan.

An HSA rarely replaces a standard medical or dental benefit plan. It is more commonly offered as a component of a flexible benefit plan or a complement to a traditional plan.



What are eligible expenses?

In addition to the "use it or lose it" principle, in order for HSAs to attract favourable tax treatment, which is non-taxable at the federal level and in all provinces except Quebec, the reimbursed expense must qualify as a medical expense under the Canada *Income Tax Act*. These medical expenses include:

- Drugs prescribed by a medical practitioner and recorded by a pharmacist
- Professional fees for medical practitioners
- Eye care expenses
- Dental fees
- Ambulance fees
- Medical devices and supplies
- Expenses required for modification of the home due to a handicap
- Laboratory, X-ray and diagnostic fees
- Portion of eligible expenses not reimbursed by a private health plan (deductible, coinsurance or excess of plan maximum)

However, an employer that implements an HSA or an insurer that manages it may restrict the range of eligible expenses.



Who is covered?

An HSA can cover eligible expenses for employees, their spouses, and any dependents for whom they may be claiming a tax deduction for the current year. This means that the definition of dependent for an HSA may not be the same as that of a traditional group plan.



How is an HSA funded?

HSAs must be entirely employer-funded. The employer may obtain the required funds by lowering the cost of traditional benefits, or by increasing cost-sharing with employees. The employer may also invest additional amounts to fund the HSA.



Advantages and other considerations

Advantages of an HSA to the employer:

- Easy to administer and understand
- Annual cost may be budgeted
- Effective future cost containment
- Enhancement of current benefit plan

Advantages of an HSA to employees:

- Expansion of eligible benefits
- Flexibility
- Favourable tax treatment
- Broadens the definition of dependent

In conclusion, it is important to note that despite the advantages noted above, the HSA is not a panacea. If an employer wishes to implement an HSA to reduce costs in the short run, then alternative options must be considered first such as changing cost-sharing with employees or revising current benefit options. In choosing to offer an HSA, employers should take into account their total plan costs, i.e., those of the traditional as well as those of the HSA or other flexible benefit plans. The amount allocated to each employee, the HSA parameters, along with the insurer's available tools and flexibility must also be carefully analyzed beforehand.

Evidence of Insurability

Unlike individual insurance, where medical evidence is required to be insured, group insurance is underwritten on the basis that in any large group of individuals, there will only be a few individuals who have medical conditions that would make them uninsurable risks. As a result, due to the large number of healthy members in a group plan, there is a good spread of risk for the insurer, which allows for the unhealthy members to be insured without medical evidence.

However, when there is not a sufficient spread of risk, medical evidence will be required from the members. There are 3 such situations related to group plans:

■ Small Groups

The definition of small group varies among insurers. However, generally speaking, groups under 10 lives fall into this category.

Evidence of insurability is generally required for all coverages under the group plan. If a member's evidence is not approved by the insurer, the member will not be eligible to become insured under the group plan. Some exceptions may exist. For instance, when a special package is offered to a small group and participation is mandatory, evidence of insurability may not be required.

■ Non-Evidence Maximums

The non-evidence maximum that may be included under the life insurance benefit, long-term disability insurance benefits or short-term disability insurance benefits is set by the insurer and based on the number of lives and/or the average volume of insurance in force for the benefit under the group plan.

Every member in the group will be covered under the benefit up to the non-evidence maximum without evidence of insurability being required. Any member whose insurance exceeds the non-evidence maximum must submit evidence of their insurability to the insurer. If the member's evidence of insurability is not approved by the insurer, the member's insurance will be limited to an amount of insurance that is equal to the non-evidence maximum.

The member will only become insured for the excess amount of insurance on the date that the evidence of insurability has been approved by the insurer.

■ Optional Life Insurance

Generally, evidence of insurability must be provided by all members who wish to apply for optional life insurance. Sometimes, there will be a guaranteed amount of optional life insurance which will be available without evidence of insurability.

If the member is applying for optional life insurance on the spouse, the spouse will be required to submit evidence of insurability.

The optional life insurance will only become effective on the date that the evidence of insurability has been approved by the insurer.

In addition, for plans under which participation by the member is not mandatory, evidence of insurability will be required of any member (and their dependents) who does not make application for the insurance within 31 days of the date he or she was eligible to become insured under the plan. These members are considered "late applicants" and if their evidence of insurability is not approved by the insurer, they will not become insured under the plan.

The reason why evidence of insurability is required for a late applicant is that the member was provided with the choice of becoming insured under the plan and chose not to. However, the member may subsequently discover a need for the insurance due to the onset of an illness or a medical condition. To allow the member to become insured without evidence of insurability would allow for "anti-selection" against the plan by the member, which would increase the cost of the plan for all members. "Anti-selection" occurs when an individual with an impaired health status or with an expected need of medical care applies for coverage financially favourable to himself or herself, but which is detrimental to the experience of the plan.

In all situations when evidence of insurability is required, the member must complete the Evidence of Insurability form available from the insurer. Once completed, the form must be submitted to the insurer for approval.

Finally, please note that in Quebec, due to the provincial health legislation regarding drug coverage, a member will become covered for the drug benefit even if his or her evidence of insurability is not approved by the insurer.



IAG Group Insurance at a Glance

Premium income in 2002

\$588 million

Corporate clients

Over 2,300

Insured members

Over 525,000

2002 market position (sales)

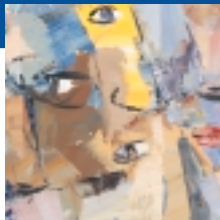
5th

Distribution of premiums by region

Western Canada: 19%

Ontario: 33%

Quebec and Atlantic: 48%



Legislation

Canadian Life and Health Insurance OmbudService

The life and health insurance industry in Canada has for many years provided assistance to consumers through the Consumer Assistance Centre (CAC), established by the Canadian Life and Health Insurance Association. The CAC provides information about life and health insurance companies and their products, sends out publications about industry products and services and deals with consumers' concerns and complaints.

Consumers may now turn to the new Canadian Life and Health OmbudService (CLHIO), an independent service that assists consumers with concerns and complaints about life and health insurance products and services, when the measures undertaken with their financial institutions and/or through the CAC have failed.

The CLHIO belongs to a national dispute-resolution system aimed at providing fair and prompt resolution of problems.

Although less than 1.5 per cent of requests for information received annually by the CAC involve concerns or complaints, the industry takes client service very seriously. That is why it has developed an explicit process to make sure consumers' complaints are not left unresolved.

The procedure to follow when a consumer is not satisfied with a product or a service is:

- To contact the insurance company involved.
- To contact the Consumer Assistance Centre (CAC) at 1-800-268-8099, by e-mail at CAC@clhia.ca or visit its web site at www.clhia.ca.
- To contact the Canadian Life and Health Insurance OmbudService (CLHIO) at 1-888-295-8112 or visit its web site at www.clhio.ca.

It is important to note that a request for review may only be sent to the CLHIO if the recourse with the insurer has failed.

The Industrial Alliance Group



The INFO Bulletin is presented to you by the Industrial Alliance Group.

Combining the strengths of Industrial Alliance, National Life and Industrial Alliance *Pacific*, the Industrial Alliance Group 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, the Industrial Alliance Group insures more than 1.5 million Canadians and has over \$17 billion in assets under management and administration, making it the 7th largest life and health insurance provider in Canada.