



2004 Ontario Provincial Budget

Integrating

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Much has been written in the almost 24 hours since the release of the 2004 Ontario Provincial Budget. This communiqué will provide you with relevant facts that pertain to you, both as a benefits plan sponsor, as well as an employer of residents of this province.

HEALTH CARE PREMIUMS

The 2004 Ontario Provincial Budget, the first for a Liberal government in 15 years, will not only be remembered for its significant investment in health care, \$2.4 billion in new spending for the current fiscal year, but also for the primary source of this funding – *health care premiums*.

In 1989, the last budget tabled by governing Liberals saw the elimination of health care premiums in favor of an Employer Health Tax (EHT). The EHT shifted the burden of funding part of Ontario's health care system from individual citizens to

employers. In 1996, as part of the Common Sense Revolution that saw the Conservative Party assume power, a Fair Share Health-Care Levy was introduced. This levy, compensating for a funding shortfall created by waiving the EHT requirement for small employers, was applied to residents who earned more than \$53,000 per year.

This week, Dalton McGuinty's Liberal party proposed an amendment to the Taxpayer Protection Act, allowing an income-dependent premium to be applied to all Ontario residents. Protecting only low-income individuals, the de facto tax is to be collected through the Canada Revenue Agency, beginning July 1, 2004, based on the following schedule:

Income Range	Remainder of 2004 Taxation Year	2005 Taxation Year (and forward)
<\$20,000	No premium	No premium
\$20,000 – \$36,000	Up to \$150	Up to \$300
\$36,000 – \$48,000	\$225	\$450
\$48,000 – \$72,000	\$300	\$600
\$72,000 – \$200,000	\$375	\$750
>\$200,000	\$450	\$900

Many are quick to compare this initiative to the funding of the health care systems of British Columbia and Alberta. We note the fundamental difference in the new health premium for Ontarians – it is not replacing the employer-sponsored health tax. Unlike in British Columbia and Alberta, where many employers pay the premiums on their employees' behalf, Ontario employers will continue to be responsible for funding health care through the EHT. They are unlikely to assume the cost of the new health care premiums, estimated at approximately \$1.6 billion in the first year, and

expected to grow to \$2.6 billion by 2008. The brunt of the new funding for health care will shift to individuals.

What does the introduction of health care premiums mean for you as an employer?

Any new tax, regardless of the way in which it is implemented, is generally unwelcome. Your employees, typically unaware of your contribution toward both public and private health care plans, will be most concerned about the impact on their disposable income. Furthermore, there will be no impact to your contributions through the EHT.

A recommended strategy to mitigate the effects of negative sentiment among your employees is to proactively communicate with them relative to their total compensation. Today, more organizations are recognizing that communicating not just salary, but the value of non-salary elements of compensation including group benefits and pensions, vacation and perquisites, as well as government-sponsored programs (read CPP, EI and EHT) helps manage employee dissatisfaction.

DE-LISTING OF OHIP-FUNDED SERVICES

A number of OHIP-funded services will be de-listed in Fall 2004 as a result of proposals contained in the budget. The list of services no longer eligible for funding under OHIP includes:

- Chiropractic services;
- Physiotherapy services (*except for those provided to seniors through long-term care or home-care*); and
- Optometry services (*except for those provided to seniors and residents under 20 years of age*).

A key message from these cutbacks is a shift in emphasis – from disease treatment to disease prevention. Coincident with the de-listing of services noted above, with expected annual savings of \$193 million, the government announced funding of approximately the same amount for chickenpox, meningitis, and pneumonia vaccinations for children. The funding for these vaccinations may have a nominal impact for those plan sponsors who currently provide reimbursement through their group plans (or offer Health Care Spending Accounts to their employees).

In the wake of the SARS and West Nile phenomena, the government has not turned its back on disease prevention, by committing to an increase in its share of public health costs. Currently, these costs are shared equally among the province and its municipalities. The budget proposed that the government increase its share of this funding to 75%, or \$469 million by 2007.

What does the de-listing of OHIP-funded services mean to you as an employer?

Generally, most employer-sponsored benefit plans contain coverage provisions related to both vision care and paramedical (including physiotherapy and chiropractic) services. Additionally, the liability for funding these benefits is typically limited through either coordination with OHIP (in the cases of optometry and chiropractic service) or internal plan maximums (i.e. \$200/24 months for vision and \$500 per practitioner per year for paramedical services).

Chiropractic Services

Chiropractic services, for example, are currently coordinated with OHIP whereby provincial funding is responsible for \$150 in claims beginning in April

of each year. Plan provisions of some group contracts, since the mandatory coordination of paramedical services with OHIP was lifted in 1996, still dictate that reimbursement will not be provided until the OHIP maximum had been reached.

For plans that still require coordination with OHIP-funded chiropractic services, access to care may be limited as the current OHIP contribution (\$9.65 for treatment after the initial visit) may leave the uninsured portion unaffordable to employees. In instances where a group plan requires exhaustion of the OHIP limit, an employee would need approximately 15 chiropractic visits before being able to submit claims to their group plan. De-listing of chiropractic services from OHIP will result in more direct access to group plan coverage, more specifically for those who previously deemed the treatment unaffordable.

Plan sponsors, already seeing a trend toward alternative therapies, may see increased claiming under their plans as a result of this direct access. This increased claiming for chiropractic care is most likely to come from the segment of the population that had not been claiming before. We also note that the wording of some group contracts protects the plan sponsor from this type of government downloading – it would be wise to review this wording with your benefits consultant to manage your plan's exposure.

Physiotherapy Services

Physiotherapy services under OHIP are funded differently than those for chiropractic care. *Schedule 5* clinics exist in Ontario, whereby physiotherapists work under license to the Health Ministry to provide services in clinics or at patient

homes. These *Schedule 5* clinics will continue to provide these services only to seniors through long-term care or home-care initiatives.

Approximately 20% of visits to *Schedule 5* clinics are for non-seniors and represent approximately 1.2 million treatments per year. The government de-listing would immediately shift responsibility for these treatments to the private purse. The shift of these services, at market-driven prices, may have a significant impact to plan sponsors.

Furthermore, we note a disparity in group plans between the maximum allowable reimbursement for physiotherapists compared to other paramedical practitioners. Some group plan provisions today continue to reflect either an unlimited, or a \$1,000 per year, maximum for physiotherapy services. This compares to the more common limit of \$500 for other practitioners. This disparity not only illustrates inconsistency in an organization's philosophy toward paramedical care, but can expose an organization to additional liability from this cost-shifting.

We recommend a review of the paramedical component of your group insurance plan to ensure its alignment with your corporate benefits philosophy. This proactive approach will allow you, along with your benefits consultant, to determine the provisions appropriate for your organization and its employees. Furthermore, you can communicate these provisions to your insurer for reflection in their adjudication processes.

Other possible solutions to increasing cost pressures include overall funding on a defined contribution basis or per-visit maximums. These initiatives can increase the appreciation for these services by employees and engages them in the funding process, either through their management of a defined contribution amount or through direct cost sharing.

Optometry Services

Vision care is one of the most “high-impact” elements of a group insurance program. Ask employees what improvements, if any, they would like to see made to their plan and invariably a vision care related answer will result. Undeterred by the inherent cash-flow pricing of vision care in group plans, an improvement to this coverage under your group plan will be well received by your employees. In the same regard, cutbacks with respect to vision care are often met with dissatisfaction.

We note that only a limited number of group plans allow reimbursement for OHIP-insured optometry services on a coordination basis. Nonetheless, the burden for the cost of both the requisite examination combined with glasses or contacts would fall on either private plans or the employee. With today's plan provisions, in which funding is typically insufficient to offset the cost of glasses or contacts alone – the cost of the examinations is expected to be passed onto the employee.

Employers can expect their employees to call for amendments (read increases) to their vision care plan provision to allow sufficient reimbursement for exams as well as glasses or contacts. Some plans have independent provisions that allow for reimbursement of eye exams, typically in

coordination with OHIP. These plans should be reviewed to ensure that their presence aligns with the intent. If your philosophy was to provide annual eye exams, coordinated with OHIP, and this philosophy was communicated to employees – they will expect that their group plan will be amended to accommodate the exams previously insured by OHIP.

Employers can position themselves well by ensuring that their benefit programs align with their philosophy and that this is communicated – both consistently and effectively to employees. As with paramedical services, optometry services can be managed under a defined contribution approach offering added equity and flexibility to all employees.

GENERAL COMMENTARY

This budget has seen the government provide additional investment in primary care, in an effort to reduce waiting times and improve access for Ontario residents. The indirect result of this investment, through improved health and wellness and reduced absenteeism, should benefit employers. The difficulty, however, lies in quantifying this benefit, while accounting for reduced access to care (or shift in funding for care) resulting from the de-listing of services from OHIP funding.

As a result of the budget announcements, we recommend you meet with your benefits consultant to review your group contract provisions and philosophy to ensure that they align and continue to meet your needs. Once confirmed, communicate them consistently to both your insurers as well as your employees.

We invite you to contact your consultant at Morneau Sobeco if you need additional information.

May 19, 2004