Canadians will expect to take various medications throughout their lives, but they’d rather not cough up to pay for them. In the Pollara-Health Care in Canada Survey, released before the end of last year, 89% of Canadians agree “employer-sponsored plans should pay for any drug that patients and their health-care provider agree is the most effective treatment.”

“That’s very reflective of a lot of employee attitudes,” says Barry Power, director of practice development, Canadian Pharmacists Association, Ottawa. “People feel that whatever the doctor writes on the sheet should be covered.”

But many employers feel somewhat differently. “I think that’s unrealistic,” says Rose Bertino, senior HR and administration manager at Pioneer Hi-Bred in Chatham, Ont. “With the amount of competitive pressure out there and the cost of the introduction of new drugs, it’s unrealistic to be able to pay for everything that’s coming out.”

According to Bertino, Pioneer Hi-Bred has absorbed a lot of employees’ drug costs up to a specific date. “But a lot of the newer [drugs], say in the last four years, we have not included,” she says, “but no one’s said anything so far.”

“It’s simply not financially viable to approach drug plans in that manner,” says Power, referring to the survey results. One reason, he says, is the drug the doctor prescribes may not be the most effective from a cost and effectiveness point for the particular patient. “Restrictions put in place by either public or private insurance are based on evidence [statistics from scientific studies], and what we often see is that the newest and most expensive drug may not be the best fit for everybody,” says Power.

Hypothetically, if drug plans did cover any drug, Barbara Martinez, a senior associate at Mercer Human Resource Consulting in Toronto, says she’d suggest employers rework their plans so they’re not the only funding source: consider using generic drugs or cost-share with employees. But Power sees the catch-22 in cost-sharing. “That sort of defeats a lot of the purpose of having a drug benefit plan,” he says.

Although an all-coverage drug plan may be a pipe dream, Martinez says plan sponsors may still have cause to worry because the future is uncertain, and new drugs may introduce new price points. Since employers’ expertise does not lie in medicine, she continues, they will need help from qualified experts – insurers, pharmacy benefit managers, plan advisers – to make the right choices for their plans.

—Brooke Smith
Moody's Methods

When Moody's Investors Service released a list of 12 Canadian companies with what it determined as troubling pension deficits, The Thomson Corporation did not expect to be on it. The list, which appears in a report titled Treatment of Canadian Pension Obligations, identifies Thomson as being underfunded by $343 million (US$300 million). It also includes Nortel ($2.9 billion/US$2.5 billion) and Alcan ($3.1 billion/US$2.7 billion).

Stephane Bello, senior vice-president and treasurer of The Thomson Corp. in Stamford, Conn., says the report is unclear. “Thomson has met or exceeded all of its governmental funding requirements, so we were disappointed in how the report was portrayed.” Thomson's Canadian defined benefit (DB) plan, he says, is 101% funded.

Bello says Moody's combined both Thomson's qualified and non-qualified plans, and the deficit is a result of the non-qualified plans. “Because such assets are not protected in the same way as qualified plans, they cannot be considered 'funded' for purposes of our regulatory disclosure.”

Waylon Iserhoff, vice-president, senior accounting analyst for Moody's Investors Service in Toronto and a co-author of the report, says the table was a demonstration of the impact of Section 158 of the Financial Accounting Standards regulations, which requires employers to state if their DB plan is overfunded or underfunded—an asset or liability—in its financial reports. “My understanding of the accounting requirements is that it does not differentiate between the funded and unfunded plans,” he says. “So what is disclosed in the table is what would be required from an accounting perspective.”

Based on Moody's report, the changes to the accounting standards would negatively impact Thomson's shareholders equity by 4%. —Leigh Doyle

LIVING LONGER ON LESS

Getting to live longer than men may not be as good as it sounds for women. The American Society of Actuaries (SOA) found that women face greater financial risks in retirement than men. In a report titled Impact of Retirement Risk on Women, the SOA uncovered that because women live longer, spend more time retired, are more often widowed, and earn less than what men do throughout their careers, they are at greater risk of having to cope with financial hardships in retirement.

Steve Siegel, research actuary with the SOA in Schaumburg, Ill., says “with the decline of defined benefit plans, women are less likely to be recipients of lifetime-guaranteed income.” Since women live longer, there is a greater chance of exhausting the retirement savings they do have. As demographic trends are similar between the two countries, the American findings can apply in Canada, he says.

In order to address these issues, employers should be more open to phased retirement, says Siegel. “If someone is at a retirement age, but isn’t ready to completely leave the workforce, an employer could customize roles to allow someone to earn an income.”

Employers can also help by developing communication and education plans for female employees to create awareness of these issues and help prepare them for the future. Such efforts have already yielded results, says Siegel, as pre-retiree women indicated in the report that they are concerned about running out of money if they live longer than expected. “The finding shows that certain efforts have had some impact, but that needs to be driven home much more.”

—Leigh Doyle

Healthcare not immune

The greying workforce could threaten the quality of Canada’s healthcare services. “The bulk of healthcare providers are baby boomers,” says Catherine Knipe, national healthcare practice lead for Kronos Incorporated, an American workforce management company with offices in Mississauga, Ont. Adding to the problem is that long-time practitioners, such as nurses and pharmacists, are looking for new opportunities. “We’re going to have quite the shortage,” says Knipe. It’s the quality of care that’s at risk if organizations don’t figure out a way to attract and retain staff.

Knipe is not without hope, however. In a recent white paper she wrote, titled Perspectives on Workforce Management Issues in Canadian Health Care, 45% of chief executive officers responding to an online survey identified that the key priority for them is having the appropriate staffing to provide services. “This tells me that there is an awareness and readiness to tackle the problem.”

—Leigh Doyle
Re: “Strength in numbers”
September 2006

We are responding to Mr. Neil Craig’s letter in the November 2006 issue regarding our September 2006 article (“Strength in numbers”). Craig states that he is “appalled” that we “continue to perpetuate the myth that multi-employer pension plans (MEPs) are defined benefit (DB) plans.” MEPs are classified as DB plans because both the benefit and the contribution are, in fact, defined—which is also why they are treated as DB plans under pension legislation. Sometimes the amount of benefit may be reduced, and, in that context, MEPs may be considered “target” benefit plans. But there is much more to the MEP model than “the spreading of costs based on asset volumes,” as Craig suggests is the only advantage.

Administration costs may be higher for an MEP than a typical defined contribution (DC) plan. But investment management fees are typically much lower, leading to lower overall costs. Craig also fails to recognize the advantages of a professional investment strategy and pooled return risks. Further, MEPs provide their members with some guidance as to the amount of pension that can be expected at retirement, even if it is a target. This is very difficult for DC plans, as the conversion to an annuity is based on prevailing market conditions at the time the individual member chooses to start his or her pension. If the DC member buys an annuity, the conversion includes profit and administration costs charged to the DC member (no such costs exist in MEPs). If the DC member self-annuitizes, then in addition to continued return risk, he or she also assumes the mortality (or longevity) risk—that is, the risk of running out of money during retirement.

We can argue whether an MEP or DC plan is better suited for a particular group of employees. What is “appalling” is Craig’s apparent dismissal of MEPs.

Mark Davis, Susan Deller, Cameron Hunter, Eckler Partners