Equitable Life of Canada®

YOUR GUIDE TO BENEFITS
FOR SMALL BUSINESS

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Introduction

Whether your company is a start-up or in growth mode, finding and keeping top talent can be difficult. Your small business is up against large companies that can afford to offer generous compensation packages and lots of perks.

A health benefits plan is becoming a must-have for smaller companies who want to compete for the best people. Most experienced professionals – particularly those with families – expect health coverage.
And even those starting out in their careers are looking for some level of benefits to enhance their lifestyle.

The problem is, group benefits can be confusing and there are few resources available to help you navigate and understand the options.

We've created this guide specifically for small businesses considering a group benefits plan for their employees. We've provided answers – in plain language – to the most common questions.

What are the options?

There are several cost-effective health benefits options available to fit a range of budgets and needs.

Traditional Health Benefits Plans

With a traditional plan, an employer provides standard benefits to its employees. Traditional plans commonly include:

- Extended health care coverage for prescription drugs, paramedical services such as massage therapy and physiotherapy, private or semi-private hospital coverage, vision care, emergency medical travel coverage and other eligible services;
- Dental coverage;
- Life insurance;
- Accidental death and dismemberment insurance;
- Short-term and long-term disability insurance;
- Critical illness; and
- Employee assistance programs.

Depending on their budget, employers can provide full coverage or share some of the costs with employees by including deductibles, co-payment amounts or coverage maximums. Employees will also often be required to pay a portion of the premium.

Health Care Spending Accounts (HCSAs)

An HCSA is basically a health benefits bank account set up for each employee to use. HCSA benefit dollar amounts are established by the employer at the start of a pre-defined benefit period. When employees spend their own money on eligible products and services for themselves and/or their dependents, these expenses can be reimbursed through their HCSA up to the predetermined maximum.

Eligible expenses under an HCSA are normally determined by the Canada Revenue Agency (CRA). In other words, if it can be claimed as a medical tax credit, it can be reimbursed through an HCSA.

An HCSA can also be added to a traditional benefits plan to cover eligible expenses that aren't covered by the plan, in excess of the plan's coverage maximums, or related to coinsurance and deductibles charged by the plan. It can also be used to cover dependents who aren't eligible under the plan, but are eligible under the Canada Revenue Agency's definition of a dependent.

Flexible Benefits Plans

Flexible – or flex – plans allow employers to meet the diverse needs and demographics of their workforce without breaking the bank. Rather than offering a defined benefits package and paying premiums based on claims paid by the plan, flex plans allow employers to define their contribution levels for the benefit period. Employees use those contributions – known as flex credits or flex dollars – to purchase benefits that meet their personal needs and the needs of their families.

There are a number of different types of flex plans offering varying levels of choice – from adding one or two optional benefits to a traditional plan to providing plan members with the ability to completely customize their benefits.

Find out more about myFlex Benefits.

What should I consider when choosing a health benefits plan?

Before offering a health benefits plan, you need to know what your objectives are and understand the needs of your employees.

Identifying your objectives

Here are some questions you should ask yourself:

- What is the reason you plan to offer health benefits? (Employee demand? Attracting the top talent? The right thing to do for my employees?)
- What will the program's primary goals be? (Provide coverage at a minimal cost? Provide flexibility to a diverse workforce? Attract and retain skilled employees?)
- What is the annual budget for providing coverage?

Understanding and identifying employee needs

What are your employees' needs and how will they change over time? (A team made up of single twenty-somethings will have different priorities than married 40-year-olds with kids.) There are some simple steps you can take to determine what type of benefits might be the best fit.

- Find out what benefits other employers in your sector are offering. Industry-specific benchmark data is available from a few sources, including The Conference Board of Canada, Cowan and Asinta and BenchMarket.
- Survey your employees to determine their needs, preferences and expectations.
- Think about the demographics of your team to determine the options that will best meet their needs.

Which benefits option is the best for your company?

Once you understand your goals and your employees' needs, you can determine which health benefits option to choose. Here's a look at which options might be the best fit, depending on your goals:

Goal	Possible options
Provide industry-competitive benefits at the lowest price	• Traditional benefits solution with basic life, extended health and dental coverage. • Stand-alone Health Care Spending Account (HCSA).
Combine flexibility while controlling costs	• Hybrid benefits plan that reduces traditional benefits coverage in exchange for an increase in Health Care Spending Account (HCSA) credits. • Cafeteria-style flexible benefits program.
Gain a competitive advantage to attract and retain skilled employees	• Cafeteria-style flexible benefits program.

Once you understand your goals and the options available, you should consider your budget and consult the right advisor.

How much do health benefits cost?

The cost of employee benefits plans vary widely and depends on the demographics of the company and the plan design and benefits selected. Group benefits benchmarking reports can provide further context on the typical benefits cost per employee.

But that amount varies by industry and the goals of the benefits program. For example, an employer that views benefits as a "cost of doing business" will have a much different budget than an employer that wants to make his employees feel special and drive appreciation of the benefit spend.

Identifying your objectives

Here is a simple calculator to see if your budget expectations are in line with your benefits goals:

1) Overall payroll amount: _____

2) % of payroll you would consider spending on benefits: _____

Total budget = Line 1 x (Line 2/100) _____

The factors

Whether setting initial plan rates or calculating rates at renewal, the following factors are usually taken into consideration when determining premiums.

Age

Age is a key determinant in the development of rates for the majority of group benefits. As we age, there is a greater likelihood of becoming ill or disabled and this is reflected in the premium rates charged. A general rule of thumb is that you can expect lower premiums for a group with a younger average age.

Gender

Gender also factors into the calculation. Generally speaking, life, health and dental premiums are higher for men, while disability rates are higher for women.

Volume of Insurance

The amount of coverage can impact your premiums in several ways. For benefits where the coverage amount is based on an employee's salary, such as Long-Term Disability insurance, higher earners will drive up premium rates. For extended health care and dental benefits, the number of employees with family coverage will impact your premiums – a typical family rate can be more than double the single rate.

Industry

The industry you work in also factors into the premium calculation. Every industry and occupation presents a different level of risk for different types of claims. Based on historical data, insurance companies apply a risk factor to your premium rate calculations to reflect your industry and the occupations within your employee group.

Turnover

Insurance companies set their rates based on the demographics of a group at a certain point in time. If employees are constantly changing, the assumptions may not hold true at renewal which could result in higher renewal premiums.

Benefits Selected

It's important to understand how each benefit in your plan contributes to the overall cost of the benefits program. There are definitely some key benefits that drive the majority of the cost, while others may not represent a significant portion of the premium yet may provide valuable coverage to employees.

Extended Health Coverage (EHC)

Extended health care tends to be the largest contributor to the cost of a benefits plan. Prescription drug coverage, in particular, has the most impact, being the most utilized benefit in any plan. It is, therefore, wise to consider plan design options that manage drug costs effectively to ensure you can sustain the program into the future.

The EHC benefit also usually includes coverage for health practitioners like chiropractors, massage therapists and physiotherapists and is considered to be an important benefit to many employees. With an increased focus on prevention, this benefit serves to help avoid other costs by helping employees stay healthy and productive.

Hospital and vision coverage are two other components of the EHC benefit that represent a significant portion of the premium associated with this benefit but are highly valued by employees.

Dental

Dental plans are usually divided into three increasing levels of coverage: Basic Services, Major Restorative Services and Orthodontic Services. Basic Services typically include regular cleanings, check-ups and root canals. Major Restorative Services include coverage for bridges and crowns. Orthodontic Services cover expenses for braces and can be limited to dependent children only or can include coverage for adults. As with the EHC benefit, it is important to include adequate cost controls to manage these expenses wisely.

Life Insurance

Most small business benefits plans include a minimal Life Insurance benefit as a mandatory component of the plan. Optional Life insurance can be used to supplement any basic Life Insurance amounts and is selected and paid for by each employee. Dependent Life Insurance is also available. Life Insurance premiums tend to be a small component of the overall cost of the plan.

Short- and Long-Term Disability

Short- and Long-Term Disability coverage replaces a portion of an employee's income while they are disabled. This is important coverage that many small businesses initially choose to opt-out of. However, if these benefits are set up on a non-taxable basis, they require no funding by the business owner. By having employees pay for the entire cost of the Short- and/or Long-Term disability premium, any benefit an employee receives if they become disabled is a non-taxable benefit.

Critical Illness (CI)

The CI benefit is becoming a more common option to include in a comprehensive benefits program. This coverage is meant to provide a lump-sum benefit for a defined list of critical illnesses and can bridge the gap for employees suffering from serious medical conditions by offsetting many of the additional costs associated with their illness.

Containing costs through plan design

There are several plan design options that business owners can use to manage the cost of their benefits plans more effectively:

Premium contribution

Although a group benefits plan is seen as a perk for employees, it is important to ensure that they share in the responsibility of managing the plan and its costs appropriately. Having employees pay a portion of the premium will help in developing a mindset of shared accountability and avoiding abuse. Most insurance companies require an employer to pay at least 50% of the benefit costs but some employers choose to pay more as part of their overall compensation and benefits strategy.

Deductibles

Including a deductible for EHC and Dental benefits is one way to reduce the cost of the benefits program. The deductible is the amount the plan member must pay before any benefits become payable under the plan. There are, however, more effective ways to have employees share in the cost of the benefits plan – coinsurance is a good example.

Coinsurance

Coinsurance represents a fixed percentage of the total cost of the claim that is payable by the plan member. Incorporating a coinsurance amount for EHC and Dental expenses helps employees understand the value of their benefits plan by participating in a small part of the cost of each claim. Depending on the type of benefit, coinsurance levels can range from 50 per cent to 100 per cent. Orthodontics claims, for example, are typically paid at 50 per cent coinsurance. This really helps to reduce the expense of offering this type of high-cost coverage.

Caps/Maximums

Most plans will include a maximum for certain types of coverage. A good example would be vision care or paramedical coverage. A maximum helps to keep costs at an acceptable level for these often expensive and recurring services. Incorporating a dispensing fee maximum in the drug plan helps to make employees smarter consumers by giving them an incentive to shop around for the most competitive dispensing fees.

Future costs of the plan – Understanding your renewal

It's important to understand that initial premium rates are established upon implementation of the group benefits plan and are typically re-evaluated, or renewed, every 12 months. Any changes to your employee make-up and claiming patterns need to be reviewed periodically to ensure the plan is priced appropriately to meet future costs. The group plan's first renewal is often extended to 15 months (or longer) which allows the insurance company to accumulate a longer period of claims history to help determine premium requirements for the coming year.

The longer the period, the more predictable, or reliable, that information will be. Using a longer time horizon will help the insurance company assess future claims trends. An accurate premium calculation that reflects the true future "risk" associated with a group will help to ensure renewal premiums from year to year are set at appropriate levels to support the group's claiming patterns.

Along with assessing the demographic changes that have occurred over the past year and the claims history of the group, the insurance company's renewal calculation takes into consideration the following additional factors:

- Inflation,
- The increasing cost of newer more expensive drugs,
- The increasing use of existing products and services,
- Government programs shifting services to private plans,
- Changes in legislation that impact health care,
- Changes in taxes, and
- Changes in interest rates.

Special considerations for small business clients

Insurance companies take two key factors into consideration when determining pricing for small business clients:

Pooling of claims for "catastrophic" benefits

For some benefits with a potentially higher pay-out, such as Life or Long Term Disability insurance, the premiums paid by any one group would normally not be sufficient to cover the costs of these claims. Most insurance companies "pool" these claims within their entire block of clients and they are not used in the calculation of the group's renewal premium. The insurer uses the claims history of their entire block of business as the basis to calculate rates for these more high-dollar, often volatile benefits. This helps to avoid wide swings in rates from year to year.

Predictability of future claims

The degree to which a group's claims history impacts its renewal premium requirements will depend, in large part, on the insurance company's assessment of how predictable or reliable claims trends today will reflect what can be expected in the coming year.

Unlike "catastrophic" benefits, such as Life Insurance or Long Term Disability, where claim amounts are significant but infrequent, Health and Dental claim frequency is high but claim amounts may be low. For these benefits, the claims history of a small business will be factored into the calculation of their renewal rates based on the degree of "credibility" the insurance company assigns.

The smaller the group, the less credible, or predictable the claims history will be. So claims for a smaller group with 10 employees will have less of an impact on the renewal rate calculation compared to a group with 100 employees. As a smaller group builds its claims history, its past claims continue to increase in credibility and become a larger factor in the renewal calculation than in the early years.

This approach helps to moderate premium fluctuations from year to year so that the plan continues to be affordable and sustainable in the long-term.

What questions should I ask my advisor?

A key component to offering the right benefits plan is developing or maintaining a relationship with an advisor. It is the role of these professionals to find the right insurance carrier that can provide the right coverage that will work within the employer's overall group benefits strategy.

An advisor can also inform you about legislative changes and their impact on your benefits plan. They can share information about new technology that would benefit you and your employees, as well as new products, services and opportunities to effectively manage the cost of the plan.

A key to developing or maintaining a productive partnership with an advisor is to ask them the questions that will ensure that they are able to meet specific needs:

- What services do you provide?
- Based on my benefit goals and annual budget what plan design do you recommend?
- What are the most effective ways to communicate the plan to employees?
- How can you help to ensure that the benefits plan continues to meet my goals given the changing demographics of the workplace and the ever-growing competitiveness of the market?
- How can you assist in ensuring a benefits plan remains competitive in a specific industry? And at the same time help effectively manage the rising costs of the benefits plan?

TOGETHER

Protecting Today – Preparing Tomorrow™

As a mutual we provide financial security differently by focusing only on our clients. We believe in the power of working together with you and independent advisor partners. Together we offer individual insurance, savings and retirement, and group benefits solutions. We help protect what matters today while preparing for tomorrow.

At Equitable Life, we are people with purpose. We are passionate to provide the right solutions and experiences for you through our partners. We have the knowledge, experience, and the financial strength to ensure we meet our commitments to you now and in the future.

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