The Certified Employee Benefit Specialist® Program

GBA1&2 Managing Benefit Plans

Textbook Update—October 2017

This material is required reading for purposes of the CEBS program and the national exams for the GBA 1 and GBA 2 courses administered on or after October 15, 2017.

Textbook Update—
Group Benefits Plan Management (2nd Edition)

The chapters affected are summarized below.

Chapter 2  Pages 2-9 to 2-11
Chapter 7  Pages 7-28 to 7-29
Chapter 8  Pages 8-5 and 8-6
Chapter 9  Pages 9-2, 9-8 and 9-12 to 9-13
Chapter 10 Pages 10-2, 10-8 and 10-16
Chapter 12 Pages 12-5, 12-7, 12-12 and 12-15
Chapter 15 Pages 15-8, 15-9 and 15-18

Instructions

There are two types of updates:

1. Minor—Where changes are made to a small section of the text, changes are indicated in **bold**.
2. Major—Entire sections are provided as a replacement.
Textbook, Chapter 2

Pages 2-9 to 2-11, from Trust Agreement on page 2-9 to Single-Employer Plans on page 2-11: Replace with the following.

Trust Agreement

Under an employee benefit trust, assets are held independently by trustees for the benefit of trust beneficiaries. A trust agreement establishes the terms and conditions for overall trust management and empowers the trustees to make decisions related to the trust operations (i.e., adopting policies for benefits, investment of funds, governance, etc.; establishing business premises for operating the trust fund and benefits plan; receiving contributions; and paying benefits from the trust fund). For an insured benefits plan, the trustee(s) should be the group policyholder(s).

The trust agreement is normally established by the “sponsor(s)” (i.e., by an employer or an association or jointly by (a) union(s) and an employer group). In trusts, the sponsors are also normally the “settlers.” The settlors establish the trust, contribute the funds, set and amend the terms of the trust, appoint the trustees and determine the beneficiaries. The trust agreement generally sets out:

- Parties to the trust (e.g., the sponsor(s) and the trustees)
- Purpose of the trust (e.g., Trustees agree to receive, hold and administer the fund for the purpose of providing benefits for beneficiaries of the trust in accordance with plan provisions.)
- Composition of board of trustees, as well as how trustees are appointed, terminated and retired
- Powers, duties and responsibilities of the trustees
- How contributions will be collected from employers and consequences if employers fail to make required contributions
- How excess trust monies (i.e., monies not needed to pay benefits) are held, invested and utilized
- How benefit payments are made (e.g., claims procedures)
- Powers, duties and responsibilities of sponsor(s) and requirements for amending or terminating the trust
- Hiring process regarding trust employees and/or service providers (e.g., lawyers, accountants, benefit advisors, third-party administrators)
- Requirements for participation agreements.
Plan design, along with powers of amendment relating to design and termination, are normally powers reserved by the sponsor(s)/settlor(s). Employers are responsible for funding the plan, and there should be enforceable collection mechanisms built into the trust structure. Individuals who act as trustees assume legal and fiduciary duties with respect to the trust.

**Participation Agreement**

Unless an employer is a signatory to the trust, or its collective agreement specifically indicates it has received and adopted the trust agreement, it is not necessarily bound to the trust or any rules established by the trustees. Employers should be careful about entering into broad statements in a collective agreement or a participation agreement. Most employers will want to ensure their responsibility is limited to providing accurate data and contributions in accordance with the trust terms in effect at the time of contracting, and not to other trust activities or to any future trust amendments made without their specific approval. Some employers may want to ensure they have input in the trust relationship. Other employers may want to be clear that they have no responsibility except to provide data necessary to administer the plan, to collect employee contributions by payroll deduction, to make and remit contributions and possibly to agree to periodic audits. If they are not parties to the trust agreement, they should have robust employer participation agreements.

**Board of Trustees**

MEPPs are generally administered by a joint board comprising an equal number of trustees appointed by the union(s) and employers. The board typically has six to eight members, though this varies depending on size and geographic dispersion of the member group and complexity of the plan.

Trustees must adhere to these rules.

- **Duty to obey the trust instrument.** This is the primary duty. Trustees are only exempt from this duty in certain circumstances (e.g., where the trust direction is illegal, clearly impractical or so uncertain that no valid trust exists).

- **Duty of care.** A trustee must act as a reasonable person and take care of the trust property as a reasonable person.

- **Duty of loyalty.** Trustees have a duty to act in the best interests of beneficiaries, a duty of impartiality (i.e., acting with an even hand) and a duty to avoid conflicts of interest (or duty).

- **Duty of discretion.** Benefit trusts should, in most circumstances, be written to limit trustee discretion, and any discretions that are granted should be carefully reviewed by the trustees.

- **No-delegation rule.** Trustees are not permitted to delegate to either agents or cotrustees the powers, discretion or duties assigned to them, unless:
(a) The trust instrument authorizes the delegation.
(b) Legislation governing trusts or trustees allows for it.
(c) It is impossible for the trustees to do the acts themselves.

- Duty of confidentiality. The affairs of the trust and any personal information relating to the beneficiaries must remain confidential. Trustees should have appropriate procedures in place to safeguard such information, especially if they have an adjudicative function relating to health and disability benefits. In contracting with insurers, trustees should ensure they have rights to certain types of confidential information. For example, insurers may receive information about plan members who pose a health or security risk to the employer. By virtue of insurance legislation, many insurance policies allow the insurer to discuss the issue with an employer that is a counterparty to an insurance policy. In a trusteed arrangement, where the insurance policy is with the trustee, neither the insurer nor the trustee may be able to advise the employer.

- Duty of disclosure. Trustees must make and keep proper records and accounts, including accounts related to their own expenses and proper documentation (and contracts) relating to any investments and insurance policies. There is a duty to properly inform beneficiaries of their interests under the trust.

It is always useful to have trustees specifically consent to act as trustees and to accept the trust. When trustees are replaced, new trustees should, in writing, consent and accept the terms of the trust. New trustees should also inquire into the actions of their predecessors, since they will be responsible for prior acts or omissions of their predecessors unless they take prompt action after their appointment to address any concerns they have about past actions.
Textbook, Chapter 7

**Page 7-28 to 7-29**, from REQUIRED PREMIUM ADJUSTMENT on page 7-28 to the end of page 7-29: Replace with the following.

**REQUIRED PREMIUM ADJUSTMENT**

The relationship between the total adjusted premiums and the sum of paid claims, change in waiver of premium or disabled life reserves, change in IBNR reserves and, if used, interest credit on reserves is known as the “incurred claims loss ratio.” This ratio is compared to the “target loss ratio,” which is effectively equal to premiums less the retention.

For example, a retention charge of 14% levied on a group leaves 86% of the premium to cover the claims charges. If the analysis results in an incurred claims loss ratio of 86%, the plan is in a breakeven position, that is, premiums are sufficient to cover both claims charges and plan expenses, and an experience adjustment is not required.

To determine the required experience adjustment, retention or expense charges are factored into the rating by dividing the incurred claims charge loss ratio by one minus the projected retention charge. For example, an incurred claims loss ratio of 94% and projected retention charge of 14% results in a required experience adjustment of +9.3%.

\[
(0.94 \div 0.86) - 1 = 1.093 = +9.3\%.
\]

The credibility of the group’s experience is then calculated. If the group’s experience is fully credible, the experience adjustment will be the premium rate requirement. If the group’s experience is partially credible, the blended premium rate is calculated as the sum of the following:

\[
\text{Required Experience Rate} = \text{Current Rate} \times \text{Experience Adjustment} \times \text{Credibility Factor}
\]

\[
\text{Required Manual Rate} = \text{Manual Rate} \times (1 - \text{Credibility Factor})
\]

The blended premium rate relative to the current rate is the required premium rate adjustment. For example, assume the current life rate is $0.10, the experience adjustment is +10% (1.10), the credibility factor is 75% (0.75) and the manual rate is $0.15. This results in a blended premium rate of $0.12.

\[
\text{Required Experience Rate} = $0.10 \times 1.10 \times 0.75 = $0.0825
\]

\[
\text{Required Manual Rate} = $0.15 \times (1 - 0.75) = $0.0375
\]

\[
\text{Blended Premium Rate} = $0.085 + $0.0375 = $0.12
\]

The required premium rate adjustment is \( (0.12 \div 0.10) - 1 = .20 = +20\%. \)
The target loss ratio is the breakeven point where claims costs are equal to a fixed percentage of premium. The incurred claims loss ratio is compared to the target loss ratio to determine the required premium adjustment.

**ANALYSIS PERIOD AND WEIGHTING FOR WI/STD, HEALTH CARE AND DENTAL**

The analysis typically uses the two most current years of experience for WI/STD, health care and dental benefits. Occasionally, three years of experience is used for WI/STD, since this benefit is subject to experience fluctuations from one year to the next.

A different weighting can be assigned to each year used in the analysis. If using two years, 75% is typically assigned to the most current year and 25% to the previous year, because the most recent experience will be more representative of the current composition and claiming patterns of the group. Alternatively, a 50/50 weighting can be assigned to both periods. If using three years of experience for WI/STD, health care and dental benefits, heavier weighting is typically assigned to the most current year of experience. Typical weightings are 50/30/20, a 3-2-1 weighting (i.e., 50/33/17), or 50/25/25. Equal weighting can also be used (i.e., 34/33/33).

For example, the incurred claims loss ratio for health care benefits is 120% for the most current year and 70% for the previous year. Using typical weighting of 75%/25%, the weighted loss ratio is 107.50% ((120% × 75%) + (70% × 25%).)
For example, an incurred claims loss ratio of 92% and projected retention charge of 16% results in a required experience adjustment of $+9.5\%$ ($0.92 \div 0.84) - 1 = 1.095$ or $+9.5\%$.

The required premium rate adjustment is $\left(\frac{0.12}{0.10}\right) - 1 = 1.20$ or $+20\%$.
Textbook, Chapter 9

Page 9-2, AGENTS, point 3: Make changes indicated in **bold**.

3. Low-high scale. Commission rates increase for a **specified period** (e.g., the first six **years**) with rates typically capped at 15% if the plan remains with the insurer. As this rewards the agent at a higher rate for every year the plan is in force, it offers the most incentive for agents to retain the plan sponsor’s business. Only a few insurers use this type of scale and usually for small groups.

Page 9-8, Prospecting or Identifying Clients, paragraph 2, sentence 2: Make changes indicated in **bold**.

The following are common reasons that a plan sponsor might choose to **market** a plan:

Pages 9-12 to 9-13, paragraph 5 and the bullets: Replace with the following.

Plan member data. This includes the following plan member information:

- Identification number
- Age or date of birth
- Sex
- Province of residence
- Dependent coverage election, if any
- Occupation or class
- Coverage amount
- Earnings (may be required if the underwriter wants to know coverage relative to earnings). Overtime pay and bonuses are typically not included in earnings for the purpose of calculating benefits; for commissioned salespeople, the percentage of their income is based on commissions.
- Date of employment.
Textbook, Chapter 10

Page 10-2, Basic Life Insurance, paragraph 1, sentence 1: Make changes indicated in **bold**.

In single-employer and multi-employer plans, generally, basic life insurance is provided for all active, **permanent** plan members and is paid for by the plan sponsor.

Page 10-8, Premium Rates, paragraph 1: Make changes indicated in **bold**.

For example, if a plan member has $150,000 of group life insurance, at a rate of **$0.20** per $1,000 per month, the monthly premium would be $30.00.

Page 10-16, Combined Maximum, paragraph 1: Make changes indicated in **bold**.

A contractual overall limit on total basic and voluntary AD&D benefits payable (referred to as the “combined maximum”) is **not very** common with voluntary coverage, because benefit amounts are selected by the plan members and catastrophic claims may be incurred in one accident.
**Textbook, Chapter 12**

**Page 12-5,** Definition of Earnings: Replace this section with the following.

The LTD benefit amount is calculated based on the plan member’s gross earnings immediately prior to the date of disability, regardless of the tax status of the benefit. For nontaxable plans, net earnings are used in the calculation of the all-source maximum.

“Gross earnings” is defined as regular earnings received from the employer and can include bonuses, commissions and overtime pay when earned on a regular basis. If included, commissions are usually based on the average commissions received in the preceding 24-month period. For plan members with less than 24 months of employment, commissions are based on the average commission received for the duration of employment.

“Net earnings” is defined as gross earnings less income tax.

**Page 12-7,** Direct, sentence 2: Replace with the following.

Offsets may also include benefits payable under automobile insurance (where permitted by law).

**Page 12-12,** Pre-Existing Conditions Limitation, paragraph 1, sentence 1: Replace with the following.

The provision excludes coverage for any medical condition that existed and for which a plan member received treatment during a specific period prior to becoming eligible for benefit coverage (these periods vary).

**Page 12-15,** PLAN FUNDING, paragraph 4, sentence 5: Make changes indicated in **bold.**

Similar legislation has **been proclaimed** in Ontario.
Textbook, Chapter 13

Page 13-6, DEDUCTIBLES, paragraphs 1 and 2: Replace with the following.

A “deductible” is an amount that a covered individual must pay before any reimbursement is payable on the expenses in excess of that deductible. Deductibles discourage claims for very small amounts. The deductible can take two forms: an annual deductible (most commonly a calendar year deductible) or a per prescription deductible. Deductibles are subject to erosion by inflation. This occurs when deductibles do not increase as health care costs increase.

A calendar year deductible is satisfied on a calendar year basis, from January 1 to December 31. Some plans administer the deductible based on plan year. For example, if the plan year begins on April 1, the deductible is satisfied during the period of April 1 to March 31.

Page 13-10, paragraph 1, sentence 1: Make changes indicated in bold.

Internal limits are benefit maximums that can be applicable annually, every two years (or some other frequency) or over the eligible individual’s lifetime, depending on the type of expense.

Page 13-10, paragraph 2, sentence 2: Make changes indicated in bold.

For example, a lifetime maximum of $1,000,000 may apply to all eligible out-of-Canada expenses reimbursed from the time of the plan member’s entry into the plan until his or her plan coverage ends.

Page 13-10, REASONABLE AND CUSTOMARY CHARGES, paragraph 1, sentence 1: Make changes indicated in bold.

Most extended health care plans pay for eligible health care services on the basis of a reasonable and customary charge (or “R&C maximum”) for the specific service or procedure. This limit is listed in a schedule of fees as determined by each insurance company.

Page 13-10, REASONABLE AND CUSTOMARY CHARGES: Strike out paragraph 2.
Page 13-12, DRUGS, paragraph 2, sentence 2: Make changes indicated in bold.

Drug Coverage Options. A common type of coverage is a “prescription drug” plan, which generally covers only drugs that legally require a prescription.

Page 13-13, Generic substitution, paragraph 1, sentence five: Make changes indicated in bold.

This provision may allow for payment for the brand name drug when the physician indicates that the generic is inadequate.

Page 13-14, point 1, sentence 2: Make changes indicated in bold.

1) Voluntary generic substitution. Under this type of plan, payment is based on the generic equivalent unless the physician indicates “no substitution” on the prescription.

Page 13-14, point 2, sentence 2: Make changes indicated in bold.

2) Mandatory generic substitution. Under this type of plan, payment is based on the generic equivalent even if the physician indicates “no substitution” on the prescription.

Page 13-27, CRA Requirements, point 3: Make changes indicated in bold.

3. The HCSA must incorporate a use-it-or-lose-it feature where any unused HCSA credits are forfeited when a plan member terminates, retires or dies.

Page 13-27, CRA Requirements: Add the following new paragraph to the end of the page.

These three design features must be included if an HCSA is part of a flexible benefits plan. If an HCSA is a standalone part of a traditional benefits plan, design features two and three apply.

Page 13-29, paragraph 1: Add the following after sentence 1.

This preserves the balance of an HCSA for the plan member.
Pages 13-30 to 13-31, Plan Design: Replace this section with the following.

There are three plan design issues to consider when determining whether to introduce an HCSA as part of a flexible benefits plan.

1. **Administrative Effort.** Initially, a plan sponsor should weigh the administrative effort involved in implementing an HCSA with the value a plan member gains from the account. For example, the net benefit in starting up an HCSA may not be worthwhile if the plan sponsor is unable to provide more than a minimal allocation to the account, such as $100, since this will not effectively offer flexibility to plan members.

2. **Funding.** The plan sponsor must decide how to fund the account (new money or money freed up from benefit trade-offs, or both). The plan sponsor must also decide how unused HCSA credits will be dealt with at year-end (i.e., credit carry forward or expense carry forward).

3. **Impact of Plan Member Choice.** An HCSA can affect a plan member’s other benefit choices. This should be communicated to plan members. A plan member can use pretax dollars to pay for expenses through an HCSA that would normally be out of pocket. For example, a plan member who expects to incur no expenses in a particular benefit area, such as orthodontics, can choose a dental option that does not cover these services; the resulting freed-up flex credits can then be used for another benefit area the plan member needs.

If an HCSA is a standalone part of a traditional benefits plan, only the first two design features apply.

Page 13-32: Add the following to the start of paragraph 2.

Taxable spending accounts are not afforded the same tax advantages as HCSAs.
Pages 15-8, 15-9 and 15-18, Tax Considerations: In October 2016, the Canada Revenue Agency (CRA) replaced IT-470R (Consolidated) Employees’ Fringe Benefits with Income Tax Folio, S2-F3-C2, Benefits and Allowances Received from Employment. The underlying guidance provided by the Folio is basically the same but reflects some different terminology and provides some additional clarification. References to IT-470R (Consolidated) Employees’ Fringe Benefits should be changed to Income Tax Folio, S2-F3-C2, Benefits and Allowances Received from Employment.

Pages 15-8 and 15-9, Tax Considerations: Replace paragraph 2 on page 15-8 and paragraph 1 on page 15-9 with the following.

Section 6(1)(a)(i) of ITA addresses taxation of employee benefits. Generally, the value of a benefit is included in an employee's income when the employee or an individual not dealing at arm's length with the employee:

- Receives an economic advantage measurable in monetary terms
- Is the primary beneficiary of the benefit.

Income Tax Folio, S2-F3-C2, Benefits and Allowances Received from Employment outlines common types of benefits and allowances received from employment and indicates whether or not their value is included in income.

Page 15-9, Examples of taxable benefits from employment include, last bullet: Make changes indicated in **bold**.

- Financial counselling and income tax return preparation (other than that in respect of retirement or reemployment).

Page 15-9, Examples of nontaxable benefits from employment include, first bullet: Make changes indicated in **bold**.

- Counselling services related to mental or physical health, **reemployment** or retirement

Remove the second bullet, “Discounts on purchases of merchandise for personal use.”