TOOLBOX

By Michael Berton

BEST-KEPT SECRET

Business owners and self-employed clients should consider a health and welfare trust to augment a group benefit plan or as stand-alone coverage.

Illustration by Amanda Duffy

As provincial governments download more expenses in the guise of "user fees" or restrict the list of eligible (paid for) medical services, group insurers have responded by re-pricing the extended healthcare (EHC) and dental benefits their clients provide to their employees. Over the last five years some employers have seen a 100% increase in the costs of providing their employees coverage.

Some employers have begun to share the cost of benefits with their employees. They have also reduced the number of eligible visits or services or the amount of coverage in the plan or increased the co-insurance percentage or the deductibles of the plan. All of these moves have been made to control or reduce the cost of EHC and dental coverage without being seen as taking away benefits.

Advisors are recommending their business-owner and self-employed clients establish health and welfare trusts or HWTs, officially known as private health services plans (PHSPs), as either augmentation to group life and disability benefit plans or as stand-alone coverage. Favourable tax treatment and a flexibility of design make these plans very attractive.

Most provincial medical plans provide coverage for a basic level of essential and critical care. To ensure themselves choices,

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many Canadians find they are spending large amounts above what the government plan will cover. These expenses are often for drugs not covered by the provincial plan (either an experimental drug or a name-brand drug where only the generic drug is covered), for treatments deemed non-essential such as laser eye surgery, or for services delivered outside the provincial healthcare system (such as private magnetic resonance imaging). Most group plans are priced such that they only cover the cost of drugs and services above what the provincial government will pay. Each employer plan varies on whether or not drugs and services not covered by the provincial plan are covered at all or at what rate they are covered. (In many instances, pre-approval for these types of expenses is required by your group plan.)

According to Section 118.2 of the Income Tax Act, the qualifying range of medical expenses for a PHSP is very broad, compared with most provincial coverage, and many group plans, too. (Please see "Private Health Services Plans: Tax Primer," below.)

Most employers will say you can't please everyone all of the time. Nowhere does this show up more than in a group plan for a diverse employee group. Younger, single employees usually aren't that interested in group benefits that don't resemble money in their pockets today unless they have a chronic health issue. Few of them have

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PRIVATE HEALTH SERVICES PLANS: TAX PRIMER

Tax legislation permits businesses to deduct 100% of the contributions made in the tax year to a trust to self-insure employee hospital, medical care or other health expenses, including dental care (except in Quebec).

- The rules require that such a trust account must be administrated by an independent trustee.
- When employees claim for a reimbursement of their eligible healthcare expenses, the payments are received tax free. They are not considered a taxable benefit.
- Incorporated businesses have no limits on the contributions they make.
- Unincorporated business owners are subject to annual limitations of their contributions. For each owner/employee and his family, a maximum of $1,500 per adult and $750 per child applies. For example, a family of two adults and two children has a maximum annual benefit of $4,500. An unincorporated business that has three employees total, each whom are married with two children, and one single worker, would have a total company limit of $15,000 ($4,500 x 3 + $1,500). Under the Income Tax Act, such plans are also required to have an insurance element. As a result, many will necessarily include an insurance plan, such as out-of-province or travel medical coverage.

These maximum limits do not restrict the amount that can be spent on each family member but rather determine the family maximum. If an employee with a wife and two children has a child with braces whose orthodontic costs this year total $3,500, the whole amount would be an eligible expense but would mean that only $1,000 was available for the rest of the family to spend in that year ($4,500 - $3,500). *—M.B.*

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many expenses in this arena. As those employees age and have children, these benefits become very important, especially once their kids need braces. Older employees nearing retirement often take medication and rely on their group plans for financial assistance with some of their medical expenses. Some employees want better drug coverage while others want more coverage for eyeglasses or other aids (e.g. hearing aids, orthotics, etc.). Others want coverage for preventive or more therapeutic services like massage and physiotherapy. Still, others hope for coverage for services from the more recently recognized professions such as naturopathy and acupuncture.

So employers are faced with the challenge of designing a plan they can afford. Group insurance plans tend to provide lists of coverage with limits at a fixed cost. The coverage list is the same for everyone regardless of need. Only in the largest or more progressive companies will you find the so-called "cafeteria plans" where employees can choose from various coverage limits and levels in almost every area. HWTs can provide an unlimited list, within rules provided by CRA, and a spending cap for each employee. Most plans we have seen provide spending caps based on family status—such as $X if you are single, $2X if you are a couple and $3X if you have children. This gives each employee the ability to determine how to spend their family medical and dental budget each year while providing certainty to the employer as to the cost of the program.

The downside of these cafeteria plans is that they are not insured. If the employer has limits on the plan it is possible that employees will not be fully covered if they have a significant medical expense in any one year. For example, a medical expense of $12,000 would only be covered up to the employee's limit each year leaving the employee to fund the rest of the expense. In an insured plan it is possible, depending on the expense, that more or all of the expense would be covered, leaving the employee better off, but the employer's premiums would rise in future years to cover that expense over time.

Aside from the attractive tax relief permitted, HWTs may be more useful for their flexibility of design and cost control. Parts manufacturer XYZ Wingnuts can control the cost of its benefit plan by limiting the amount of money that is contributed per plan member. By establishing a "health spending account" of $2,000 per year for individuals or couples and $3,500 per year for families, the employer has drawn a

line on plan costs. At the same time, employees appreciate the flexibility to choose what benefits they wish to spend their plan dollars on. For example, if an employee wants to purchase expensive eyeglasses, he can direct more of the funding to that, while another can use her family account to cover costs associated with her children's dental expenses. Employees covered under a spouse's group plan can claim under the spouse's plan first, then claim any remaining unpaid amounts under the HWT.

The spending caps are not written in stone; they can be based on a review of past claims and can be adjusted by the directors at any time. In addition, they vest to the employee monthly to protect the plan from large claims made early in the year by a departing employee.

Under the PHSP rules, premiums paid to the trust are for the employee's beneficiaries. The funds in a PHSP are considered an asset of the company for accounting purposes and can revert to the company but the amount that is "repatriated" is taxable to the company. This activity raises eyebrows at CRA and is not recommended.

The trust must be an arm's-length entity and cannot be connected to the employer. The independence of the trustee is essential so the majority of the trustees must not be appointed by the employer.

A PHSP is not an insured EHC and dental plan. Although the client can build up a savings or pre-paid balance in their account to reasonable limits, the plan can also be funded on a pay-as-you-go basis. Each time an employee submits a claim to the plan the employer could make the contribution (plus the processing fees and taxes) to fund the claim. Employers must ensure they are always able to meet claim payments, so most employers will build up a reserve within the plan or fund one-12th or their annual limit exposure each month until they have at least six to 12 months of a reserve in the account.

Take for example two business partners in a small consulting business. They have established an HWT for themselves, their employees and their employees' families. As non-incorporated individuals, they are subject to CRA premium limits so they must keep track of their contributions over the year. Limited cash flow dictates that they must make a monthly contribution. Their advisor assists them by ensuring they contribute within the limits. He also reminds them to renew the out-of-province travel medical coverage of the plan to ensure it still qualifies as a PHSP.

While CRA has allowed welcome relief from income tax, that is the end of the free ride. Alas, all Canadians must pay GST on the administration fee charged for each claim. In addition, recent changes in Ontario require its residents to pay 8% PST and 2% premium tax on the gross claim amount (including administration fees).

Whether your self-employed clients are incorporated or not, in most cases an HWT will cost them less than a traditional extended benefit and dental plan, and be more valued by their employees. AE

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