MDM Insurance Services Inc.

The Guardian

news / winter / 2004

Delisting Chiropractic Service

Impact of Delisting Chiropractic Service to Ontario Plan Sponsors

In June 2004, MDM circulated a bulletin further to the May 18, 2004 announcement by the government of Ontario regarding de-listing of services from the Ontario Health Insurance Plan (OHIP) including chiropractic, physiotherapy and optometry services.

Currently under OHIP, fees for chiropractic services are covered to an annual maximum of $150 or about 15 visits. OHIP pays $11.75 for the initial visit and $9.65 for subsequent visits to the annual maximum. The OHIP year for chiropractic services runs from April 1st to March 31st. The information available to date from the Ontario Chiropractic Association (OCA) indicates effective December 1, 2004, OHIP will no longer cover any cost of chiropractic services. As per the OCA, there has been no formal written communication.

Refer to your benefit plan wording to determine how your plan currently pays for chiropractic services. Those employee group benefit plans with chiropractic services listed with the Ontario Health Insurance Plan (OHIP) as first payor (from first visit) will be impacted by the Province de-listing these services for Plan Members residing in Ontario. Right now, these plans reimburse the difference between the amount paid by OHIP and total expense incurred by the Plan Member, up to the per visit/annual benefit maximum. Potentially, there is no out-of-pocket expense to the Plan Member.

As stated in June 2004, MDM anticipates an increase in the claims paid under the employee benefit plan and a cost-shifting to plan sponsors for plans which currently have chiropractic services listed with OHIP as first payor. This results as these plans effectively become first payor for services no longer reimbursed by the Province.

As the Plan Sponsor should you decide to amend your benefit coverage for chiropractic services please contact your Agent/Broker.

Planning a Trip?

Fall has arrived much to the dismay of all the Summer loving folk! With its arrival, many of us are planning a winter get-away. Wherever your destination, it is important you understand your Emergency Out-of-Canada coverage.

For people travelling outside of Canada, the Government Health Insurance Plan (GHIP) covers only emergency health services. Emergency health services are those given in connection with an acute, unexpected condition, illness, disease or injury that arises while outside Canada and requires immediate treatment.

The charges for Medical Care must be eligible for reimbursement by the GHIP to be considered for eligibility under the Emergency Out-of-Canada benefit with MDM.

The costs associated with hospital stays, physician charges, and routine treatments such as x-rays, can be astronomical in other countries. Consider the following true scenario: Two days hospitalization which included IV solutions, blood tests, x-rays, lab fees and an ultrasound came to a grand total of $18,322.74 (USD). Of this, OHIP paid $800.00. You would be responsible for the balance.

It is important to know that your Emergency Out-of-Canada benefit covers exactly that - EMERGENCY health issues. It does not cover stolen or lost luggage, hotel rooms, meals, flying a loved one to you, etcetera. These benefits are considered "Travel Insurance" and can be purchased as a supplement to your Emergency Out-of-Canada coverage.

Please refer to your employee benefit booklet for more detailed information regarding the Emergency-Out-of-Canada benefit.

To find out more on what OHIP covers visit the following website:
www.health.gov.on.ca/english/pub/ohip/travel.html

In this Issue:

Measuring the Value and Performance of benefit plans

"Health benefits coverage provides peace of mind for plan members. They feel secure knowing they'll be covered in the event of a critical, possibly expensive, medical situation"

Canadian plan members place high value on their employer-sponsored benefits plans and are protective of the coverage provided, particularly in light of changes being made to the services available through provincial health plans.

To define the value placed on benefit plans, a list of hypothetical trade offs or "carrots" were proposed to plan members in the Aventis Healthcare Survey 2004. These included an extra week of vacation or straight cash buy-outs escalating in stages from $2,000 to $8,000. Only 13% opted for an extra week of vacation in exchange for their benefit plan, and just 11% said they would choose the highest cash buy-out, even though most aren't likely to be receiving $8,000 in services from their plans each year.

Plan sponsors and insurance companies should continue efforts in plan member education. Not only about what's covered and how to submit claims, but also to address costs associated with providing the plan and the importance of making informed choices when using the coverage. Educating plan members about how to use their benefits properly can help protect your benefits investments and meet claims management objectives. Some of the ways to do this include:

- Have Plan Members be sure their Explanation of Benefits (EOB) reflects services received;
- Recommend they ask service providers about the cost and medical necessity of services;
- Urge them to sign claim forms on an "as needed" basis, and to notify the Insurance Company if a service provider requests they pre-sign forms.

Keeping plan members satisfied is only part of the story. Plan sponsors also need to be confident their investment is paying dividends in terms of reduced absenteeism, greater productivity and increased job satisfaction among plan members.

Eighty-five (85%) percent of Aventis respondents indicate their benefit plans are a "very positive" or "somewhat positive" reflection on their employers. Although that positive opinion isn't often expressed with gifts and cards, it's far more likely to translate into increased efficiency and loyalty in the office and on the production floor - *where it counts the most!*

Sources: Ipsos-Reid, *The Aventis Healthcare Survey 2004*, SunLife Assurance Company of Canada

Alberta Aids to Daily Living (AADL)

AADL helps provide authorized basic medical equipment and supplies to people with a chronic disability or illness and those who are terminally ill. Patients must pay 25% of the cost of the equipment, up to a maximum of $500 per family per benefit year (July 1 to June 30). Patients on income supplement programs and those with low income are exempt from cost sharing. Some basic medical equipment and supplies include:

- Back supports
- Bathing and toileting equipment
- Catheter supplies
- Hospital beds
- Patient lifters
- Ostomy supplies
- Oxygen
- Respiratory equipment
- Wheelchairs (manual and power)

For further information on the Alberta Aids to Daily Living Program call 780-427-2631 or visit their web site at: www.health.gov.ab.ca

Do you have an eligible dependent attending school full-time outside of the Country ?

Many eligible dependents are taking up residence outside of Canada for the purpose of attending school full-time.

Do they have enough insurance coverage under your group policy plan?

Here are a few important factors to consider:

- A person will only be considered a Dependent if they normally reside in Canada but have taken up residence outside of Canada for the purpose of attending school on a full-time basis (they must still meet the qualifications of an eligible student);
- Coverage is restricted to what MDM would have paid had they been resident in Ontario (or another province in Canada);
- Anything their GHIP (Government Health Insurance Plan) would have paid for; MDM will not reimburse (ie. Emergency room treatment, regular hospital ward accommodation, x-rays, lab tests, physician's fees etc.)

Therefore, you may want to consider purchasing additional private coverage for your child.