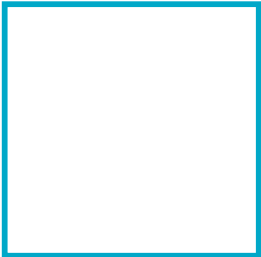
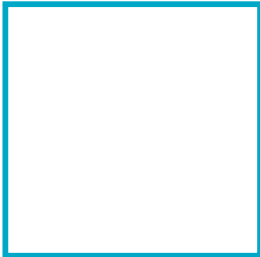
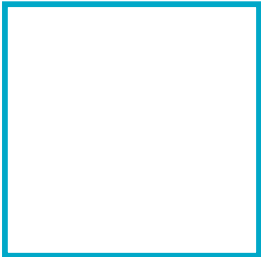


17 NOVEMBER 2011

COST TRENDS IN HEALTH BENEFITS FOR ONTARIO BUSINESSES: ANALYSIS FOR DISCUSSION

Commissioned by the Ontario Chamber of Commerce for release at the Ontario Economic Summit





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Introduction

Ontarians take great pride in Canada's universally accessible health care system, though there is a general fear that the current system is not sustainable. Over the past decade, numerous credible and authoritative voices have expressed concern about the future of our current model.

Much of the focus around health care sustainability has been on provincial government spending and on the upcoming renewal of the federal-provincial health accord in 2014. Last year, TD Bank pointed out that at the current pace of expenditure growth, nearly 80% of the provincial budget of Ontario will be taken up by healthcare services by 2030 (up from 46% in 2010)¹. TD's key premise for urgent action is straightforward: "the status quo featuring rapid growth in health care spending is not sustainable."

Ontarians and the province's business community fund our health care system through taxation – yet there is another side to the health care debate – the cost of supplementary employee benefits (disability, vision care, dental benefits, drug plans, and other costs) to Ontario businesses. These health benefits impact employers' costs as well as Ontario's ability to attract new investment in today's globally competitive marketplace. To understand the trends in employer health care costs, the Ontario Chamber of Commerce retained the consulting services of Mercer. This report has been prepared by Mercer to explain recent trends in employer benefit plans, and the impact of these costs on Ontario businesses going forward. The Ontario Chamber of Commerce's intent is to foster discussion and debate on benefit trends from an employer competitiveness perspective.

This discussion paper sets out some of the current health care challenges facing Ontario businesses. Benefit cost and design trends in Canada and the U.S. are reviewed and the U.S. approach to controlling costs is examined. Ontario's current benefit costs and cost management practices are described and areas for improvement are outlined. The expected future impact of high cost drugs is examined. Finally, future cost projections are presented, and examples of employer cost mitigation strategies are described.

¹ TD Bank, "Charting a Path to Sustainable Health Care in Ontario", May 27, 2010

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Current Challenges in Health Care

Ontario employers face significant challenges that may hinder their corporate growth. Some challenges are outside the organizations' control, including an unsettled economy, a higher Canadian dollar and the impending retirement of the baby boom generation. Others may be overlooked such as health care benefit costs as they have been relatively affordable to date. Employers have placed much reliance on a low Canadian dollar, government health programs, insurers and third party benefit providers to keep costs low and remain competitive in a globalizing economy. Forecasting the future has its own unique challenges, but Mercer believes the big picture is about to change in ways unforeseen only a year ago. In short, employer and government ability to sustain drug programs in current forms will likely face many pressures.

Affordability and sustainability of employer life, health and disability benefit programs is being challenged by diverse cost drivers that many employers may not be considering beyond the current year's cost. Affordability in a global context is taking on increasing importance as labour cost vies with the need for productivity growth to remain competitive. Sustaining benefits in the longer term requires employers to plan for rapid cost escalation over the remainder of the decade and to develop strategies to maintain benefit plans that will become increasingly important to attract and retain employees as the baby boom generation retires. The challenge will be to do so while mitigating cost increases.

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Trends in Canada Versus the U.S.

Benefit design and employee cost sharing arrangements are undergoing rapid change in Canada, particularly at Canadian divisions of global organizations. Changes are designed to maintain affordability and ensure a sustainable competitive advantage. As more decision making is moved offshore, organizations have used the past decade to restructure to reduce compensation costs. Human resource, finance and other key organizational decisions are increasingly made from global head offices outside Canada, and the pressure to globalize incentivizes organizations to reduce costs related to health and other employee benefits. This strategy is often considered fundamental by U.S. and global organizations.

We have traditionally viewed group benefit costs from the perspective of the private payer or employer. Using this model, Canadian healthcare remains inexpensive versus the U.S. However, benefits in general include both public and private payer programs, including Medicare, Pharmacare and extend well beyond health care to include employment insurance, workers' compensation and retirement programs. The following chart reflects 2007 Canadian and U.S. public and private program costs, indicating total compensation costs are likely too close to represent a significant competitive advantage for Canadian employers.

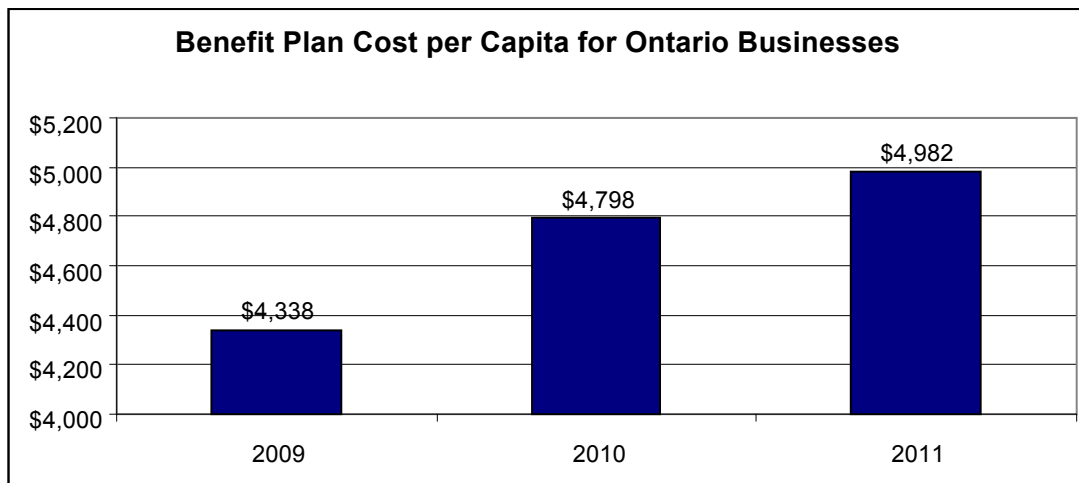
**Canada/U.S. Differentiators – 2007
Cost as a Percentage of Pay**

					
Employer Sponsored Plans	Life Health Dental STD LTD } 18.7% of Pay	25.6%	Life Health Dental STD LTD } 11% of Pay	23.6%	
	Savings, Pension, Bonus & Profit Sharing		Savings, Pension, Bonus & Profit Sharing		
Statutory Plans *	WCB, EI, Old Age Survivors & Employer FICA Taxes	9.3%	WCB, EI, C/QPP & Provincial Medicare	11.0%	
		34.9%			34.6%

* *Employer Paid – Excludes rest periods, holidays and vacation pay
US data source – U.S. Chamber of Commerce – Canadian data compiled from various referenced sources
- Payroll costs may vary by province/state and industry*

Since 2011 U.S. companies have taken action to mitigate their payroll costs. Federal Insurance Commission Act (FICA) payroll taxes represent employer contributions to fund Social Security and Medicare in the U.S. In 2007, these taxes represented about 7.65% of payroll. In 2011, employer-paid FICA taxes were reduced by about 2% of payroll costs and there is a proposal to cut them in half to encourage hiring. Workers Compensation Benefits (WCB), Employment Insurance (EI) and Canada/Quebec Pension Plan (C/QPP) costs exceed similar benefits in the U.S.

Since 2007, U.S. employer healthcare costs have increased approximately 29% and Canadian costs have escalated by about the same rate, albeit on a much lower base. U.S. employers have taken remedial actions to mitigate cost by shifting more to employees and by introducing better cost management practices. Most Canadian employers have taken little action. The employer-provided health growth rate has moderated somewhat in Ontario due to the patent cliff and provincial drug reforms in 2010, but is likely to pick up its pace in the near future.



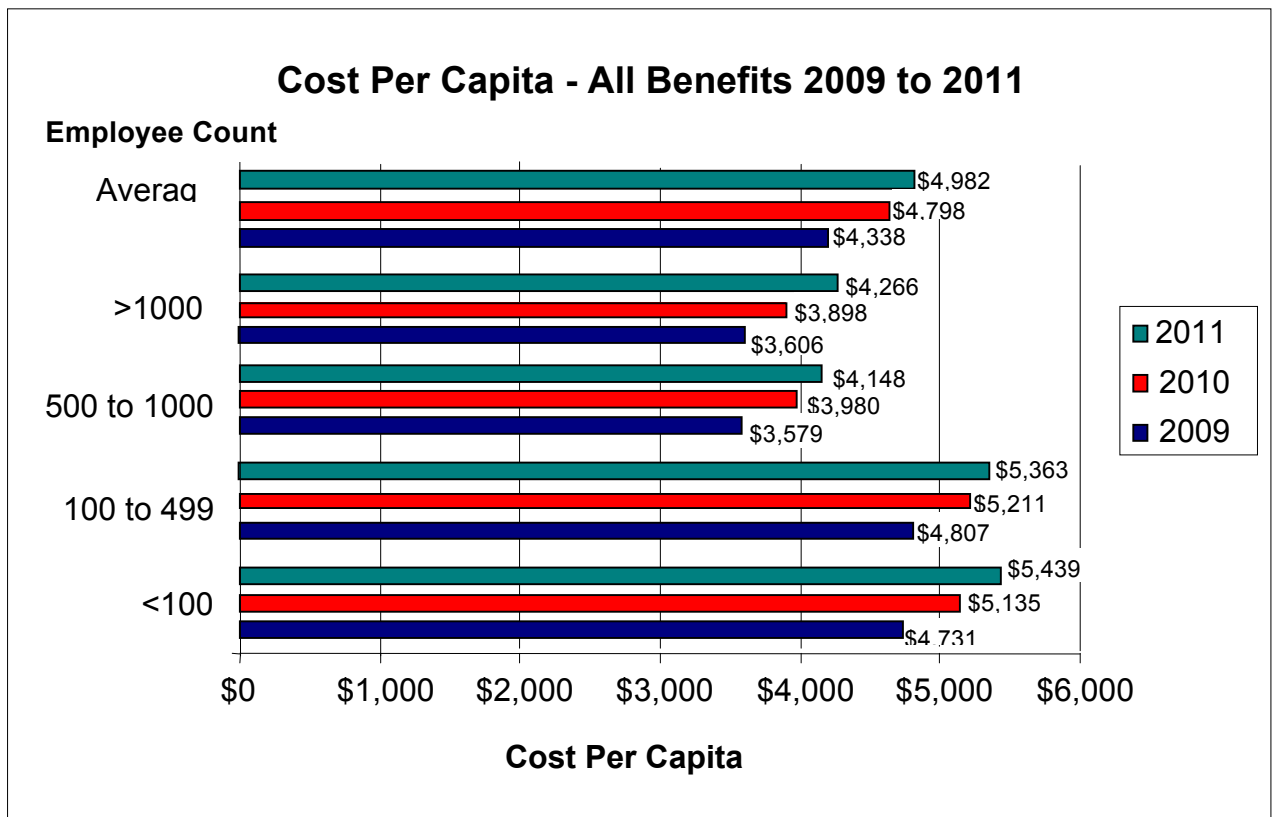
Based on Mercer's financial database, the chart shown above reflects an average benefit cost per employee in 2009 of \$4,338. This increased by 10.6% to \$4,798 in 2010 and grew an additional 3.8% in 2011 to \$4,982. Benefits include life, accidental death and dismemberment (AD&D), short- and long-term disability (STD and LTD, respectively), extended health care (EHC) and dental. Employee assistance programs add about \$36 per employee, per year. Numbers do not distinguish between employee and employer cost sharing and represent total cost per capita. The numbers include employees from other provinces if the employer plan is managed from Ontario.

As the chart below demonstrates, benefit costs are not distributed equally across all employer groups. Smaller businesses, with fewer employees, pay significantly more per capita than larger employers. Lower insurer expense loads and the ability of larger employers to assume greater risk reduce insurer risk charges. Organisations with 500 or more employees also tend to have more extensive benefit coverage, but offset by lower reimbursement levels. In Mercer's experience the largest employers are more likely to have introduced flexible benefits and credit systems in efforts to better control employer contributions.

Flexible benefit arrangements may be structured with or without credits. If a credit system is in effect, employers may control costs by freezing the credits or limiting the credits awarded employees to an outside indicator such as the consumer price index (CPI). As a result, as health costs escalate at a higher rate than CPI, the employee pays a greater share of the cost. Lastly, as the client size increases and fluctuation in cash flow becomes less important, larger employers tend to self insure salary continuation instead of relying on short-term disability through insurance arrangements.

Mercer's database indicates that larger employers with 500 or more employees are more likely to replace short term disability benefits with salary continuation programs covering the majority of employees. Such an arrangement typically adds between \$1,000 and \$1,500 of cost per

capita, depending on absence rates and average salary. These costs are not included in the chart.



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Current Cost Management

Canada has one of the largest baby boom (those born between 1946 and 1965) populations in the world. As this generation ages, medical conditions, absence, disability and life insurance costs will increase. Until baby boomers retire, employers will face increasing demands on benefit programs due to demographic change. The worsening health status of Canadians will exacerbate the situation with higher obesity rates driving medical, drug and disability rates through increased risk from diabetes, heart disease and other medical conditions. Rates of smoking are much lower than a decade ago, but those that still smoke are highly resistant to quitting.

Disability costs are rising and will likely continue to increase for several more years or until one of two things happen; the baby boomers retire or longer-term investment returns improve. Low interest rates and poor investment returns have negative cost consequences on the reserves held to fund future claim payments for life insurance and long-term disability benefits (LTD). With each 1% reduction on investment return, the premium for LTD increases by about 5%. Life insurance has a cost escalation of about 3% from the same investment reduction.

Conversely, when investment returns improve, LTD rates should decrease by a similar 5%. Since investments used to fund these benefits typically have maturities of about eight years, higher premiums due to the level of returns are likely limited to 3 or 4 more years of declining investment returns.

The paragraphs below analyse how employers have addressed some elements of cost mitigation that may not provide adequate redress to trends driving benefit costs higher. Employer strategies include shifting larger costs to employees, such as LTD, and making dental plan design changes to overcome shortcomings in payment practices used by insurers. Wellness programs are becoming more focussed and effective and offer longer-term solutions to rising healthcare costs as do Employee Assistance Programs (EAP).

1) Employee Paid Long-Term Disability (LTD) Plans

Over the past 4 years, about 9% of Mercer's clients have shifted from employer paid or employer contributory LTD to 100% employee paid LTD. A majority or 53% of employers now provide employee-pay-all LTD. Smaller employers are more likely to offer this type of arrangement, but larger businesses are taking advantage in increasing numbers. Arrangements of this nature serve two purposes; they offer employees a tax-free benefit and transfer a fairly significant cost to the employee. Cost transfers benefit the employer and appear to be an easy way to shift costs without tackling the more thorny issue of cost management within health benefits.

Hidden complications within tax-exempt LTD benefits and evolving pension plan arrangements may produce unwanted side effects unless care is taken with retirement plan design. Typically organizations have relied on income from three sources to fund an employee's retirement; the company's pension plan, individual savings and government retirement benefits. The combination of employee-pay-all LTD and a move to defined contribution pension plans could significantly reduce or even eliminate retirement income from one or more of these sources.

Under a traditional defined benefit pension plan, many employers continued service accrual during the disability period. Pension service accrual could be severely reduced or eliminated under a new defined contribution arrangement, if it is not appropriately structured, reducing the company pension at retirement age.

Income from tax-exempt LTD does not serve as contribution room to an RRSP under the *Income Tax Act*, reducing or eliminating the disabled employee's ability to self fund a tax effective retirement plan.

Lastly, about 70% of individuals receiving LTD are not considered sufficiently disabled under the Canada Pension Plan (CPP) definition to qualify for CPP disability benefits. Implications are considerable as, without this approval the disabled individual does not continue to accrue service towards CPP pension benefits.

At age 65, when LTD benefits typically cease, some employers may face individuals who have little or no retirement income from any source but the Old Age Security and Guaranteed Income Supplement. In some cases, the employee may even demand their job back. Depending on the employment contract, disabled individuals may continue to be defined as employees during their disability, but could be at a significant disadvantage: ineligible to accrue an employer pension; loss of CPP pension accrual; inability to save tax effectively individually. This is a potential reputational risk to the employer. The risk is especially great for recent immigrants or older entries to the workforce who have not accrued significant years of service under CPP prior to disability.

According to the Mercer Plan Design Database, employers with fewer than 500 employees and that have transferred LTD to an employee-pay-all arrangement may also be reducing the short-term disability (STD) period to 17 weeks and about 4% have made STD an employee-pay-all

benefit — a trend likely to continue. The most prevalent design among larger employers continues to offer 26 weeks of benefit. Similar to LTD, the transfer to employee-pay-all eliminates income tax on the STD benefit.

2) Dental Benefits

Dental benefits are subject to variation in the cost of services outlined in the Ontario Dental Fee Guide which insurers use to determine the reasonable and customary cost of services. The fee guide is just that, a guide to help dentists to bill for their services and does not represent actual billing rates. If it were so, the Competition Bureau would likely intervene. Ontario has the only provincial guide that allows for a range of fees or multiple codes for similar services. Some dentists charge generally more units of time for periodontal scaling or others may charge over \$1,000 for an extraction with similar services at \$200 under a different fee code. Since the numbers are in the guide and insurers approve claims based on the guide, both claims are eligible. The result has been cost escalation well above the consumer price index.

3) Employee Assistance Plans

According to the Mercer Plan Design Database, employee assistance plans are offered by 70.5% of Ontario employers and provide an impartial third party resource to employees on a wide range of subjects, ranging from financial assistance to medical questions. Providers typically charge a fixed monthly fee for the services, often linked to an assumed utilization level. But like other benefits, providers need to be audited for price as well as quality and service delivery. Scrutiny of this benefit is often overlooked by employers in the annual review.

4) Wellness Programs

Wellness programs for the most part have comprised a disjointed series of offerings that are only starting to come together as effective longer-term cost reduction arrangements. Effective wellness programs need to encompass the following elements:

a) Health Risk Assessment (HRA)

The HRA identifies both the employee population risks, such as weight, smoking status and other health risks in general throughout the population and individual health status. Population risk identification ensures that programs designed to improve health in general are introduced to change behaviours of significant groups within the employee population. Individual HRA results are used to educate employees through confidential medical assessments of their own medical status and the need for personal actions, such as taking blood pressure medications and/or weight management needs.

b) Employee Health Status

Employee categorization into separate health risk categories allow for programs to be tailored to the needs of each category. Healthy and not at risk; healthy and at risk; unhealthy and catastrophic or multiple medical conditions require different programs to ensure positive outcomes.

c) Outcome-Based Interventions

Based on individual health status, programs should be designed to keep healthy employees and family members healthy, reduce or eliminate risk to at-risk individuals and where possible, ensure unhealthy people are receiving appropriate treatments. Programs should have on-line components to lower operating costs and personal coaching to ensure the best outcomes where more intervention is needed.

d) Measurement

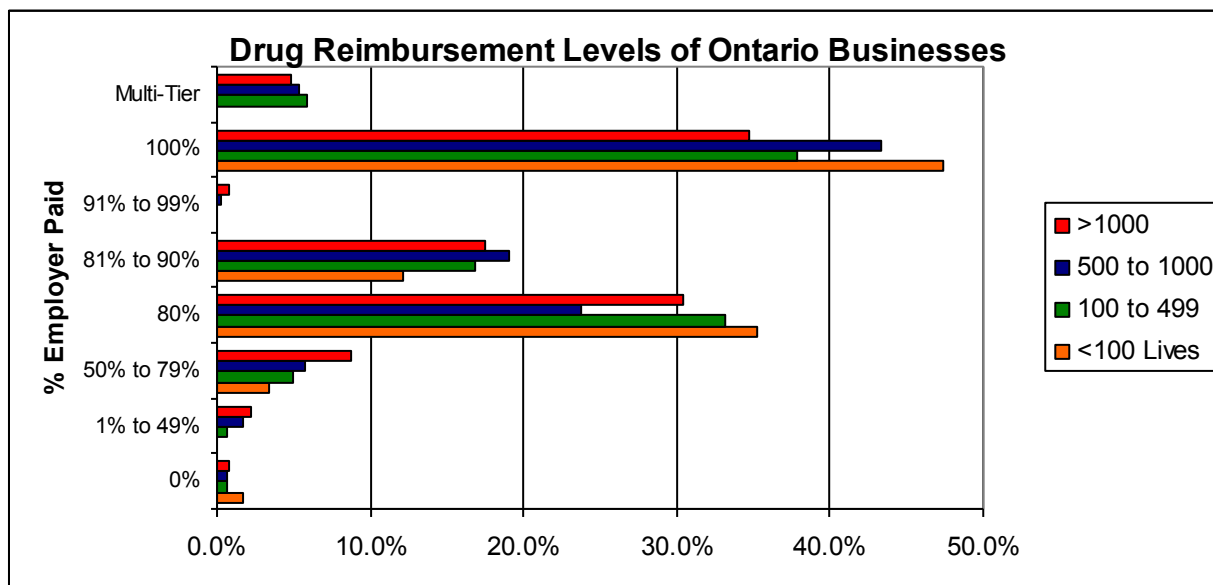
A key to success in wellness programs is establishment of a baseline prior to program start and measurement of both population health and improvement to individual health status over time. In any successful program, packaging the various elements is important.

5) Ontario's Drug Reform

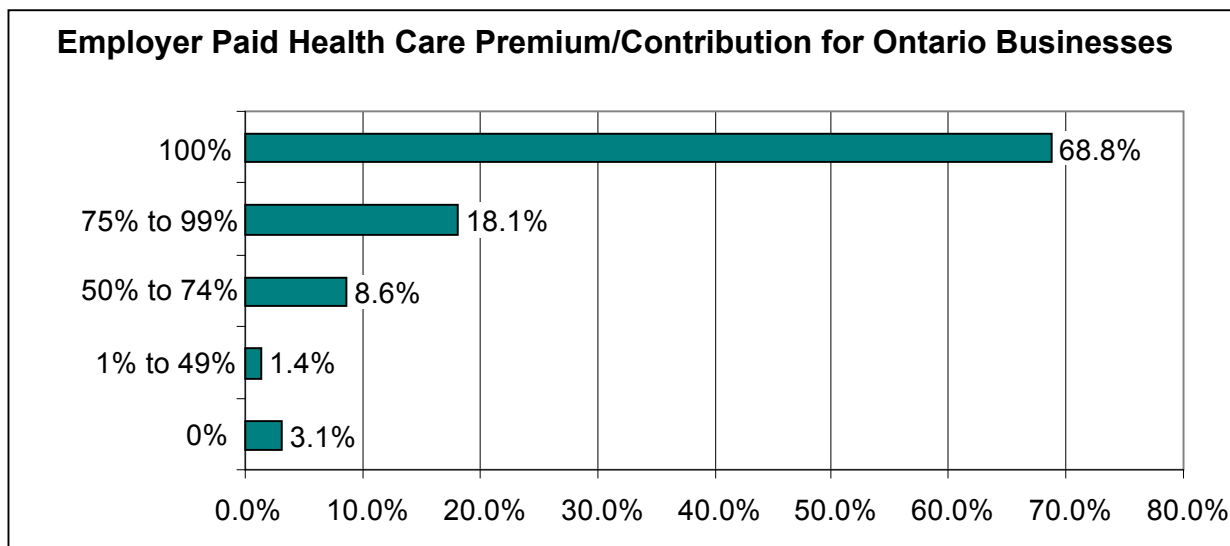
Ontario's drug reform was introduced in 2010 and changed the way pharmacies charge private payers for generic drugs. Drug costs are comprised of three elements; ingredient cost, pharmacy mark-up on the ingredient cost, and a pharmacy dispensing fee. Prior to the reform, the pharmacy could charge employer plans significantly more for generic drugs than that charged to the public plan. By April 1, 2012, pharmacies will be required to reduce generic drug costs to 25% of the original brand cost. Prior to drug reform, pharmacy rebates from generic manufacturers could be sufficiently large to push the ingredient cost up by 50% or more, which allowed for higher mark-ups to the ingredient cost.

Mercer's database indicates that 26.6% of employers use a reimbursement plan arrangement instead of a pay direct or deferred drug card. Reimbursement plan arrangements mean that an employee pays the pharmacist for the drug then submits the claim to the insurer. The insurer in most cases is unable to determine what the ingredient cost is and therefore; pays based on incomplete information on the receipt. Mercer claim audits indicate that some pharmacies are charging higher costs for drugs that are reduced for Ontario businesses through the use of a drug card. Those employers that have not yet adopted drug cards for their plans are concerned about the anticipated cost increases from higher utilization. Changing pharmacy charging practices should help to lower the cost to the employer of implementing a drug card.

As an alternative, a deferred payment drug card may help reduce costs. Deferred drug card arrangements are very common in Quebec and less so elsewhere in Canada. They require the employee to pay the pharmacy, but the claim is adjudicated on-line at the point of purchase using standard drug card features and pricing practices. Claims are submitted automatically for direct payment to the employee. Since the employee pays up front, the card has about a 10% reduction in cost from a typical pay-direct drug card.



As outlined in the chart above, approximately 38% of Ontario-based employers provide 100% reimbursement of drugs. This means the employee or their family members may shop for drugs at any pharmacy, no matter the cost. Significant cost differences — sometimes over 20% — exist among pharmacies. On a comparative basis, Ontario employers have implemented fewer cost management strategies than Canadian employers in general. Only about 5% have included a multi-tier drug plan where some drugs are paid at a higher reimbursement than others (the higher reimbursement usually applies to selected lower cost drugs).



Premium cost sharing wherein the employee pays part of the premium is perhaps the easiest way for employers to reduce expenses. The chart above demonstrates that cost sharing is not widely used in Ontario. This is likely because such arrangements are not effective cost mitigation tools. Once employees pay their premium share, their sense of entitlement to claim an employee benefit increases. Cost sharing arrangements are generally more effective when reduced reimbursement levels require employees to participate in the purchase decision, including shopping for better prices, or perhaps waiting to ensure they need the service. Adding an out-of-pocket maximum protects the employee should a high-cost claim be incurred.

5



Soaring Cost of Ontario's Employer-Paid Health Care

Managing the cost of health benefits is going to become more critical to employers. With drugs comprising 70% to 80% of employer health costs, effectively managing drugs will become key to cost mitigation. Drug cost escalation has recently moderated to annual increases of between 6% and 8%, which may lead to complacency on the part of employers. Drug trend rates have reduced as a result of effective provincial drug reform in Ontario, but also from the patent cliff relating to blockbuster drugs losing patent protection. However, complacency should not become entrenched as we anticipate costs to escalate rapidly during the balance of the decade. By well before 2019 we expect drug costs to soar by 2.5 to 3 times their current levels or between 3% and 5% of payroll.

Costs grow with the availability of new, high-cost specialty and biologic drugs. A 2010 Mercer analysis of pharmaceuticals indicates that 74 new high-cost drugs and 61 new cancer medications are in late-stage development. Of the cancer drugs, 22 are expected to be produced in pill form and therefore, not administered in hospital. This has the potential to make these drugs eligible for payment through employer plans. Based on Mercer's analysis, in 2009 only 12 biologic drugs were responsible for about 10% of employer drug spend and cancer drugs represented another 1.5% of the total. By using very conservative assumptions to project the cost of the new drugs, we estimate that about 60% of the total cost of drugs to the employer will be for these high-cost categories. Since additional drugs are in mid-stage development and some of these are likely to arrive in pharmacies before 2019, we believe our estimated costs to be low.

6



Anticipated Drug Pooling Changes

Drug pooling is the process whereby the insurer removes drug experience above a specified threshold from the claims used to determine the future required premium. In effect, it keeps premiums low by sharing the claim costs across all employers participating in the pool. In return for this risk reduction arrangement, the insurer charges a separate pooled premium to support the claims and expenses of operating the pool.

The insurance industry has publicly stated that recurrent annual high cost drugs are problematic to drug pooling arrangements. The cost of these claims is known after the first year and either needs to be built into the pooling charge in second and subsequent years or paid through the employer contributions used to support the annual non-pooled or experience-rated claims. The insurance industry has reviewed the issue from many perspectives and has few options; either increase the pool charge or, similar to U.S. practices, charge the full claim back to the business. Mercer estimates that pool charges would need to increase by over 2,000% to support the pool charge by 2019 (based on a \$7,500 pooling threshold) or about \$1,000 per employee. Increases of this nature would likely result in employers without pooled claims terminating pooling protection and worsening the situation within the pool.

The alternative is to have employers with high-cost recurrent claims pay them as part of their non-pooled premium. Should the insurance industry eliminate pooling of these high cost recurrent claims, costs will soar for employers facing such a claim. For example, an employer with a \$10,000 pooling threshold and with an employee diagnosed with rheumatoid arthritis incurs a recurrent annual \$23,000 biologic drug claim. The employee has other continuing drug costs of \$3,000 or \$26,000 in total. Under the arrangement in effect today, the pooling removes \$16,000 of these claims and pays them from the pool. If the claim is no longer covered under the pool, \$16,000 will be added to the experience used to set the premium rates in the second and subsequent year. If this is a 1,000-employee plan it works out to about \$16 of additional premium per employee per year, less any reduction to the pool charge; a 100-employee plan adds about \$160 per employee and a 10-employee plan adds about \$1,600 per employee per year.

Larger employers are not exempt from this risk as the probability of incurring claims will increase due to exposure from the number of employees suffering serious medical conditions. As new and more effective drug therapies become available the probability of multiple high cost claims will increase.

For many individuals with serious medical conditions, the lack of effective treatment has meant an inability to work. Many of these new drugs represent effective, albeit costly, treatment and change the lives of people living with disease. Part of any increase in drug costs should be offset by lower absence and disability rates and increased productivity of employees remaining at work, not to mention reduced costs to the provincial medical plan through reduced hospital and physician charges.

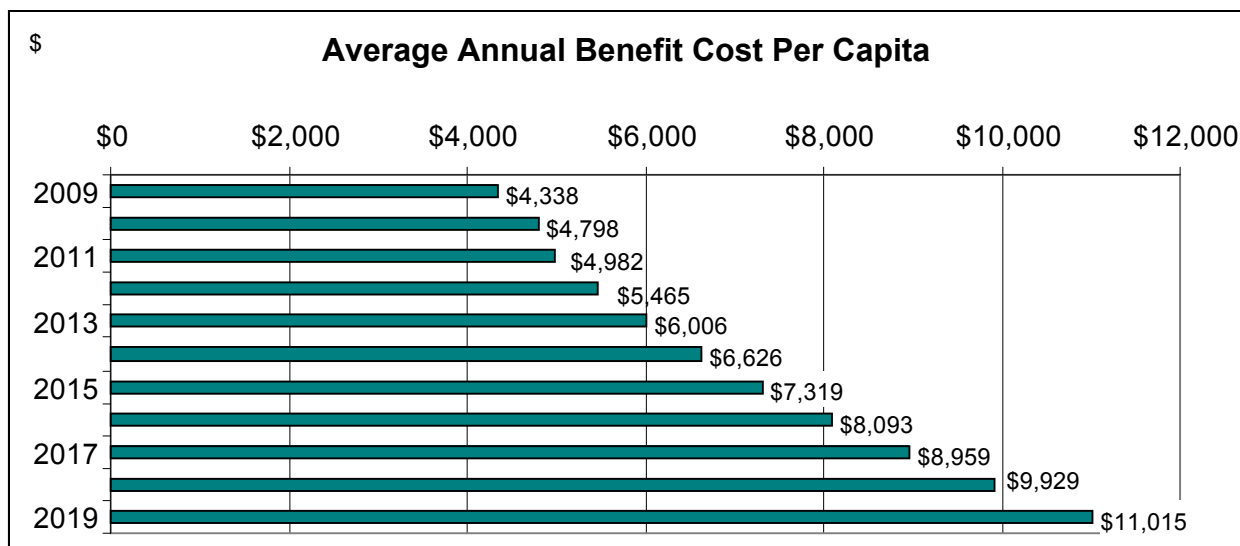
The extent of the issue facing the employers we work with, and the need for effective treatments of catastrophic medical conditions, led Mercer to obtain tacit agreement from the insurance industry at an insurance industry strategy session in 2010 that new practices will be needed. The industry agreed with Mercer's recommendation that an integrated private/public program is necessary. We believe such a program could be structured to have the insurer pay the claim for a specified period of time, such as two or three years, or until a dollar threshold is reached, such as \$50,000, or \$100,000, then the claim would move to the public plan. The ability of the private payer to quickly assess eligibility for a drug is an important element to keep an employee at work and productive without the delays that may be found under public arrangements. During this payment period the insurer would retain drug pooling.

7



Future Cost Projections

So where do we see employer benefit costs going? Ontario employers continuing with the status quo will likely see costs increase by over \$6,000 per employee from an average of \$4,980 in 2011 to about \$11,000 per capita by 2019.

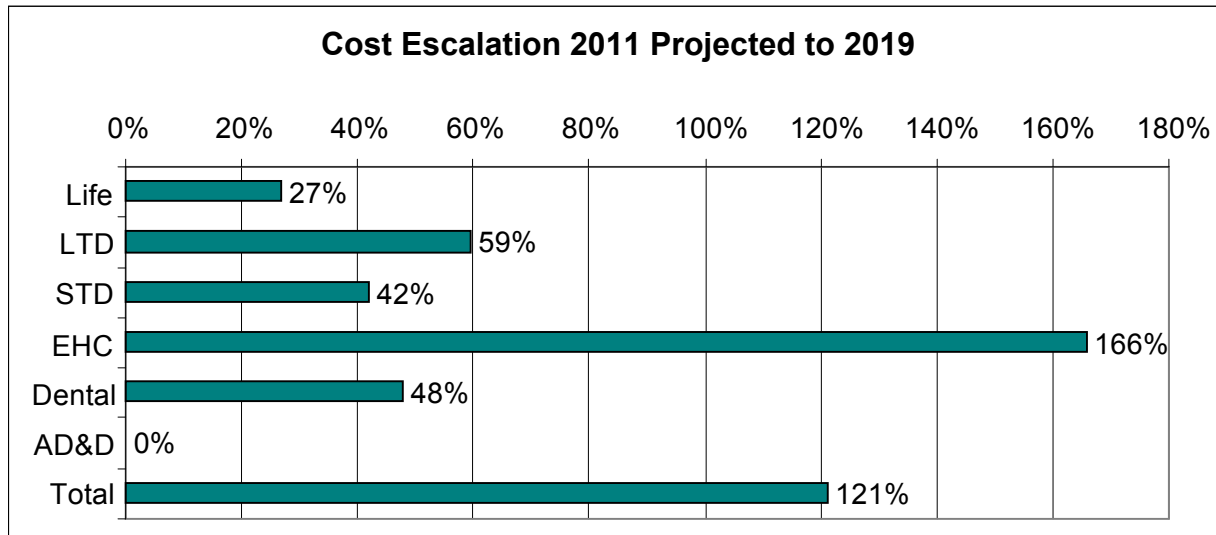


Our projections are conservative, and do not include wage escalation, which has the effect of increasing wage related life, LTD, STD and accidental death and dismemberment (AD&D) benefit costs that are not fixed amounts.

Cost projections reflect demographic change and low investment returns resulting in the following anticipated changes to annual premiums:

- life insurance increase of 3%
- long-term disability increase of 6%
- non-drug health increase of 5% (applies to 20% of total health costs)
- drug increase of 15% (applies to 80% of total health costs)
- dental increase of 5%

Costs will vary depending on design, demographics and cost management introduced by employers. The following chart represents the relative cost change expected by 2019 without intervention by employers. EHC and AD&D, represent extended health care and accidental death & dismemberment.



8



Retiree Benefits

Organizations providing retiree health coverage can anticipate even greater cost increases as the seniors' Ontario Drug Benefit (ODB) program with a capped \$100 co-pay policy may need to change to a means-tested arrangement in order to prevent the TD Bank scenario of 80% of the Ontario's budget being allocated to healthcare by 2030. Employer liabilities could double if the co-pay changes to match most other provincial plans at 4% of family income. Combined with rising drug costs, liabilities could increase four fold or even more.

A recent drug survey Mercer conducted indicates 65% of employers that continue to provide retiree benefits are likely to eliminate drug coverage for future retirees if liabilities double, but more significantly, 33% will attempt to eliminate or limit coverage to current retirees as well. Termination of existing coverage without appropriate wording at the time the employee retires may expose the employer to legal and financial risk. Effective cost management of retiree benefits will become critical if retiree plan continuance is important.

9



Future Cost Management: Examples

The world is about to change. Employers who do nothing are certain to experience higher risk and rapid benefit cost escalation just as they need to become more competitive in order to retain market share. De-risking benefit plans is not simple. Employee reactions, insurer and other provider capabilities all play significant roles in the outcome.

Going forward, most employers need to identify what their benefit programs are meant to provide the company and employees. Should health and dental be first dollar benefits designed to keep most employees from having to pay significant amounts (happy employees) or should it offer more catastrophic protection (protect the company from cost and keep people at work with higher employee co-pays)? Drugs are shifting to a more catastrophic arrangement with some drugs for rare diseases costing from \$500,000 to over \$1,000,000 a year; does the benefit program need to change too?

Employers may also want to question their providers on cost management strategies. Insurers and some pharmacy benefit managers have not enabled most cost management features in their drug cards. Dental services could have the range of fees established at a mid point, eliminating dental ranges that expose plans to higher cost. Disability plans could be strengthened to ensure as early a return to work as is feasible. There are a range of actions that some employers are taking to mitigate cost increases in the future. Some examples of those activities include:

1. Introduction of an effective drug card. Without it there are no restraints on drug costs paid through the plan,
2. Obtaining advice on appropriate drug plan design features and cost management arrangements as defined by corporate philosophy and objectives,
3. De-risking of corporate benefits as higher cost drugs and other expensive services come to market. Lifetime and other limits should be considered to reduce exposure under company benefit plans,
4. Regular review of pooling thresholds and arrangements to mitigate risk in alignment with corporate objectives,

5. Strengthening Board oversight of benefit plan arrangements to ensure effective expenditures that align with corporate goals, and
6. Employee education of benefit issues and employee responsibility as consumerism becomes more entrenched and employees participate to reduce plan costs. A shift to consumerism requires clear communication on the role employees will play to minimize cost and why their active participation is necessary. A drug card can serve part of the purpose, restraining costs at point of purchase, but does not fully replace the need for information before the purchase. A well-informed employee is an important investment.

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Summary

Employers will need to become more prescriptive in their demands to service providers. Few insurers have maximized opportunities for cost management features. Employers increasing pressure on insurance providers to provide effective cost management is anticipated. Unfortunately, the coming cost wave will require employees to pay more or have less choice and financial protection in benefit arrangements of the future.

Change is never easy. As the benefits environment evolves and cost pressures increase, more Ontario employers will need to embrace change to remain competitive. Paying an expected premium of \$11,000 per employee could result in a significant compensation reduction to employees as employers increase cost sharing, or affect the employer's ability to attract talent. In a global economy such a shift is likely to become the norm; however, effective cost mitigation strategies are available to offset cost increases and the introduction of new strategies is more easily accomplished through measured, proactive change than as a reaction to unexpected costs.

APPENDIX A

Appendix A – About Mercer

Mercer is a global leader in human resource consulting, outsourcing and investment services, with more than 25,000 clients worldwide. Mercer consultants help clients design and manage health, retirement and other benefits and optimize human capital. The firm also provides customized administration, technology and total benefit outsourcing solutions. Mercer's investment services include global leadership in investment consulting and multimanager investment management.

Mercer's global network of more than 20,000 employees, based in over 40 countries, helps ensure integrated, worldwide solutions. Our consultants work with clients to develop solutions that address global and country-specific challenges and opportunities. Mercer is experienced in assisting both major and growing, midsize companies.

Mercer's Health and Benefits business serves employers of all sizes—public, private and not for profit—across Canada from 12 offices. We work with employers to develop and design a health and benefit philosophy and programs that meet the needs of the organization and its employees, are sustainable, and identify and manage risks.

The company is a wholly owned subsidiary of Marsh & McLennan Companies, which lists its stock (ticker symbol: MMC) on the New York and Chicago stock exchanges. www.mercer.ca

APPENDIX B

Appendix B – About Author

David West

David West is a Mercer Partner in its Health and Benefits business. He has over 30 years of experience in the employee benefits field, including over 20 years with Mercer.

David specializes in benefits plan design and funding strategies, as well as the assessment and mitigation of risk through effective cost management. He is a frequent speaker and author on drug plan management. He Co-chairs the Employer Committee on Health Care Ontario and is called upon to participate in submissions on provincial health legislation.

David is a member of the National Board of The Arthritis Society and has been on a biologic to treat two serious forms of arthritis for the past eleven years.

Speaking Engagements:

Public Policy Forum, Shared Responsibility for Cancer Drug Costs: Envisioning a New Model of Coverage,
Health Charities Coalition of Canada,
Insurance Industry Strategic Forum, Catastrophic Drugs
Ontario's Citizens' Council



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