Deloitte & Touche

Healthcare Benefit Trust

An Independent Review
January 29, 2004

INFORMATION CLASSIFICATION: CONFIDENTIAL

Deloitte & Touche LLP
Enterprise Risk Services
P.O. Box 49279
Four Bentall Centre
2800 - 1055 Dunsmuir Street
Vancouver, British Columbia
V7X 1P4

Tel: (604) 669 4466
Fax: (604) 684 5916
www.deloitte.ca

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January 29, 2004

Mr. Arn van Iersel
Comptroller General
Ministry of Finance
Province of British Columbia
2nd Floor, 617 Government Street
Victoria, B.C. V1X 7X9

Dear Arn:

Re: Independent Assessment of Healthcare Benefit Trust

The enclosed report provides a summary of our findings from an independent assessment performed of the Healthcare Benefit Trust by Deloitte & Morneau Sobeco.

We value the opportunity to work with you and certainly appreciate the efforts of your Steering Committee and the Healthcare Benefit Trust management and staff in supporting us in this assessment. If you have any questions regarding this report, please do not hesitate to contact Wade Harding at (604) 642-5201 or myself at (604) 640-3261.

Yours truly,

DELOITTE & TOUCHE LLP

Deloitte & Touche LLP

Shayne Gregg, CISSP, CISA, CMC
Partner

cc: Nan Bennett, Chief Executive Officer, Healthcare Benefit Trust

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1. Executive Summary

1.1 Introduction

The Healthcare Benefit Trust (HBT) was established in 1979 by the Health Labor Relations Association (HLRA) to hold and administer a trust fund for the purpose of providing group health and welfare benefits for eligible employees, their eligible dependents and beneficiaries. The primary benefits are Group Life, Group Accidental Death and Dismemberment (AD&D), Weekly Indemnity, Long Term Disability (LTD), Extended Health and Dental. Participating employers sign a participation agreement. As of September 30, 2002 HBT had an unfunded actuarial liability of $198 million, including a negative balance in the Investment Fluctuation Reserve (approximately $46 million). Based on the draft 2003 Annual Report, the total unfunded liability increased to $261 million (including the negative balance of approximately $35 million in the Investment Fluctuation Reserve) as of September 30, 2003.

At the invitation of HBT's Board of Trustees, the Comptroller General, Ministry of Finance and the Deputy Minister, Strategic Initiatives and Corporate Services, Ministry of Health Services, with the assistance of Internal Audit & Advisory Services (Office of the Comptroller General, Ministry of Finance), have requested Deloitte & Touche and Morneau Sobeco to perform an independent review of HBT. The objectives of this review are to:

- Perform an assessment of the financial and actuarial viability and the overall mandate of HBT;
- Assess the current benefits delivery model, and to identify alternative models; and to
- Provide an opinion on the accounting treatment of the unfunded actuarial liability in the financial statements of Fraser Health Authority and the province of British Columbia.

1.2 Assessment of the Viability and Mandate of HBT

1.2.1 Financial and Actuarial Assessment

Our high level review of HBT's actuarial assumptions and methodology indicate that they conform to acceptable actuarial practices. To the extent that the data used was complete and accurate and that the calculations were performed correctly, we believe that the results reported by HBT's actuaries for the liabilities, before considering the Investment Fluctuation Reserve, are within the range of acceptable actuarial practice. We do believe, however, that certain assumptions could be more conservatively applied given the size and growth rate of the current unfunded actuarial liability.

Our benchmarking of HBT's cost structure against similar private and public plans across the country indicates that the HBT cost model is very competitive. While expense charges are a factor in ensuring the cost of benefits delivery are kept to a minimum, the most significant driver is the actual cost of claims. Even a significant reduction in expense charges (e.g. 20%) would still only have a minimal impact on the overall financial position of HBT. We did note, however, that HBT's LTD claims incidence rate has been consistently high in the last five years averaging approximately 19 LTD claims per 1,000 active employees over this period. This is a direct indicator of poor claims experience within some of the participating employers.

Since LTD losses have been steadily increasing over the past five years averaging approximately $60 million for the last two years, in a period where contribution rates have increased, it may be more prudent to consider the use of more conservative assumptions in the determination of future contribution rates to ensure that contributions do not significantly deviate from emerging trends.

Most multi employer/multiple-employer health and welfare benefits models provide for a mechanism to build contingency reserves to stabilize claims from year-to-year. This is similar to an insurer's claims fluctuation reserve, and would be used to mitigate the volatility of claims. Unfortunately, the current delivery model does not allow for the creation of such funds or reserves within HBT without triggering taxation issues, possibly resulting in the loss of HBT's Trust status. This must be addressed.

The Trustees are responsible for asset allocation and selection of investment managers. The investment managers make all decisions relating to the investments. The Trustees have acted responsibly in managing the funds. However, accountability is potentially a contentious issue as the Trustees determine and decide on the risks to be assumed by HBT, but the employers are responsible for all the consequences of the Trustees' and investment managers' decisions.

There have been three strategies developed to address the unfunded actuarial liability:

- Adjustments to future contributions;
- Positive investment returns; and
- Improved claims management.

HBT's funding strategy is to require additional deficit recovery funding through future contributions to reduce the unfunded liabilities over a 10-year period, in order to achieve a funding level of 95% by the end of the 10th year. This funding strategy will more likely result in a deficit than a surplus, and although the deficit recovery strategy is consistent with acceptable actuarial practice, we are recommending a more comprehensive funding policy be considered, as well as an overall focus on improving claims management within the industry.

1.2.2 Purpose, Structure and Governance

The primary objective of HBT is to hold and administer a trust fund for the purpose of providing group health and welfare benefits on behalf of participating employers. Many functions and activities can fall within this service. In general, we believe HBT has effectively discharged its mandate as defined in the Trust Agreement, and certainly Trustees appear to take their responsibilities with regard to the specific mandate very seriously. The mandate to provide a vehicle for volume purchasing and centralized claims administration is also still legitimate.

It is open to interpretation; however, as to whether all of the services provided by HBT are best delivered by HBT under the current mandate. For example, this could include the delivery of rehabilitation services, and employee and workplace health services (EWHS). Any change to HBT's role in the current rehabilitation and EWHS services delivery model, however, should only be made in conjunction with a review of the disability management process for the healthcare and social services sector and should incorporate the investments made in this area by the individual participating employers.

1.2.3 Overall Conclusion on the Viability and Mandate of HBT

In summary, although it appears that there are some operational challenges existing within HBT, it is simply the vehicle for processing and administering the health and community services sector benefits

programs, and as such, we must not only look to the ability of the participating employers to repay the unfunded actuarial liability, but also for further insights as to the reasons for the rapidly escalating contribution rates and unfunded actuarial liability.

1.3 Assessment of the Overall Delivery Model

1.3.1 The Current Delivery Model

During our review, we noted a number of attributes in the current delivery model that we believe are relative strengths and should be recognized as critical to the ongoing success of HBT. If a change were to be considered in the future, we would recommend these strengths be preserved, where possible:

- Commitment of the HBT Board and management;
- Depth of accumulated information and knowledge;
- Capability of the HBT staff;
- Diligence around investment performance measurement;
- Efficiencies leveraged from volume purchasing; and their
- Focus and commitment to the healthcare and social services sector.

A number of significant challenges in the current delivery model were also identified. In some cases these concerns originated within other parties within the current delivery model, but outside of the scope of HBT. However, we believe HBT should play a significant role in working with the other stakeholders to address them:

- Imbalance of employer representation;
- Communication issues between HBT, the participating employers and other stakeholders;
- Inequitable accountability of employer claims experience;
- Absence of alternative underwriting options;
- Lack of contingency reserves for management of claims and investment fluctuation;
- Potential for issues relating to taxation;
- Lack of participating employer understanding around LTD claims adjudication issues;
- Achieving a return on investment on benefits administration system development;
- Lack of control over plan design and collective bargaining;
- Volatility of investment performance during the past five years;
- Diversification and change in size of participating employers; and the
- Disjointed process for disability management across the sector.

Our review of the current health and welfare delivery model indicates a number of fundamental issues exist. The two most significant concerns are the escalating unfunded actuarial liability and the increasing volatility in the employer contribution rates. These issues stem directly from a number of root causes including:

- The rapid drop in investment returns in recent years;
- Contribution rates that are not covering current costs;
- An accelerating trend in an already high LTD claims incidence rate within some of the large participating employers;
- Lack of control over the plan design, resulting in minimal cost-containment and cost-sharing mechanisms;
- Poor LTD claims experience and inconsistent disability management processes; and a
- Lack of sufficient reserves to buffer adverse investment and claims experience.

1.3.2 Alternative Delivery Models

The healthcare sector in British Columbia has experienced significant change since the inception of HBT, particularly in the last two years where there has been a significant restructuring and reorganizing of the Health Authorities. Based on these recent changes in this sector, the challenges faced by HBT, and our understanding of the current needs of the stakeholders, a number of alternative delivery models could be considered (for example, a buying group, captive insurer, or some form of reciprocal insurance arrangement).

There are a number of fundamental features that are generally considered 'best practice' in the delivery of health and welfare benefits. Based on our significant collective experience assessing, designing and implementing public and private sector health and welfare benefit programs, the following attributes were identified as key elements in a best practice delivery model:

- Access to volume purchasing;
- Equitable representation from all stakeholders;
- Optimal use of resources;
- Accountability to the employer;
- Independence from the claims process;
- Employer-driven investment and claims management strategies;
- Ability to accumulate contingency reserves;
- Choice of underwriting options for employers;
- Existence of a mandatory disability management program; and
- Control over effective plan design.

It should be noted that some of these attributes are already present in the current delivery model, and therefore any proposed change to the model, or HBT in particular, should seek to leverage these best practices.

Unfortunately, simply changing the delivery model will not solve these fundamental issues of rising claims costs and the growing unfunded actuarial liability. Extensive changes to plan design, collective agreements, and the management of disability claims will need to be addressed regardless of the delivery model.

There are also a number of significant implications associated with changing the current delivery model, including financial cost, taxation issues, repayment of the unfunded actuarial liability, and opening of existing collective agreements. These implications, even considered independently, seriously impact the feasibility of considering any significant change. We believe that an alternative delivery model should only be considered if the government's mandate were to establish an entirely new benefits program for the healthcare and community services sector in the future regardless of the significant financial and political costs.

However, the dramatic change within the industry sector, the growing unfunded actuarial liability, and the current volatility of the contribution rates dictate that some measure of change must be made. We are not, however, concluding that the original purpose of the current delivery model is no longer valid, but simply that enough concern exists amongst the stakeholders that it is clear that changes will have to be made. A recommended approach with regard to HBT is to consider a transitional solution or strategy that would allow for the creation of a stabilization fund, and would provide a strong foundation for optimizing the current delivery model or implementing a new model in the future. The real challenge; however, is addressing the root issues of poor claims experience, plan design and disability management.

1.3.3 Overall Conclusion on the Delivery Model

Improving the plan design and claims management process across the entire delivery model is likely the most significant factor in reducing the unfunded actuarial liability and the escalating cost of employee benefits. Effective disability management requires a holistic integrated approach, including an early intervention program, mandatory participation of all employers, and effective independent LTD claims adjudication. The success of the claims management process is dependent on strong communication and cooperation between all stakeholders and clear accountability to each other. A key factor in controlling claims costs begins with more informed collective bargaining, resulting in a plan design that balances benefits with costs.

1.4 Determination of the Accounting Treatment

The primary objective of our review of the possible accounting treatment for the unfunded actuarial liability ("the Liability") was to report on the appropriate application of Canadian generally accepted accounting principles, to the facts and assumptions provided to us, in respect of the accounting for the unfunded actuarial liability in the financial statements of Fraser Health Authority[1] ("the Authority") and the B.C. Government ("the Government"). More specifically, to make comments with respect to the following:

- Whether a portion of the Liability of HBT should be allocated to the Authority for fiscal years ending on or after March 31, 2005 or whether it should continue to be pooled;
- The most appropriate way for the Authority to account for the Liability if it is determined that a portion of the Liability should be allocated to the Authority; and
- The impact that the accounting for the Liability will have on the Government's financial reporting assuming that the Health Authorities are each allocated a portion of the Liability and become part of the government's reporting entity for fiscal years ended on or after March 31, 2005.

In order to answer these questions, we are effectively providing a formal accounting opinion. Section 7600 of the CICA Handbook requires that we follow a defined process to do this, specifically requiring the prior consent and acknowledgement of the various facts surrounding this issue by the Authority, the Auditor General and the Comptroller General. We have followed this process in reaching our opinion on the treatment of the Liability in the books of the Authority (as an HBT participating employer audited by the Auditor General) and the Government's summary financial statements. Our formal conclusions and opinion on the treatment of the Liability in the financial statements of the Authority and the Government is contained in *Appendix B: Accounting Treatment of the Unfunded Liability* and this should be read in conjunction with our observations and conclusions in this report.

Through discussions with the Trust's actuary and Chief Executive Officer, it was determined that insufficient information is available to allocate the plan assets to the Participating Employers. However, the Authority received correspondence (dated February 27, 2003) and an "experience rating file" from the Trust, disclosing the percentage increases in the long-term disability contributions levels under the trustees' DRP for the years commencing April 1, 2003, 2004 and 2005. The Trust Agreement gives authority to the Trustees to, in their discretion, calculate, based on actuarial advice, the amount of any Liability attributable to the Authority. It appears that the Authority can reasonably

[1] In order to assess the accounting treatment of the unfunded actuarial liability within government, the project Steering Committee selected Fraser Valley Health Authority as the subject of this review.

determine a liability to the extent that the Authority is informed of increases in future contribution rates that relate to a recovery of the Authority's share of the Liability under the trustees' DRP. The fact that the Authority was provided with a choice regarding the payment of these contributions i.e. either incremental rates increases over a three-year period or a higher rate increase in the first year only, could be considered to be indicative of a financing arrangement to settle a portion of the Liability.

Based on our opinion at *Appendix B*, it would be appropriate for the Authority to recognize a liability to the extent that the Authority is informed of, and can reasonably measure, its future incremental contributions to the Trust under the DRP. Such liability would be determined based on the present value of these contributions and would be recognized on a prospective basis in the period in which these criteria are first met. The Authority would also recognize an expense in respect of the contribution cost for the period. For purposes of full disclosure, it is desirable that this expense be disclosed in the notes to the financial statements. Retroactive restatement would be appropriate if it was determined that either the prior periods were in error i.e. that the Authority had all the information and could have reasonably measured its share of the Liability in those periods, or if the change could be argued to represent a change in accounting policy. The final determination of whether retroactive treatment is appropriate is a matter which should be determined between the Trust, the Authority, the Government and their respective auditors.

In summary, we believe that it would be appropriate for the Authority to recognize in its financial statements a portion of the unfunded actuarial liability of the Trust to the extent it can be reasonably determined. If the Authority is informed of its share of required incremental contributions that relate solely to recovery of the unfunded Liability, then we also believe that a reasonable basis for recording the Liability would be to determine and record the present value of such incremental contributions. Finally, in the event that the Government will be required to consolidate the Health Authorities, the Government would recognize the portion of the total Liability applicable to the Health Authorities.

The Public Sector Accounting Board approved an exposure draft on Liabilities, Contingent Liabilities and Contractual Obligations in October 2003. The exposure draft provides a new definition of liabilities and identifies three essential characteristics of liabilities. The Government would need to consider the implications of the proposed new standard if and when it is released.

The ultimate responsibility for the decision on the appropriate application of Canadian generally accepted accounting principles for the Liability described above rests with your management as preparers of the financial statements of the Government and with the Authority's management as preparers of the financial statements of the Authority who should consult with the Office of the Auditor General. Our judgment on the appropriate application of Canadian generally accepted accounting principles for the Liability described above is based on the facts and assumptions provided to us, and Canadian generally accepted accounting principles as they currently exist. Should the facts or assumptions change, our opinion at *Appendix B* may change.

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1.5 Conclusion – Moving Forward

Any change to the current delivery model will not necessarily resolve the fundamental issues as many are beyond the control of HBT. However, we believe there are some opportunities immediately available to optimize the current delivery model. We also believe there would be significant financial, taxation, and union-related implications to changing the delivery model, so further analysis should be completed before any radical change is implemented. In the interim, we recommend that the current delivery model continue, but action be taken by following the transitional solution or strategy to address the issues outlined above and to improve the claims management process, the equitable allocation of risk, the communication with stakeholders, and to reduce the volatility of the contributions – while seeking to rapidly eliminate the existing unfunded actuarial liability.

1.5.1 Summary of Recommendations

We identified a number of opportunities to improve the existing health and welfare benefits delivery model, including a number of recommendations that could be led by, or specifically affect, HBT:

Communication:

1. While we recognize HBT has attempted to provide information to participating employers and government in the past, we recommend the approach to disseminating information be reviewed to ensure proactive, regular interaction between all parties regarding all aspects of plan performance. Participating employers should also be frequently consulted to ensure the information provided is meeting their needs.

Governance:

2. Earlier this year the Board expanded to include two representatives from the Health Authorities. While this expansion was designed to improve the direct participation on the HBT Board, we recommend additional Trustee(s) from areas of the healthcare and social services sector not currently represented to ensure balanced representation. Given the impact of the LTD program on the overall financial position of HBT, consideration should also be given to individuals with a strong disability management background.
3. Regardless of whether a stabilization fund or contingency reserve were to be introduced, the government might consider introducing regulatory oversight (e.g. FICOM or Superintendent of Pensions) to provide protection and accountability. If HBT were regulated today, however, this oversight mechanism would have likely forced the contributions to escalate more rapidly as soon as an actuarial liability situation arose, and certainly may have demanded a model that provided suitable claims fluctuation reserves.

Information Systems Development:

4. We recommend the participating employers work with HBT as they develop and implement their own HRIS systems. The primary objective would be to integrate and leverage the functionality of each party's system and avoid duplication of unnecessary expenditures.

Investment Management:

5. While HBT do review their investment strategy and performance on a regular basis, we do however; recommend HBT work closer with the participating employers to incorporate their risk profile and budgeting requirements in the investment review process.

Risk Tolerance:

6. We recommend a contingency or claims fluctuation reserve be established to ensure more stability in contribution levels, ideally without triggering any taxation liability.

7. The majority of benefits provided through the HBT are fully pooled by risk group, with the exception of LTD, where experience-rating is applied at the employer level based on a credibility formula. We recommend increased accountability, particularly for the large participating employers. This can be achieved by setting contribution rates on each participant's claims experience for all benefits. However, the pooled approach could be maintained for the smaller participants. This approach maintains equity between participating employers, and makes employers responsible for their own employee benefit costs and also addresses the issue of cross-subsidization.

8. Currently there is no flexibility to allow participating employers to select an underwriting option that is consistent with their risk tolerance. We recommend the establishment of a HBT pool and allow participating employers to choose whether to participate in the pool or select a stand-alone underwriting arrangement within HBT. Under this approach, all participating employers would still have access to the same reduced expense charges negotiated by HBT for the entire program.

Actuarial Assessment:

9. We believe that it may be more prudent to consider the use of more conservative assumptions (e.g. interest rate) while the current unfunded actuarial liability exists, but the impact on contribution rates should still be considered.

10. We understand the practice of relying on possible investment gains above the actuarial assumption is no longer going to be utilized by HBT, and we recommend it not be reconsidered in future rate setting.

11. Although we believe the use of an IFR is acceptable for funding purposes, there is a lack of consistency in its application. We recommend a review of the continued use of this reserve and the appropriateness of its inclusion and presentation in the financial statements. .

12. While absence of margins in the determination of actuarial reserves would not be unusual for a plan like HBT, based on emerging trends, we recommend some margin in the contribution rate setting process. While we recognize over-funding will present taxation issues, the intent of the margins would not necessarily be to reduce the probability of a deficit, but could be designed to ensure the contribution rates do not significantly deviate from the anticipated LTD claims costs. In other words, there could be a lag between the experience used in determining contribution rates and the emerging experience over a period of three to five years to avoid the build up of large deficits.

13. We recommend rate setting and deficit recovery strategies be considered in conjunction with the funding policy. The current deficit recovery strategy focuses on required rate increases that will achieve a 95% funding level over a 10-year period. This funding strategy will more likely result in a deficit than in a surplus. During a period where claims costs are consistently high, as has been the case in recent years, there is a danger of continuously falling behind and, if no offset comes from excess investment performance, contribution rates could be expected to increase significantly over a prolonged period. A more comprehensive funding policy would address the following components:

- Rate required to fully-fund the cost of new claims plus administration expenses including the approach and degree by which emerging trends are recognized in the rate setting process; and the
- Rate required to amortize the unfunded liability over the selected period or periods.

14. There should also be a clear, direct relationship and connection between the employer's effectiveness of the claims management process and their contribution premium. In short, the employers' contribution levels should be directly related to their effectiveness in claims management and their risk tolerance.

Plan Design:

15. We recommend the government, the participating employers and the unions approach future collective bargaining and wage discussions with the intention of ensuring an equitable plan design, consistent with other similar plans in the healthcare and other related sectors. This would include cost containment and cost sharing features and benchmarking to comparative programs.

Disability Management:

16. While the analysis of the disability management program is beyond the scope of our review, we recommend an organization that has direct contact with all union representatives, is involved in all areas of absences (e.g. sick leave, WCB, and LTD), and has the authority to make participation mandatory should design and deliver this initiative. Ideally, the program would be fully supported by all the unions (if applicable) as well as the employers and should have an integrated approach with respect to sick leave/STD, WCB, and LTD claims.

    Any change to HBT's role in the current rehabilitation and EWHS services delivery model should only be made in conjunction with a review of the disability management process for the healthcare sector and should incorporate the investments made in this area by the individual participating employers.

17. To the extent it is not occurring, there should be a focus on rehabilitation and early return to work for recent LTD claims. It is generally acknowledged that early intervention and rehabilitation has a positive impact on LTD claims duration and terminations, and is most effective in the early stages of an LTD claim.

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2. Background

The Healthcare Benefit Trust (HBT) was established in 1979 by the Health Labor Relations Association (HLRA) and Health Employees' Union Local 180 (HEU) to hold and administer a trust fund for the purpose of providing group health and welfare benefits for eligible employees, their eligible dependents and beneficiaries. The primary benefits are Group Life, Group Accidental Death and Dismemberment (AD&D), Weekly Indemnity, Long Term Disability (LTD), Extended Health and Dental. Participating employers sign a participation agreement.

As of September 30, 2002, six Health Authorities, with approximately 200 amalgamated organizations, and 750 other organizations throughout British Columbia and the Whitehorse General Hospital in the Yukon participate in HBT, representing over 80,000 employees of acute care and long-term care hospitals, community care, social service agencies, and specialty organizations within the health care and community care sector. Approximately 70% of the covered employees under HBT are Health Authorities employees. HBT has been administered internally since 1986 through four departments under the direction of a Chief Executive Officer. In addition to collecting contributions from its clients, the HBT includes an investment portfolio to meet its future benefit obligations. As of September 30, 2002 HBT has an unfunded liability of $198 million, including a negative balance in the Investment Fluctuation Reserve (approximately $46 million). Based on the draft 2003 Annual Report, the total unfunded liability increased to $261 million (including the negative balance of approximately $35 million in the Investment Fluctuation Reserve).

At the invitation of HBT's Board of Trustees, the Comptroller General, Ministry of Finance and the Deputy Minister, Strategic Initiatives and Corporate Services, Ministry of Health Services, with the assistance of Internal Audit & Advisory Services (Office of the Comptroller General, Ministry of Finance), have requested an independent review of the HBT. The purpose of this review is to independently assess the HBT focusing on the following objectives:

1. **Financial Model for HBT:**
    - To determine the best model for HBT in terms of its finances and administration. This includes long-term financial viability, assessing whether the member contribution rates properly reflect the benefit costs/claims (for example, by member organization and type of employee), and the financial model itself.
    - To perform a benchmarking of costs against similar private and public sector funds; and
    - To perform a high level review of the most recent actuarial assessment in terms of its implications for HBT and its clients as well as compared to other alternatives.
2. **Purpose, Structure, and Governance:**
    - To review the original mandate of HBT to assess whether it is still valid and appropriate for current needs;
    - To identify other models or structures, if it is determined that the original purpose is no longer valid; and
    - To review HBT's governance structure to ensure strategies exist to minimize benefit costs and equitably align assets and liabilities going forward.

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3. **Accounting for Liabilities:**

   - To report on the most appropriate application of Canadian generally accepted accounting principles, to the facts and assumptions provided to us, in respect of the accounting for the unfunded actuarial liability in the financial statements of Fraser Health Authority and the B.C. Government;
   - More specifically, to make comments with respect to the following:
     - Whether a portion of the unfunded actuarial liability of HBT should be allocated to the Fraser Health Authority for fiscal years ending on or after March 31, 2005 or whether it should continue to be pooled;
     - The most appropriate way for the Authority to account for the unfunded actuarial liability if it is determined that a portion of the Liability should be allocated to the Authority; and
     - The impact that the accounting for the unfunded actuarial liability will have on the B.C. Government's financial reporting assuming that the Health Authorities are each allocated a portion of the unfunded actuarial liability and become part of the government's reporting entity for fiscal years ended on or after March 31, 2005.

The remainder of this report details our observations, findings and conclusions regarding the above project objectives.

3. Our Assessment Approach

3.1 Our Assessment Process

Our approach to performing this independent review entailed the performance of the following specific tasks or activities:

1. Planning & Initiation;
2. Assess Delivery Model;
3. Review Governance Structure;
4. Determine Accounting Method; and
5. Present the Final Report.

3.1.1 Assess the Delivery Model

Our actuarial team performed a detailed analysis of the delivery model of HBT. This included the following specific activities:

- Performed qualitative analysis;
- Reviewed actuarial assessment;
- Assessed existing cash flow projections;
- Performed limited benchmarking against other private and public sector plans; and
- Developed improved or alternative delivery models.

3.1.2 Review Governance Structure

We reviewed HBT's overall governance structure, organizational structure, and decision-making processes including the following activities:

- Reviewed Trust Agreement;
- Reviewed relevant Trust documentation (including Trustees Terms of Reference, Trust Investment Policy, Board minutes, various legislative and regulatory materials, descriptions of roles and responsibilities, actuarial reports, annual reports, internal and external communications, formal reports, policies, procedures and other documents);
- Interviewed Board of Trustees;
- Interviewed other relevant stakeholders; and

- Investigated other health and welfare trust programs.

In order to effectively conduct our review, it was important for us to understand the level of awareness around HBT's stated role, mandate and responsibilities. This was achieved by interviewing the following stakeholders:

- Representatives from the six Health Authorities;
- Representatives from HEABC;
- CEO of CSSEA;
- Representatives from other participating (i.e. Affiliates/Contract) employers;
- Representatives from HBT Board of Trustees;
- HBT senior staff and Actuarial Consultant; and
- HBT Actuary.

The interviews were conducted in person, or depending on timing and location of participants, by telephone. Our key objectives in each of the interviews were to understand the interviewee's perspectives and to:

- Understand their view of the HBT's stated objectives;
- Understand their opinion on the HBT's effectiveness to date against the perceived mandate;
- Identify the key strengths of, and opportunities facing, the HBT;
- Identify past and current challenges for the HBT; and to
- Assess the clarity of roles and responsibilities.

3.1.3 Determine the Accounting Implications

Our accounting advisory team gathered relevant facts and assumptions and performed research to make comments on the most appropriate accounting treatment for the unfunded actuarial liability in the financial statements of Fraser Health Authority and the B.C. Government. Our recommendations are formerly documented in our report included under section 6. Key activities of the accounting advisory team included:

- Gather relevant facts and assumptions;
- Perform relevant research and investigation using existing and proposed Canadian generally accepted accounting standards;
- Consult with the Office of the Auditor General and Fraser Health Authority regarding their interpretation of the facts and assumptions (as required by GAAS);
- Develop format and content for communication of opinion/recommendations; and
- Review recommendations with Comptroller General and other key personnel.

Additionally, we also sought an independent taxation opinion from our own tax specialists on the nature of potential issues that could trigger a taxable liability in the existing trust-based delivery model.

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4. Assessment of the Current Delivery Model

To review the original mandate of the HBT to assess whether it is still valid and appropriate for current needs.

4.1 Overview of the Mandate and Delivery Model

The primary objective of HBT is to hold and administer a trust fund for the purpose of providing group health and welfare benefits on behalf of participating employers. Many functions and activities can fall within this service. In general, we believe HBT has effectively discharged its mandate as defined in the Trust Agreement, and certainly Trustees appear to take their responsibilities with regard to the specific mandate very seriously. The mandate to provide a vehicle for volume purchasing and centralized claims administration is also still legitimate.

4.1.1 What is a Health and Welfare Trust?

Health and welfare trusts are generally established in accordance with the Income Tax Act. They can be established for single employer plans, but are more common in multi employer/multiple-employer arrangements. A trust can be sponsored by the employer or union, or can be jointly trusteed. A health and welfare trust is established as an arms-length entity from the sponsor (e.g. employer) to eliminate the perception of influence by the sponsor. This should not restrict the Board membership as the Trustees have a fiduciary obligation to act in the best interest of the beneficiaries.

A trust is created by a formal written document known as a Trust Agreement. The Trust Agreement outlines all matters relating to governance such as the number of trustees, and the manner in which they are appointed, trustee responsibilities and powers, requirements for meetings, provisions for amending and terminating the trust, for example.

A health and welfare trust is one delivery vehicle of employee benefits; however, there are other delivery models, which we have described in section *5.2 Alternative Delivery Models* of our report. The relative advantages and disadvantages of establishing health and welfare trusts are as follows:

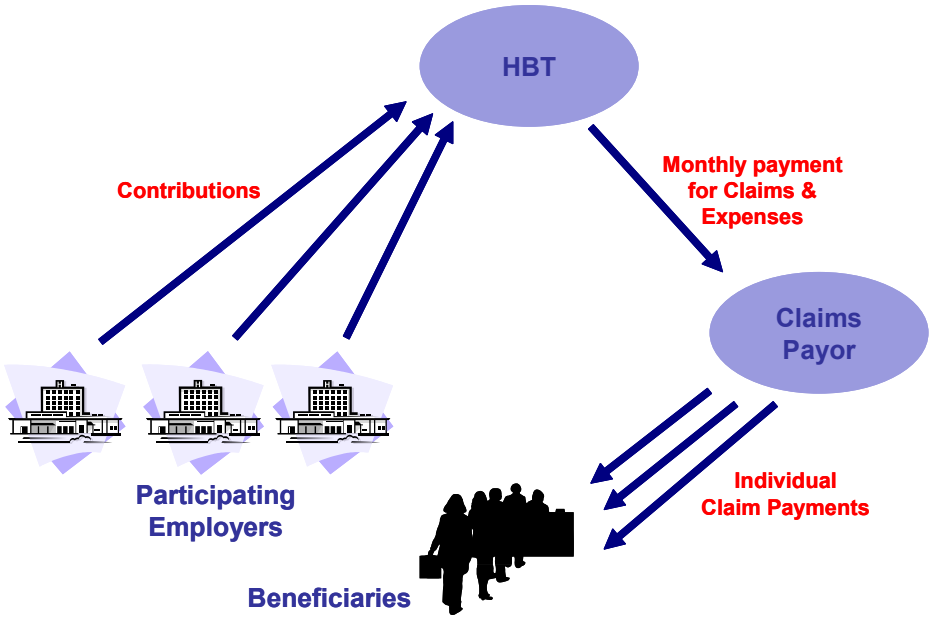
Relative Advantages	Relative Disadvantages
▪ Access to volume purchasing ▪ Arms-length relationship from sponsor ▪ Formalized governance ▪ Union acceptance ▪ Commonly used vehicle for health and welfare benefit plans	▪ Less direct control for sponsor ▪ Inability to accumulate contingency/surplus reserves within the trust ▪ Possibly subject to taxation ▪ Relatively complex infrastructure ▪ Possible duplication of administration between trust and employer(s)

4.1.2 The HBT Delivery Model

The HBT was initially established in January 1979 as a jointly trusteed plan between the HRLA, which is now part of the Health Employers Association of British Columbia (HEABC), the HEU, and Trustees of the HRLA Health and Benefit Trust. Subsequently, the Trust was reformed to become an employer sponsored Trust in May 1980. The current Trust Agreement was established in December

1993 between HEABC and the Trustees of HBT. In 1997, the HBT membership was expanded to include members of the Community Social Services Employers' Association (CSSEA). The primary objective of HBT is to hold and administer a trust fund for the purpose of providing group health and welfare benefits on behalf of participating employers. Although HBT is very similar to an insurance vehicle, it is currently an unregulated entity.

Within the HBT delivery model, the contributions remitted for LTD by the participating employers are calculated and collected by HBT in order to fund the cost of current and future liabilities for HBT. On behalf of all participating employers and beneficiaries, HBT will negotiate with a number of service providers (i.e. claims payors) to adjudicate and administer claims. Claims are submitted by employers and/or beneficiaries to the claims payors for approval and payment. Payments are generally made to the beneficiaries. The claims payor will provide an invoice to HBT for the cost of claims, and any applicable administration and stop-loss charges. This can be illustrated as follows:



4.1.3 Role of HBT Board of Trustees

The HBT Trust Agreement requires a minimum of five and a maximum of 12 Trustees, with the actual number of Trustees to be determined and appointed by HEABC. However, in practice HBT nominates potential non-healthcare candidates in the selection process. Currently, there are ten Trustees serving HBT.

To manage the operations of HBT, the Board has established three committees with specific responsibilities to discharge the mandate of HBT:

Executive Committee

- To ensure the Board and the operations of HBT adhere to the Trust Agreement and policies of the Board;
- To consider and recommend to the Board of Trustees upon the salary and other employment terms of the Chief Executive Officer (CEO);

- To provide guidance to the CEO in the exercise of his/her responsibilities in dealing with staff situations, salaries, working conditions, etc;
- To review and report on key result areas, objectives and performance indicators as presented by the CEO;
- To discuss and make recommendations to the Board of Trustees upon future direction of HBT; and
- To represent HBT at meetings with, or appearances before, Ministers of the Crown, Parliamentary Committees, Ministerial Boards, etc.

Finance and Audit Committee

- To review, amend as necessary, and make recommendations to the Board of Trustees on the annual Trust budget as prepared by the CEO and staff;
- To establish and review policies regarding the level of contributions and premium rates and to make appropriate recommendations to the Board of Trustees;
- To review HBT's performance against budget on a continuing basis and to review the financial statements and recommend their acceptance to the Board of Trustees;
- To act as the Audit Committee of the Board of Trustees, and to report as such to the Board of Trustees;
- To make recommendations to the Board of Trustees with respect to an Audit firm to be retained by HBT; and
- To deal with other related matters.

Investment Monitoring Committee

- To review, amend as necessary, and make recommendations to the Board of Trustees on the Investment Policy and Investment Manager Mandates as prepared by the CEO and staff;
- To monitor the allocation of assets and to make appropriate recommendations to the Board of Trustees;
- To monitor HBT's investment performance against the 'Performance Standard' stipulated in each Manager's Mandate and report to the Board of Trustees;
- To act as the Investment Monitoring Committee of the Board of Trustees, and to report as such to the Board of Trustees;
- To make recommendations to the Board of Trustees with respect to Investment Managers to be retained by HBT; and
- To deal with other related matters.

4.1.4 Responsibilities of HBT Management and Staff

To execute the objectives of the Trust, HBT employ approximately 54 full-time equivalent employees to manage the majority of functions internally in four departments described below. An organization chart of HBT is provided in *Appendix C: HBT Organization Chart*:

Plan Administration

The Plan Administration Services department has a staff of approximately 14 employees and acts as the primary day-to-day liaison between HBT, HEABC, CSSEA, and Affiliates/Contract employers. The primary functions of this department include, but are not restricted to, the following:

- Explaining the group health and welfare benefits to participating employers;
- Answering inquiries on administration and claims procedures;
- Acting as a liaison among employers, union, and claims paying agents;

- Working with employers to ensure that unionized benefit plans are in accordance with the applicable collective agreement;
- Providing communications material for employers and employees;
- Coordinating rehabilitation review committees; and
- Third-party administration of the two Health Sciences Association (HSA) LTD Trusts.

The staff also coordinates committees to review disputed LTD claim decisions and rehabilitation plans, as well as third party subrogation claims.

Financial Services

The key functions of the Financial Services department are the collection of contributions, cash flow management, and coordinating the data collection process. The department has a staff of seven employees. The staff is not involved in the investment of the contributions, which is delegated to six external investment managers. However, the Financial Services department is responsible for asset allocation re-balancing, preparation of the monthly financial statements, including projections of the actuarial liabilities, and the monitoring of the performance of the investments of the Trust's assets, as well as ensuring that the assets are invested in accordance with the investment policy.

Employee and Workplace Health Services

The Employee and Workplace Health Services (EWHS) was introduced to improve employees' quality of life and productivity at work, reduce the incidence, severity, and costs associated with illness and injury. The EWHS department has a staff of approximately seven employees, and provides consulting services to participating employers if requested. The primary objective of the EWHS department is to assist employers with managing employee and workplace health. Some areas of focus include:

- Musculoskeletal injury prevention/ergonomics;
- Depression in the workplace;
- Aggressive behavior management;
- Health promotion/stress management/substance abuse management; and
- Workplace hygiene.

Rehabilitation Services

The Rehabilitation Services department was established at HBT in 1992 as a means to assist employees who are receiving LTD benefits to return to work and help member organizations control LTD claims costs. The department currently has a staff of approximately 20 employees located throughout the province. The service was largely voluntary until 1998, when the participation was made a mandatory part of the LTD plan for unionized healthcare employees. The Rehabilitation Services department provides a broad scope of programs including, but not limited to, the following:

- Early rehabilitation services (pre-LTD), if requested;
- Work conditioning;
- Psychological and support counseling;
- Vocational assessment;
- Career counseling;
- Work site assessments;
- Graduated and modified return to work; and
- Retraining.

Rehabilitation consultants work with participating employers and a variety of other stakeholders to develop rehabilitation plans with LTD claimants. They also make use of community resources and external service providers, where appropriate.

4.2 Observations on the Mandate and Delivery Model

4.2.1 Execution of the Mandate

All the activities of HBT are outlined in section *4.1.4 Responsibilities of HBT Management and Staff*. The nature of these functions has evolved over the last decade. While some of these responsibilities were part of the original mandate and in HBT's interest to deliver, it is open to interpretation as to whether all of these services are best delivered by HBT, for example:

- Delivery of rehabilitation services; and
- Delivery of employee and workplace health services.

4.2.1.1 Rehabilitation Services

While the management of claims is an important factor in containing the cost of disability benefits, concerns were raised by the larger participating employers as to whether these services are best provided by HBT. These employers expressed concern around the integration of rehabilitation services with programs currently being provided by the employer and/or other service providers (e.g. Workers' Compensation Board and Occupational Health and Safety Agency for Healthcare). HBT has estimated the cost for rehabilitation services to be $2.3 million for the 2002/2003 fiscal year.

4.2.1.2 Employee and Workplace Health Services (EWHS)

There was a strong view from the larger employers that HBT may be involved beyond their mandate with respect to occupational health and disability management services. With the fact that some employers now have personnel specializing in these areas, and with the jointly managed (union and HEABC) Occupational Health and Safety Agency for Healthcare (OHSAH) initiative, it is clearly evident that the delivery of these services for healthcare employees is disjointed. In our experience with other programs, a disjointed disability management delivery process is a significant contributing factor for increased LTD claims incidence, duration, as well as lost opportunity for rehabilitation; although employee demographics, labour and policy issues are also contributing factors.

HBT has indicated they have assisted some employers with the establishment of a fully integrated disability management programs which directly involve unionized employees; however, we understand these programs were undertaken on a voluntary basis. HBT has estimated the cost for EWHS to be $1.1 million for the 2002/2003 fiscal year.

While the analysis of the disability management program is beyond the scope of our review, we recommend an organization that has direct contact with all union representatives, is involved in all areas of absences (e.g. sick leave, WCB, and LTD), and has the authority to make participation mandatory should design and deliver this initiative. Ideally, the program would be fully supported by all the unions (if applicable) as well as the employers and should have an integrated approach with respect to sick leave/STD, WCB, and LTD claims. Based on these best practice criteria, HBT would be excluded given their current mandate; however, they could be considered if their mandate were to be expanded.

Any change to HBT's role in the current rehabilitation and EWHS services delivery model should only be made in conjunction with a review of the disability management process for the healthcare

sector and should incorporate the investments made in this area by the individual participating employers.

4.2.2 Strengths of Current Delivery Model

During our review, we noted a number of attributes in the current delivery model that we believe are relative strengths and should be recognized as critical to the ongoing success of HBT. If a change were to be considered in the future, we would recommend these strengths be preserved, where possible.

4.2.2.1 Commitment of Board and Management

The project team conducted a high level review of the HBT governance structure, organizational structure, and decision-making processes. Based on our observations and interviews with the various stakeholders, we believe the Board of Trustees and HBT staff has operated in a prudent manner in carrying out their respective responsibilities in serving HBT. We observed the high level of dedication and commitment to serving the mandate of HBT.

A number of sub-committees, as described above, have been established and there are direct links back into the organization from these committees. There is internal as well as external representation from the healthcare sector at the Trustee level, as well as strong business, legal, and financial experience present on the Board.

4.2.2.2 Depth of Information and Knowledge

HBT has accumulated a significant amount of data, information and analysis on all aspects of the various plans. They have invested heavily in developing a sophisticated knowledge database to support the accumulation and analysis of all benefit related data. Management has leveraged this information to provide detailed reports on their business.

HBT has accumulated detailed records of the various plans under administration and is able to use this information to the advantage of the participating employers. For example, HBT staff has been able to play a positive role in representing employers in arbitration cases. Also in this regard, many of the senior staff have been associated with HBT for many years and have a significant ‘corporate memory’. While we recognize HBT has attempted to provide information to participating employers and government in the past, we recommend the approach to disseminating information be reviewed to ensure regular updates on all aspects of plan performance as well as appropriate interpretation of the data are provided.

4.2.2.3 Capability of the Staff

Based on our observations, the staff of HBT is qualified and capable of carrying out their responsibilities. The Trustees also expressed their confidence in the staff and commented on their efficiency, particularly in taking on additional work when the number of participating employers increased.

4.2.2.4 Investment Performance Measurement

HBT has sought high quality fund managers, have used independent investment consulting services, regularly evaluates the fund managers’ performance, and the Board consists of individuals with strong treasury and finance backgrounds. This is supported by regular performance measurement services from third parties.

4.2.2.5 Use of Volume Purchasing

With more than 80,000 beneficiaries, HBT is one of the largest self-insured health and welfare plans in the country, although, stop-loss arrangements for some benefits are insured through their claims payors. HBT has effectively used their size to obtain volume purchasing advantages for claims administration and most overheads, providing a low-cost delivery of benefits. This was confirmed in our review process and detailed in section *4.3 Benchmarking Against Similar Funds* of our report.

4.2.2.6 Commitment to Healthcare and Social Services Sector

All the efforts and resources of HBT appear to be focused on serving the health and community social service sector. HBT's operating model, as opposed to a typical insurance company, also appears to be relatively cost effective. Certainly they are not burdened with much of the normal overhead that comes with operating a comprehensive insurance entity, such as extensive marketing campaigns, a commissioned sales force, and a bureaucratic management structure, for example.

4.2.3 Challenges of Current Delivery Model

A number of significant challenges in the current delivery model were identified. Aside from being challenges inherent in the current delivery model, many of these are root causes of the significant unfunded actuarial liability, although other root causes also exist outside of the delivery model (e.g. ageing population, nature of health sector duties, increase in mental illness, etc.). In some cases these concerns originated within other parties within the current delivery model, but outside of the scope of HBT. However, we believe HBT should play a significant role in working with the other stakeholders to address them.

4.2.3.1 Balance of Employer Representation

Trustees selected to serve HBT are currently appointed by the HEABC. However, in practice, HBT nominates the potential non-healthcare candidates for the selection process. Until recently, the majority of the Board was made up of members from the private business community with particular expertise in finance and investments. Although we do not discourage the use of 'external' Trustees, having a Board with primarily employer and/or union representatives directly relating to the beneficiaries is more common, based on our experience with similar programs.

Earlier this year the Board expanded to include an additional representative from the Health Authorities. While this expansion was designed to improve the direct participation on the HBT Board, we recommend additional Trustee(s) from areas of the healthcare and social services sector not currently represented to ensure balanced representation. Given the impact of the LTD program on the overall financial position of HBT, consideration should also be given to individuals with a strong disability management background.

4.2.3.2 Inconsistent Communications

There are clearly communication issues between HBT and the participating employers. Based on our interviews with the various stakeholders, HBT generally has relationships with the individuals at the participating employers that are responsible for the benefits program on a day-to-day basis, but have not always consistently communicated with all key stakeholders at all levels (e.g. senior finance and/or human resource personnel, government, etc.). This is a fundamental problem as these individuals are responsible for policy setting within their organizations.

There is currently no formal mechanism in place to provide input from the participating employers to HBT beyond the Trustee level. Participating employers believe they have been ignored by HBT;

however, HBT has tried to develop channels of communications in the past, but with limited success. HBT has also not always proactively sought input or feedback when formulating policy and service delivery decisions. Many of the organizations interviewed indicated a desire for a more formal structure that includes these communication mechanisms (such as satisfaction surveys, detailed rate change information, rationale behind key decisions, emerging issues, claims trends and forecasts, and other regular updates), although we did note that HBT does distribute a significant volume of information to participating employers including some of the items noted above. We recommend the current communication strategy be reviewed to ensure proactive, regular interaction between all parties, including government. Furthermore, participating employers should be frequently consulted to ensure the information provided is meeting their needs.

4.2.3.3 Inequitable Allocation of Employer Contributions

We understand that the majority of benefits provided through the HBT are fully pooled by risk group, with the exception of LTD, where experience rating is applied at the employer level based on a credibility formula. We recommend increased accountability, particularly for the large participating employers. This can be achieved by setting contribution rates on each participant's claims experience for all benefits. However, the pooled approach could be maintained for the smaller participants. This approach maintains equity between participating employers, and makes employers responsible for their own employee benefit costs and also addresses the issue of cross-subsidization.

4.2.3.4 Absence of Underwriting Options

Some participating employers have indicated that their risk tolerance may not be consistent with that of HBT. Currently there is no flexibility to allow participating employers to select an underwriting option that is consistent with their risk tolerance. We recommend the establishment of a HBT pool and allow participating employers to choose whether to participate in the pool or select a stand-alone underwriting arrangement within HBT. Under this approach, all participating employers would still have access to the same reduced expense charges negotiated by HBT for the entire program.

4.2.3.5 Lack of Contingency Reserves

Aside from the implementation of an Investment Fluctuation Reserve to smooth the asset values, which indirectly serves to reduce some volatility of contribution levels, HBT may be unable to hold either a contingency reserve or surplus within HBT and still maintain their health and welfare trust status for taxation purposes[2]. Any future surpluses that are generated through strong investment performance or over-contributions by the participating employers would likely be used primarily to eliminate the outstanding unfunded actuarial liability, but potentially could be used to maintain a surplus for managing contribution/claims fluctuations while the deficit continues to exist. HBT indicated it examined holding a contingency reserve outside of HBT, and the decision was to continue the current practice, as this was not supported by the participating employers who felt that it was more appropriate to utilize the funds for other means. It is a standard insurance industry practice to hold these reserves in order to manage the claims volatility inherent with benefits such as Life, Accident, and LTD insurance. We recognize that some funds are held on deposit with the claims payors (e.g. health and dental deposit with Pacific Blue Cross); however, we do recommend a claims fluctuation reserve be established to ensure more stability in contribution levels. Such a reserve is a component of both the optimal and transition models discussed later in this report.

[2] This has been confirmed by our Deloitte Tax specialists in an opinion at *Appendix A: Tax Opinion on HBT Surplus.*

4.2.3.6 Creation of Taxation Issues

The majority of participating employers are considered non-profit organizations, and as such, are not subject to income taxation – but it should be noted that some of the participating employers are. The nature of the HBT entity introduces potential taxation complications requiring a cautious and somewhat restrictive operational model. For example, holding a significant surplus, or contingency reserve to manage claims and investment volatility, may trigger a taxable situation but could perhaps also jeopardize the trust status of HBT based on our interpretation of relevant wording in the Trust documents.

4.2.3.7 Lack of Understanding around LTD Claims Adjudication Issues

Based on input received in the interview process, some employers perceive that HBT is not supporting them with respect to the claims adjudication process. However, during the course of these same interviews, it was acknowledged that there were incidences where pressure was applied to HBT to accept or decline questionable claims. It is likely that these situations arise due to a lack of understanding, on the part of the employers, of HBT's role in the claims adjudication process, and the financial implications of a LTD claim.

4.2.3.8 Return on Investment on Benefits Administration System

To date, we understand that HBT has invested approximately $15 million in their Health Administration Link (HAL™) administration system. Given the significant change in technology since the inception of this project, it would be difficult to measure the return on this investment or its cost relative to other options. However, HBT has commented that a return on investment in technology can be supported by the reduction in their accounts receivables and other administrative costs. HBT has also indicated two international accounting firms conducted a feasibility study and business plan supporting the systems development. Based on our observations, the insurance industry has made significant advances in the area of administration technology during the development stage of HAL™, such as the provision of on-line premium billings and enrolment, employee self-service tools, and client electronic data exchange. As well, there are third-party vendors that specialize in the area of employee benefits administration with similar capabilities. However, we understand some of the return on this investment is intended to come from revenue sharing from future sales of HAL™ by the developer. We also recognize that HAL™ is intended to generate significant efficiencies in the benefit administration processes and the electronic storage of benefits information.

While HAL™ is intended to improve the various administration functions for both HBT as well as participating employers, it is currently not delivering all the services anticipated and in the timeframe expected by some employers who were interviewed. Some employers also indicated that they are already using tools provided by HBT's service providers for non-HBT benefit plans with satisfaction; however, HBT believe many of the HBT functionality requirements are unique. We recommend the participating employers work with HBT as they develop and implement their own HRIS systems. The primary objective would be to integrate and leverage the functionality of each party's system and avoid duplication of unnecessary expenditures.

4.2.3.9 Lack of Control over Plan Design

The primary objective of HBT is to administer a trust fund for the purpose of providing group health and welfare benefits on behalf of six regional health authorities and more than 750 participating employers. HBT's mandate is to simply deliver what has already been negotiated in the employers' collective agreements and it is not within HBT's mandate to direct bargaining. HBT has no power to alter the provisions of these agreements. The cost of employee benefits is directly related to the types

and level of coverage designed into the plan as a result of these collective agreements. Based on our observations, there are a number of generous provisions in the current benefit plans that increase LTD claims incidence, such as the definition of disability and indexing of benefits, for example. HBT has no direct control over, or input into, possible strategies to contain or share costs. As a result, we expect there will be continuing upward pressure on overall benefit costs as long as these provisions exist. While a detailed review and benchmarking of the various plan designs are not within the scope of this review, generous provisions will have a significant impact on overall benefit costs. We recommend the government, the participating employers and the unions approach future collective bargaining and wage discussions with the intention of ensuring an equitable plan design, consistent with other similar plans in the healthcare and other related sectors.

4.2.3.10 Volatility of Investment Performance

Some of the recent volatility in the contribution rates can be attributed to rapid fluctuations in investment performance due to the rapid rise and fall in the financial markets. Certainly the strong performance of the investments has masked the consistently poor claims experience. It is also not clear whether HBT's investment returns and strategies reflect the risk profile, investment strategies, and budgeting requirements of the participating employers. HBT has indicated Trustees made changes to the asset allocation mix in 1994 and 1996 based on consultation and feedback from employers. We are not aware of any further changes to the asset mix since 1996. The use of risk management mechanisms such as counter-cyclical investments, financial hedges, or swaps designed to reduce the volatility of the investment performance have been considered but not deployed in any significant manner, upon the advice of HBT's external advisors.

4.2.3.11 Diversification and Change in Size of Participating Employers

There has been significant restructuring of the healthcare and community social services sectors within BC over the past two years, and this change will continue into the near future. This change has created, and will continue to pose, significant challenges to the entire sector, and HBT's ability to manage and administer the benefits programs provided by these employers. The area of most concern relates to monitoring and implementing the various plans and the implications of employer changes, collective bargaining and restructuring activities.

4.2.3.12 Disjointed Process for Disability Management

We believe that the disability management process is disjointed and this was confirmed in our discussions with representatives of the participating employers. HBT offer some disability management services, while other organizations (e.g. Health Authorities, Occupational Health and Safety Agency for Healthcare, WCB) offer similar services; however, these services are not integrated from a communication and delivery perspective. In our experience with other programs, a disjointed disability management delivery process is a significant contributing factor for increased LTD claims incidence, duration, as well as lost opportunity for rehabilitation; although, employee demographics, labour and policy issues are also contributing factors. These other programs ensure disability management services are integrated in order to control the claims incidence rate and duration of these claims. The plan sponsor of these programs have direct contact with union representatives, are involved in all areas of absences (e.g. sick leave, WCB, and LTD), and have the authority to make participation mandatory.

As previously discussed, while the analysis of the disability management program is beyond the scope of our review, we recommend a detailed review of the disability management process for the healthcare sector should be undertaken.

4.3 Benchmarking Against Similar Funds

To perform a benchmarking of costs against similar private and public sector funds.

To evaluate the costs of administering the HBT plan, we have benchmarked with a number of comparator programs both within this province and across the country. Although we have attempted to evaluate the expense charges for each plan on a similar basis, there are differences due to the varying administration requirements of each plan surveyed, and in the manner the service providers express their expenses. For this reason, we have expressed the results as simply being either higher (upward red arrow) or lower (downward green arrow) than HBT's expense levels. As claims costs are the largest driver of benefit costs, we have also provided commentary with respect to LTD claims incidence rates with other programs.

4.3.1 Retention charges

We have made a high level comparison of the expense charges paid by HBT to the various service providers with a sample of large plans in the private and public sectors. A brief description of the samples with which we compared HBT is as follows:

- **Plan A –** Multi-employer organization covering approximately 30,000 employees;
- **Plan B –** Health sector organization covering approximately 10,000 employees.
- **Plan C –** Multi-employer LTD plan covering approximately 12,000 employees.
- **Plan D –** Single employer plan covering approximately 60,000 employees.
- **Plan E** – Health sector organization covering approximately 55,000 employees.
- **Plan F** – Single employer plan covering approximately 12,000 employees.
- **Plan G** – Multi-employer plan covering approximately 20,000 employees.

In the table below, we have shown HBT's expense charges as a percentage of contributions. We have not included HBT's infrastructure costs for operating the Trust, which amounted to approximately 1.42% of contributions in 2001/2002 fiscal year. We have also excluded HBT's internal claims management costs, which amounted to approximately 3.57% of LTD contributions for the 2001/2002 fiscal year. This approach allows us to provide consistent comparison between the plans. The information shown in the table below is based on the most recent data available from HBT and the comparative plans.

	Number of Covered Employees	Group Life & Accident	Long Term Disability	Extended Health	Dental
HBT*	**80,000**	**0.57%**	**4.0%**	**4.17%**	**3.70%**
Plan A	30,000	↑	N/A	↑	↓
Plan B	10,000	N/A	N/A	↑	↑
Plan C	12,000	N/A	↓	N/A	N/A
Plan D	60,000	N/A	N/A	↑	↑
Plan E	55,000	↑	↓	N/A	N/A
Plan F	12,000	↑	↑	↓	N/A
Plan G	20,000	↑	↑	↑	↑

As illustrated above, there are plans with lower expense charges for certain benefits; however, HBT's expense charges appear to be very competitive when evaluating all benefits.

While operating costs, including expense charges, are a factor in ensuring the cost of benefits delivery are kept to a minimum, the most significant driver is the actual cost of claims. For example, HBT received $202 million in contributions in 2001/2002 (before investment income and market value changes) and the total operating cost (including internal infrastructure, external services and special projects) was $22 million, representing approximately 11% of contributions. Even a significant reduction in these overhead charges (e.g. 20% reduction or $4 million) would have a minimal impact on the overall financial position of HBT relative to reducing claims cost by the same percentage (as claims comprise 89% of contributions).

4.3.2 LTD Incidence Rate

We were able to compare the HBT claims incidence rate with similar programs in two other provinces. While the number of comparisons is limited and plan designs are not identical, the comparative programs cover similar populations in the healthcare sector and, therefore, are relevant to this review.

	Number of Covered Employees	LTD Claims Incidence Rate (per 1,000 employees)
HBT*	**80,000**	**19**
Plan E	55,000	9
Plan F	12,000	15

As shown above, the LTD claims incidence rate for HBT is significantly higher than the comparative plans. There is a direct relationship between the relatively high contribution rates required for the employers participating in the HBT and the high LTD claims incidence rate. Furthermore, HBT's LTD claims incidence rate has been consistently high in the last five years averaging approximately 19 LTD claims per 1,000 active employees over this period. Although it is recognized that claims duration and recovery rates are also significant factors, this information was not available for the comparative plans.

4.4 Review of the Recent Actuarial Assessment

To perform a high level review of the most recent actuarial assessment in terms of its implications for HBT and its clients as well as compared to other alternatives.

4.4.1 Conclusions from Actuarial Review

Our high level review of HBT's actuarial assumptions and methodology indicate that they conform to acceptable actuarial practices. To the extent that the data used was complete and accurate and that the calculations were performed correctly, we believe that the results reported by HBT's actuaries for the liabilities, before considering the Investment Fluctuation Reserve, are within the range of acceptable actuarial practice. We do believe, however, that certain assumptions could be more conservatively applied given the size and growth rate of the current unfunded actuarial liability.

4.4.1.1 Actuarial Valuation

High-level observations about the recent actuarial valuation of HBT include the following:

- **Interest rate** – While within the acceptable range, the current interest rate of return on investment assumption of 7.5% may be on the high side for a plan where a good portion of the benefits are not indexed. Based on some of the documents we reviewed, it appears an assumption for indexing of 1.5% was made, although this was not mentioned in the Report of the Actuaries which forms part of the Annual Reports. We have not determined the appropriateness of this indexing assumption. Our experience with valuations of similar plans suggests interest rates between 6.5% and 7.0% as being more appropriate. However, it is also our experience that LTD liabilities tend to be less sensitive to a change in the interest assumption than other types of benefits, such as pensions.
- **Recovery rates** – The recovery rates assumed for the valuation of LTD liabilities are based on the plan's experience. The assumption appears to be consistent with the recovery rates we have seen for large LTD plans.

- **IBNR claims reserve** – The 'incurred but not reported' (IBNR) claims reserve is established to recognize the future liability associated with claims that are incurred in the current period, but are reported in a subsequent period. The HBT formula for the calculations of the IBNR claims reserve is reasonable and does not depart from what we have seen in the industry. However, we note that in fiscal year 2001/2002 there was a reported loss of $7.5 million due to late reporting of claims from prior to October 1998. HBT has advised that this was a one-time event; however, the IBNR should be adjusted should this not be the case.
- **CPP approval rate** – The assumption for the Canada Pension Plan (CPP) approval rates and pending claims acceptance rate appear to be reasonable.
- **Assumption for delayed reporting of terminations** – When valuing existing disability claims, an assumption may be included for existing claims that are no longer active as their disability status has terminated but not yet reported. The assumption for delayed reporting of terminations reflected in the HBT plan valuation presumably was derived from plan experience and we have no means to verify its reasonableness as this would be unique to HBT, but we have no reason to believe that this assumption is inappropriate.

The above observations focus on the assumptions used by HBT's actuaries when determining the reserve requirements and liabilities of the plan. The assumptions used are at the discretion of HBT's actuaries provided they are within the range of acceptable actuarial practice. However, changes to the assumptions could have a material impact on the financial results of a plan. For example, the lower the interest rate assumption, the higher the liabilities, and vice-versa.

We believe that it may be more prudent to consider the use of more conservative assumptions while the current unfunded actuarial liability exists, but the impact on contribution rates should still be considered.

4.4.1.2 Rate Setting

The assumptions and methods underlying the development of contribution rates and establishing actuarial reserves reflect the Trustees' philosophy/objectives of maintaining and maximizing the tax efficiency of the model and also by their belief that the establishment of any contingency reserve or the retention of any fund surplus within HBT may impact HBT's Trust status.

Based on our discussion with HBT's actuaries, there is little or no margin reflected in the setting of contribution rates and actuarial reserves to mitigate the effects of adverse experience. We understand that the contribution rates are set based on the most recent year's results plus additional amounts for any deficit recovery with the objective of reaching a 95% funding level by the end of the 10th year. Furthermore, we understand that actual and anticipated investment gains were taken into account in the rate setting process. This funding strategy will more likely result in a deficit than in a surplus.

We also noted that in the 2002 Annual Report (page 10), there was a $28 million loss identified due to total claims costs exceeding contributions (i.e. more than 14% of contributions) and a further loss of $30 million (including a one-time IBNR adjustment of $7.5 million for pre-1998 claims) due to claims costs on pre-September 2001 claims. Although the losses were not unexpected, the LTD contribution rates were understated. We understand the practice of relying on possible investment gains is no longer going to be utilized by HBT, and we recommend it not be reconsidered in future rate setting. There is no indication of whether the reserving basis needs to be changed because of these losses. Since LTD losses have been steadily increasing over the past five years, averaging a total of approximately $60 million for the last two years, in a period where we understand

contribution rates have increased, we recommend additional caution in the determination of future contribution rates to ensure that contributions do not significantly deviate from emerging trends.

4.4.2 Investment Policy

The Trustees are responsible for asset allocation and selection of investment managers. All decisions relating to the investments are made by the investment managers. The Trustees monitor the investment managers for compliance with their respective mandates and investment results.

The Trustees exercise their independence, and set the investment policy and objectives for HBT with very little input from the employers. HBT and the Trustees are not accountable to anyone relating to their investment decisions provided they act in good faith and in a prudent manner. The Trustees have acted responsibly in managing the funds. However, accountability is potentially a contentious issue as the Trustees determine and decide on the risks to be assumed by HBT, but the employers are responsible for all the consequences of the Trustees' and investment managers' decisions.

4.4.3 Investment Performance

Prior to 2001, HBT had been successful in achieving investment rates of return on average that exceeded the actuarial assumption of 7.5%. Most of the investment gains were applied to reduce the LTD contribution rates otherwise necessary to cover claims costs. Therefore, the rates implemented did not reflect the actual claims experience for the plan. The LTD contribution rates were reduced in 1996 and remained unchanged until 2001. This practice benefited the employers directly; however, several participating employers indicated that they did not understand this rate setting methodology. This practice may have prevented some employers from recognizing the seriousness of the poor LTD claims experience, which would ultimately translate to contribution increases when the investment gains were not available to offset the increasing costs from the poor LTD claims experience.

The collapse of the investment markets prior to, and following, September 11, 2001 resulted in net investment losses to HBT in 2001 and 2002. This, coupled with poor claims experience, resulted in significant contribution rate increases to some employers. While continued strong investment performance could have partially mitigated losses, it is important to note that the claims experience losses on LTD alone over the past three years amount to $168 million, a period where the unfunded liability of the plan increased by $145 million.

As illustrated below, the investment rates of return for HBT over the past four years ending September 30th reflect the volatility of the investment market. As a simple comparator, we used SEI Investments Pooled Fund Survey (SEI Investments) and the Morneau Sobeco Performance Universe of Pension Managers' Pooled Funds (MS Performance Universe). These comparators provide a quarterly survey of the investment returns of various pooled pension funds managed by 70 and 50 leading investment managers, respectively. The following table shows the one-year rate of return at September 30th for each of the years from 2000 to 2003 for HBT and the comparators.

One-Year Return	HBT*	SEI Investments[3]	MS Performance Universe[4]
2003	**9.90%**	11.69%	11.76%
2002	**0.10%**	-0.82%	-2.57%
2001	**-11.10%**	-5.44%	-8.32%
2000	**20.80%**	19.57%	20.85%

The above comparisons indicate that HBT's rates of return fluctuated between +3% and -6% against our comparative benchmarks. This reflects HBT's investment policy and the performance of the HBT's fund managers.

Four-Year Return	HBT*	SEI Investments	MS Performance Universe
2003	**4.26%**	5.79%	4.80%

Although HBT has exceeded their benchmarks as defined in their Investment Policy (which determines HBT's asset mix), the four-year return ending September 2003 for HBT is below the median value of our comparators for the same period. As another comparison, the median four-year return ending September 30, 2003 reported by API Asset Performance Inc., a major fund measurement service firm, among 120 leading balanced pension funds is 5.2%, which is also slightly higher than HBT's four-year return as well as the median return among the pooled diversified funds in the MS Performance Universe. HBT have also obtained external investment performance measurement, which indicates they have exceeded their investment returns defined in their Investment Policy.

4.4.4 Investment Fluctuation Reserve

An Investment Fluctuation Reserve (IFR) is a mechanism designed to reduce the impact of fluctuations in investment asset values from year to year, thereby stabilizing the funding model. This process typically uses any reasonable (actuarial) method to delay the recognition of investment gains/losses of the assets over a period usually not to exceed five years. In practice, an account (i.e. a reserve) is maintained, the balance of which is made up of the unamortized amounts of any investment gain or loss from the year in question, and of the balance carried forward from prior years. Each year, the asset value used in the actuarial calculations is equal to the market value adjusted to reflect the amortized amount transferred from the IFR, providing the market related value of the assets at a particular date.

4.4.4.1 Financial Reporting

While appropriately and clearly disclosed in the Report of the Actuaries, included in the financial statements, there are differing opinions as to the treatment of the Investment Fluctuation Reserve

[3] Pooled balanced funds median values as at September 30th.
[4] Pooled diversified fund median values as at September 30th.

(IFR) in the financial statements of HBT, where the IFR is included in actuarial liabilities for plan benefits in the statement of financial position. We have not provided our opinion in this report.

The use of an IFR is not uncommon in the valuation and costing of pension plans. The main purpose of its use in the pension plan is to reduce the volatility of asset values from year to year. The application of an IFR results in the creation of a market-related value (MRV) of assets, instead of a fair market value (FMV). Canadian generally accepted accounting principles (CICA) handbook section 3461.067 allows the MRV to be used to determine the benefit expense charged to a plan sponsor in a particular fiscal year. In contrast, CICA handbook sections 3461.155 and 4100.10 require the use of FMV as the basis of measurement of plan assets for financial reporting purposes. However, from an actuarial perspective, actuarial liabilities are not directly impacted or affected by the value of investments or the IFR; rather, they are primarily affected by benefit levels, number of claimants and expected claim duration. If gains or losses are realized on investments, they will impact the financing of the plan - not the direct benefit costs and related liabilities. This may bring into question the basis for inclusion of the IFR in actuarial liabilities for plan benefits in the financial statements of HBT, and possibly its inclusion in the financial statements as a whole, as it may be argued that it is neither an actuarial or accounting liability. Certainly our experience indicates that the inclusion of an IFR in the financial statements of pension funds is inconsistent across Canada.

CICA recently introduced handbook sections 1100 and 5600, which will be effective for HBT's fiscal year beginning October 1, 2003. Section 1100 identifies the sources of Canadian GAAP and a hierarchy for the primary sources of GAAP. Section 5600.02 requires that GAAP be the basis for general-purpose financial statements. The accounting treatment of the IFR may need to be reviewed in light of these developments.

4.4.4.2 Use of the IFR

The use of an IFR in determining HBT's funding status by HBT's actuaries was intended to stabilize HBT's funded position from volatile returns on investments. In the 2000 Report of the Actuaries, it was stated "the IFR is only established if HBT is in a fully funded position, and the Reserve will be limited to the excess of the available assets over the actuarial liability". The amount transferred to the IFR would be amortized over a five-year period in that one-fifth of each year's allocation is removed from the IFR in each of the subsequent five years. It was further stated that the amount that can be held in the IFR was "subject to a maximum reserve of one year's expected return on the portion of the assets that support the actuarial liabilities". Based on the assets at September 30, 2002, the maximum that could be held in the IFR under this provision was approximately $22 million.

Commencing in 2001, the use of the IFR changed when investment returns fell below the expected returns and the IFR balance became negative. Furthermore, there was no lower limit imposed on the amount of negative balance the IFR could carry, and as of September 2002, the IFR held a negative balance of $46 million. The absence of a lower limit with respect to a negative IFR is inconsistent with the existence of an upper limit on a positive IFR. The existence of a negative IFR indicates that some portion of the unfunded actuarial liability will not be immediately funded by the scheduled increase in the contribution rates.

4.4.4.3 Conclusion on the IFR

Although we believe the use of an IFR is acceptable for funding purposes, there is a lack of consistency in its application. We recommend a review of the continued use of this reserve and the appropriateness of its inclusion and presentation in the financial statements.

4.4.5 Unfunded Actuarial Liability

In the 2002 Report of the Actuaries, HBT was reported to have an unfunded liability of $152 million, plus another $46 million of unfunded liability that was allocated to the IFR, making the total unfunded liability $198 million. Based on the draft 2003 Annual Report, the total unfunded liability increased to $261 million (including the negative balance of approximately $35 million in the Investment Fluctuation Reserve).

The unfunded actuarial liability is mainly attributable to the LTD plan. There are a number of factors and assumptions impacting the value of the unfunded actuarial liability with respect to the LTD plan. These include, but are not limited to, the following:

- Incidence rate of LTD claims;
- Duration of LTD claims;
- Termination rate of LTD claims;
- Rates of return on investments;
- Anticipated salary increases; and
- Anticipated increases to LTD benefit payments due to inflation.

In addition to a 25% increase for the LTD contribution rates to cover the current expected annual claims costs, a further increase in the LTD contribution rates of 12% for each of the next two years are being required of the participating employers in order to amortize this unfunded actuarial liability over 10 years, with the objective that HBT would achieve a 95% funding level by the end of the 10th year. Participating employers were also presented with two alternative, equivalent deficit recovery schedules from which to choose.

Underlying this deficit amortization schedule is the current assumption that HBT will earn an average rate of return of 7.5% per annum over this period. To the extent that HBT is able to achieve a rate of return greater than 7.5% and depending on the extent of any losses relating to claims costs (i.e. claims costs exceed contributions), the deficit may be amortized sooner, which may translate to a reduction of the additional contribution rates to the employers. However, to the extent that HBT is unable to achieve a rate of return at least equal to 7.5% or if HBT's loss from claims costs exceed any investment gains that results in additional unfunded actuarial liability, additional layers of contribution may be imposed on the employers to amortize the additional unfunded actuarial liability. Based on the draft 2003 Report of the Actuaries, retroactive changes in plan design within the employers and corresponding changes in the actuarial assumptions resulted in additional unfunded actuarial liability, despite positive investment returns for the current period.

Deloitte & Touche

4.5 Review of the Deficit Recovery Strategy

To review the HBT's governance structure to ensure strategies exist to minimize benefit costs and equitably align assets and liabilities going forward.

4.5.1 Deficit Recovery Strategies

There have been three strategies developed to address the unfunded actuarial liability:

- Adjustments to future contribution;
- Positive investment returns; and
- Improved claims management.

4.5.2 Adjustments to Future Contributions Strategy

HBT's funding strategy is to require additional deficit recovery funding through future contributions to reduce the unfunded liabilities over a 10-year period, in order to achieve a funding level of 95% by the end of the 10th year. As noted earlier, this funding strategy will more likely result in a deficit than in a surplus. These required increases in the LTD contribution rates calculated in the September 30, 2002 actuarial valuation resulted in an increase of 25% to the 2003 contributions, followed by a 12% increase for each of the subsequent two years. Employers were also presented with two alternative equivalent deficit recovery schedules from which to choose.

This deficit recovery strategy is consistent with acceptable actuarial practice. It could be argued a deficit recovery strategy with a timeframe longer than 10 years to achieve full funding would reduce volatility in contribution rates because the required increase may be reduced. However, we note the volatility in the LTD contribution rates is not caused by increasing the amortization period since the actuarial present values of the liabilities are the same regardless of the amortization periods. Rather, volatility is caused by understating the LTD contribution rates resulting in losses from claims costs exceeding contributions, and overly aggressive actuarial assumptions resulting in plan deficits. A long amortization period, on the other hand, would be of concern if there is a risk that no contributions would be forthcoming to cover any remaining deficits should the plan be terminated prematurely. We are aware of some self-insured LTD plans that have adopted a longer time horizon for their deficit recovery policy. On the other hand, the time frame that would be required to liquidate the deficit would be much shorter (i.e. three to five years) if this plan were underwritten through an insurance carrier.

Based on the information found in the Annual Reports, over the past three years the new LTD claims have generated experience losses of approximately $30 million in each year. While absence of margins in the determination of actuarial reserves would not be unusual for a plan like HBT, based on emerging trends, we recommend some margin in the contribution rate setting process. While we recognize over-funding will present taxation issues, the intent of the margins would not necessarily be to reduce the probability of a deficit, but could be designed to ensure the contribution rates do not significantly deviate from the anticipated LTD claims costs. In other words, there could be a lag between the experience used in determining contribution rates and the emerging experience over a period of three to five years to avoid the build up of large deficits.

As with HBT's rate setting practices, the rate increases reflected in the deficit recovery strategy do not include any margin for investment and claims experience losses. An additional rate increase would be required in the event of such loss.

We recommend a more comprehensive funding policy. The current funding policy focuses solely on the achieving a 95% funding level and the required rate increases to reach this target in 10 years. This funding strategy will more likely result in a deficit than in a surplus. During a period where claims costs are consistently high, as has been the case in recent years, there is a danger of continuously falling behind and, if no offset comes from investment performance, contribution rates could be expected to increase significantly over a prolonged period.

A comprehensive funding policy would address the following components:

- Rate required to fully-fund the cost of new claims plus administration expenses including the approach and degree by which emerging trends are recognized in the rate setting process; and the
- Rate required to amortize the unfunded liability over the selected target period or periods.

4.5.3 Investment Return Strategy

The Trustees have adopted an investment strategy that balances acceptable risk against returns required to offset increases in contribution rates. The use of risk management mechanisms such as counter-cyclical investments, financial hedges, swaps or other derivatives designed to reduce the volatility of the investment performance were considered but not deployed in any significant manner, upon the advice of HBT's external advisors. HBT's Board of Trustees last altered the asset mix in 1996, prior to the restructuring of the healthcare sector in BC and the dramatic changes within the capital markets, but HBT do review their investment strategy and performance on a regular basis. We do, however, recommend HBT work closer with the participating employers to incorporate their risk profile and budgeting requirements in the investment review process.

4.5.4 Improved Claims Management

A significant challenge for HBT is the disjointed process for disability management for healthcare sector employees - a major factor impacting the LTD benefit costs. HBT offer some disability management services, while other organizations (e.g. Health Authorities, Occupational Health and Safety Agency for Healthcare, WCB) offer similar services; however, these services are not integrated from a communication and delivery perspective. This lack of integration and early intervention are primary contributors to the high LTD claims incidence rate, as well as the duration of these claims; although, employee demographics, labour and policy issues are also contributing factors. In order to control the claims incidence rate and duration of these claims, organizations in other jurisdictions ensure disability management services are integrated. These organizations have direct contact with union representatives, are involved in all areas of absences (e.g. sick leave, WCB, and LTD), and have the authority to make participation mandatory. However, in the meantime, to the extent it is not occurring, there should be a focus on rehabilitation and early return to work for recent LTD claims. It is generally acknowledged that early intervention and rehabilitation has a positive impact on LTD claims duration and terminations, and is most effective in the early stages of an LTD claim.

5. Optimizing the Delivery Model

To identify other models or structures, if it is determined that the original purpose is no longer valid.

To determine the best model for HBT in terms of its finances and administration. This includes long-term financial viability, assessing whether the member contribution rates properly reflect the benefit costs/claims (for example, by member organization and type of employee), and the financial model itself.

The dramatic change within the industry sector and the current volatility of the contribution rates dictate that some measure of change must be made. Certainly there is significant concern amongst the participating employers that we interviewed; suggesting much repair of the current model is needed. We are not, however, concluding that the original purpose is no longer valid, but simply that enough concern exists amongst the stakeholders interviewed that it is clear that changes will have to be made – not necessarily to the original purpose, but with the delivery model.

It should be noted the fundamental issues of rising claims costs and the growing unfunded actuarial liability will not be solved by simply changing the delivery model. More importantly, changes to plan design, collective agreements, and the management of disability claims will also need to be addressed, regardless of delivery model.

5.1 Attributes of an Optimal Delivery Model

There are a number of fundamental features that are generally considered 'best practice' in the delivery of health and welfare benefits. Based on our significant collective experience assessing, designing and implementing public and private sector health and welfare benefit programs, the following attributes were identified as key elements in a best practice delivery model:

- Access to volume purchasing;
- Equitable representation from all stakeholders;
- Optimal use of resources;
- Accountability to the employer;
- Independence from the claims process;
- Employer-driven investment and claims management strategies;
- Ability to accumulate contingency reserves;
- Choice of underwriting options for employers;
- Existence of a mandatory disability management program; and
- Control over effective plan design.

It should be noted that some of these attributes are already present in the current delivery model, and therefore any proposed change to the model, or HBT in particular, should seek to leverage these best practices.

5.1.1 Access to Volume Purchasing

Volume purchasing enables clear competitive advantages from a financial perspective with the primary purpose of reducing the insurers'/claims payors' expenses. If savings can be achieved in the

insurers'/claims payors' expenses for justifiable reasons (i.e. volume purchasing), the savings will be sustainable over the long term.

5.1.2 Equitable Representation from all Stakeholders

There should be balanced representation from all stakeholders. This would include members that have a direct relationship with the beneficiaries and potentially could include external members and Trustees. This will allow direct input and feedback from the various stakeholders the plan is serving.

5.1.3 Optimal Use of Resources

Obviously an optimal model would consider the optimal use of resources. This would include assessing whether internal staff members are most appropriate to develop and administer each aspect of the program, or whether external service providers could be leveraged. Also, synergies between the claims administrator and participating employers with regard to roles and responsibilities should be sought.

5.1.4 Accountability to the Employer

The plan sponsor (i.e. policyholder or designated claims administrator) would ensure that appropriate data is provided to all stakeholders on a consistent basis, and coordinate the renewal process to ensure that it coincides with the participating employer's budgeting process. Accountability to the participating employers would include the following:

- Maintain and update on an annual basis a database of all key contacts that are responsible for employee benefits delivery;
- Provide claims experience to all participating employer key contacts and provide commentary on emerging trends for their specific plan;
- Coordinate renewals so that they coincide with the participating employer's budgeting process. A face-to-face meeting should be arranged when possible, and the renewal should be presented to the senior finance and human resource personnel in conjunction with the employer's budgeting process;
- Provide details in an easily understood format to participating employers with respect to explaining the underwriting/risk sharing arrangement between the plan and the participating employer, as well as any required contributions changes; and
- Provide forecasting information to assist participating employers with data to prepare their budgets for employee benefits.

5.1.5 Independence from the Claims Process

Although the plan sponsor may coordinate resolution of claims disputes, they should be independent of the claims process and provide the claims payor complete autonomy (based on guidelines provided by the plan sponsor) with respect to claims adjudication. If there are claims disputes, these should include the participating employer and the respective union/employee, although an independent medical panel should exist to review disputed LTD claims.

5.1.6 Employer-Driven Investment and Claims Management Strategies

The investment strategy for the program should be consistent with the participating employer's budgeting cycle. There should also be a clear, direct relationship and connection between the employer's claims management process and their contribution premium. In short, the employers' contribution levels should be directly related to their effectiveness in claims management and their risk tolerance.

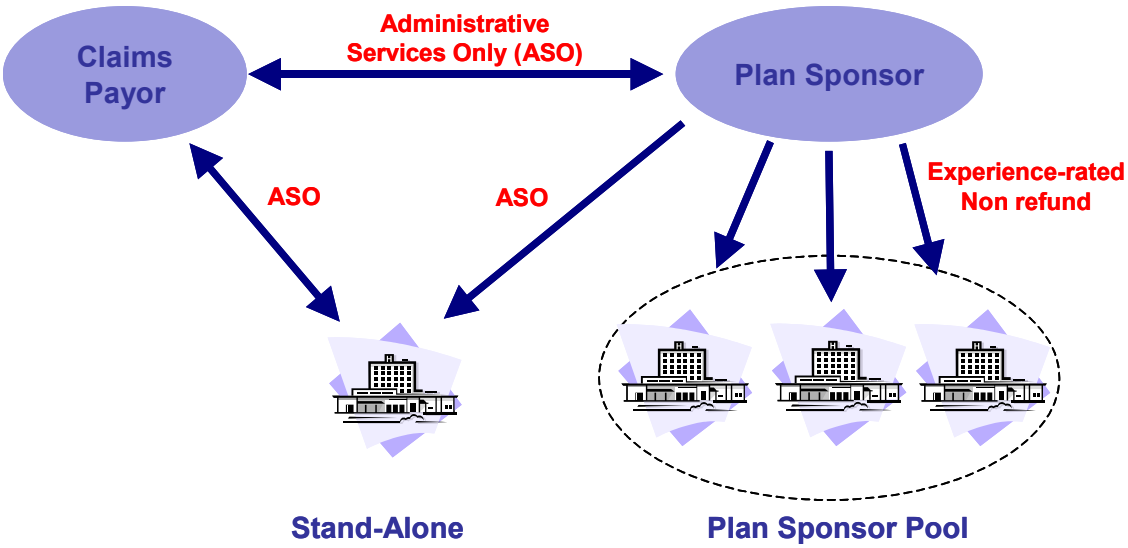
5.1.7 Ability to Accumulate Contingency Reserves

Most multi employer/multiple-employer health and welfare benefits models provide for a mechanism to build contingency reserves to stabilize claims from year-to-year. This is similar to an insurer's claims fluctuation reserve, and would be used to mitigate the volatility of claims. Typically, these contingency reserves are in the range of 10% to 25% of total annual contributions/premiums and vary depending on the benefit.

5.1.8 Choice of Underwriting Options for Employers

Although a plan sponsor would be responsible for negotiating the financial and underwriting arrangements, there should be some flexibility in allowing participating employers of the program to determine their insurance risk tolerance. This can be accommodated by allowing a participating employer to join the plan sponsor's 'pool' for certain benefits, or seek a stand-alone approach where they will have their own financial arrangement within the program. However, regardless of underwriting method, all participating employers would have access to the same volume purchasing expense charges negotiated by the plan sponsor for the entire program.

A stand-alone approach may be applicable to larger employers where they may be better able to absorb a higher level of risk, whereas the 'pooled' approach may be preferable for the smaller employers. An example of a possible arrangement would be as follows:



Although cross-experience-rating benefits for some participating employers may still apply in certain situations (i.e. 'pooled' approach), each participating employer would still be responsible for their own claims cost. This approach maintains equity among participating employers, increases accountability, and makes employers responsible for their own claims experience and employee benefit costs.

5.1.9 Existence of a Mandatory Disability Management Program

The National Association of Disability Evaluating Professionals (NADEP) has indicated that the likelihood of an unassisted individual ever returning from an absence due to illness or injury of over 6 months is 50%, over one year is 20%, and after two years is 10%. We note that the incidence rate and resulting cost of LTD claims for some of the participating employers are significantly higher than other public sector plans across Canada. This is one of the main contributors to the increase in benefit costs for participating members. Unless proper disability claims management is introduced, these costs may continue to increase regardless of the delivery model.

As part of an effective disability management program, a mandatory joint early intervention service is imperative in any best practice delivery model. The benefits of an early intervention service are realized by both the employer and employees, and include:

- Better management of the financial cost of absenteeism;
- Prevent feelings of loneliness and abandonment that reduces the employee's motivation to get well;
- Assist in reducing delays in the employee obtaining appropriate health/rehabilitation services;
- Help avoid a 'run-around' for the employee from one health care professional to another;
- Assist the employee and their family in re-establishing a sense of control; and
- Increase the likelihood of a successful rehabilitation outcome.

Seeking timely medical treatment, following medical recommendations of the treating physician or health care professional, and if appropriate, participation in an early return to work accommodation plan are vital in improving the affected employee's quality of life and successful return to pre-disability health.

Typically an organization that has direct contact with union representatives, is involved in all areas of absences (e.g. sick leave, WCB, and LTD), and has the authority to make participation mandatory would lead this initiative. Ideally, the program would be jointly supported by the unions (if applicable), as well as the employer, and should have an integrated approach with respect to sick leave/STD, WCB, and LTD claims.

5.1.10 Control over Effective Plan Design

Plan design is one of the most critical influencing factors in determining the cost of employee benefits. Typically an optimal delivery model would balance plan design with cost. This would include cost containment and cost sharing features and benchmarking to comparator programs.

5.2 Alternative Delivery Models

The healthcare sector in British Columbia has experienced significant change since the inception of HBT, particularly in the last two years where there has been a significant restructuring and reorganizing of the Health Authorities. Based on these recent changes in this sector, the challenges faced by HBT and our understanding of the current needs of the stakeholders, a number of alternative delivery models could be considered. These are outlined below, with the perceived advantages and disadvantages relative to the current health and welfare trust-based model.

It should be noted that many of the optimal model attributes deal with the relationships between the key stakeholders and the plan sponsor, while our analysis of alternative delivery models primarily considers HBT's responsibilities within the delivery model. The attributes of mandatory disability management and effective plan design are currently outside of the control of HBT and, as such, are examples of areas that cannot be addressed without considering the input of all stakeholders (e.g. unions, employer associations, employers, and government). Any changes to the model should consider all stakeholders, and not just HBT or its equivalent.

5.2.1 Reciprocal Insurance Exchange

A reciprocal insurance exchange is an unincorporated insurance association that most closely resembles a cooperative. In a reciprocal, members (i.e. policyholders) are bound by a Subscriber's Agreement and exchange insurance contracts under a common name. Therefore, the members contract with each other to share their risk in a predetermined manner. The Subscriber's Agreement is the chartering and governing document of the reciprocal. Subscribers are required to contribute equity and pay insurance premiums. This is a popular property and casualty insurance model in use in the public sector across Canada.

One key difference between this model and HBT is the ability for the reciprocal to accumulate a surplus or reserve to manage future claims fluctuations and, therefore, reduce the volatility of the employer contributions. As an insurance vehicle, it is regulated as a financial institution and may increase the administrative requirements.

Relative Advantages	Relative Disadvantages
▪ Equitable representation and risk sharing ▪ More direct control for participating employers ▪ Can accumulate contingency reserves/surplus to reduce volatility in contribution costs ▪ Excess surpluses may be distributed ▪ A surplus will not trigger income tax	▪ Less direct control for HEABC and/or government ▪ Currently not a commonly used vehicle for health and welfare benefit plans ▪ Additional administrative and regulatory accountability and requirements ▪ Union acceptance could be challenging ▪ Non-mandatory participation may reduce buying power ▪ Premium taxes may be levied

5.2.2 Multi Employer/Multiple-Employer Buying Group

A volume purchasing program can be arranged by establishing a buying group where a plan sponsor acts as facilitator to purchase benefits delivery from service providers. This could be either a multi employer plan and/or a multiple-employer plan as defined under CICA 3461. The plan sponsor would be strictly responsible for negotiating the financial and underwriting arrangements, and overall

management of the buying group infrastructure. To maintain favourable tax treatment, the program could be sponsored by a non-taxable entity (e.g. HEABC). As a buying group, this would be an unregulated model, and each employer could be directly accountable for its own risk management and contribution strategy or limit their risk through some form of pooling. A claims fluctuation reserve or surplus could be accumulated within the employer or centrally in the multi-employer buying group.

Relative Advantages	Relative Disadvantages
▪ Simple infrastructure (e.g. doesn't require complex trust model) ▪ More flexibility and control for employers ▪ Employers could be directly accountable for their own risk, if desired ▪ Excess surpluses may be distributed ▪ Can accumulate contingency reserves/surplus within buying group or employer ▪ Reduced volatility in contribution costs	▪ Less independence from employers than a trust ▪ Union acceptance could be challenging ▪ Non-mandatory participation may reduce buying power ▪ Potential duplication of administration between employers ▪ Potential increase in responsibility and workload for employers

5.2.3 Captive Insurance Company

The term 'captive' is used generally to describe an insurance company that insures the risks of its owners who are not in the business of insurance. Captive insurance programs grant a plan sponsor the ability to retain the profits normally assumed by the insurance carrier. The captive insurer would be regulated and have similar accounting requirements of a normal insurer. This model will also allow the captive to accumulate reserves and surpluses, which in some cases can actually be returned to the employers. Under the captive model, the employers or employer associations would become the owners and clients. The participating employers would collectively be required to contribute equity and reserves of approximately $300,000, and monthly contributions would be paid as insurance premiums.

Relative Advantages	Relative Disadvantages
▪ Can accumulate contingency reserves/surplus within the captive insurance vehicle and reduced volatility in contribution costs ▪ Excess surpluses may be distributed ▪ More flexibility and control for employers ▪ Employers directly accountable for their own risk as they are self-insuring	▪ More complex infrastructure ▪ Subject to corporate taxes and premium taxes ▪ Currently not a commonly used vehicle for health and welfare benefit plans ▪ Additional administrative and regulatory accountability and requirements ▪ Non-mandatory participation may reduce buying power, but tighter controls over entry/exit

While the delivery models suggested above are the most obvious, feasible alternatives to the current model would require significant further legal, taxation, financial and actuarial analysis to determine which is the most optimal vehicle for the delivery of health and welfare benefits in this sector within the province. Unfortunately, all of these models are sufficiently complex such that they would unlikely to be able to be implemented within a reasonable period of time to address the core issues. Implementing these models will also give rise to a number of critical implications.

5.3 Implications of Changing the Delivery Model

We believe that an alternative delivery model should be considered if the government's mandate were to establish an entirely new benefits program for the healthcare and community services sector in the future. However, there are a number of significant implications associated with changing the current delivery model. These implications, even considered independently, seriously impact the feasibility of considering such a change.

5.3.1 Costs to Change Delivery Models

While various efficiencies could be generated under an alternative delivery model, there would be significant costs in both winding-up HBT as well as creating the new delivery model. In our opinion, the cost to complete this exercise would likely outweigh the advantages.

5.3.2 Unfunded Actuarial Liability Crystallization

Any alternative model that would no longer utilize HBT or require any dissolution of the Trust will likely trigger a crystallization of the unfunded actuarial liability under the existing Trust Agreement. HBT would then have to determine the respective liability of each employer. Given the size of the current unfunded actuarial liability this would likely create a significant liability in the financial statements of the participating employers.

A change in delivery model will not directly address the issue of the growing unfunded actuarial liability. This will have to continue to be directly addressed and resolved whether changes are made to the delivery model or the status quo maintained.

5.3.3 Accounting and Taxation Issues

Implementing any of the alternative models in the place of HBT would likely require HBT to calculate the shared unfunded actuarial liability for each participating employer, and as such, this liability would clearly become measurable. This unfunded actuarial liability would be directly attributable to the participating employer and would have to be recognized in their financial statements (i.e. an accounting liability).

Any shift to the alternative delivery models will have to address the complex taxation issues generated by an insurance or benefits vehicle that manages its own investment funds, particularly where the participating employers do not have Not-For-Profit Organization (NPO) status. However, there could be tax advantages available to those employers that are NPO's.

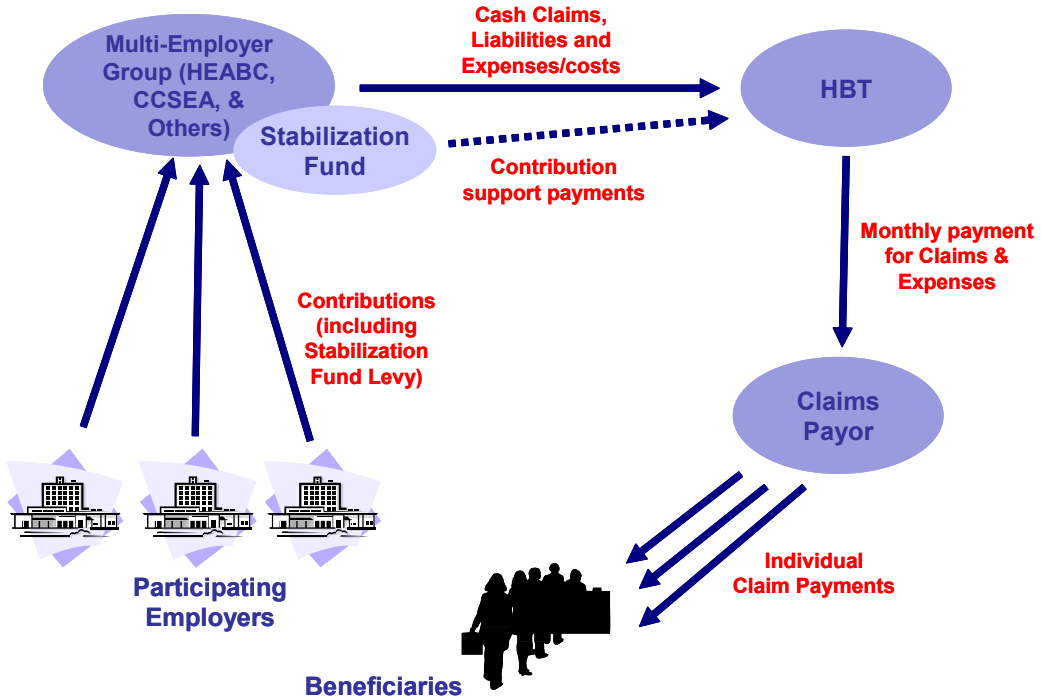
5.3.4 Collective Agreements

Based on our observations, we believe the various unions prefer an 'arms-length' provider of health and welfare benefits. This is validated by the fact that some collective agreements stipulate that the health and welfare benefits must be administered by HBT and/or their respective claims payors. Any change to the current delivery model will have to address or preserve the requirements of the various individual collective agreements in place.

5.4 A Transition Strategy

Regardless of whether an alternative delivery model was to be implemented or significant changes made to the existing model, the implications outlined above clearly have to be addressed due to their importance. Alternatively, if the status quo model utilizing HBT as the core of the delivery model were to be maintained, the challenges raised in previous sections will still have to be addressed. All of our alternative delivery models described above employ some form of multi employer/multiple-employer group (MEG) as the core delivery mechanism, allowing them to access the volume purchasing advantages currently enjoyed by the HBT-based model, as well as allowing them to create a form of claims fluctuation reserve, or stabilization fund. There are, however, various transitional solutions or strategies that allow for the creation of a stabilization fund, and would provide a strong foundation for optimizing the current delivery model or implementing a new model in the future.

If the decision were made to retain the existing trust-based model in the near-term, due to the critical nature of the implications of changing it, a MEG (for example, a buying group, captive insurer, or some form of reciprocal insurance arrangement described in the previous section with HEABC, CSSEA, and others as plan sponsors, as exists today) could be created between the participating employers to provide a forum for facilitating and addressing some of the concerns raised in previous sections, as well as a vehicle for holding a stabilization fund outside of HBT. This could be illustrated as follows:



5.4.1 Advantages of the Transition Strategy

This strategy would address a number of the core issues identified, would facilitate the implementation of many of our recommendations throughout this report, and would take advantage of the following attributes identified as core to an optimal delivery model:

- **Access to volume purchasing -** Given that all participants would remain in the HBT program, the savings that have been negotiated with the current service providers would remain.
- **Equitable representation from all stakeholders** – To ensure balanced representation, the participating employers would appoint additional Trustee(s) to HBT from the MEG.
- **Optimal use of resources** – All administrative and non-administrative roles and responsibilities would be examined to determine which should be outsourced or reclaimed given the new requirements of the transitional model.
- **Accountability to the employer** – HBT and the MEG would work together to identify the specific reporting requirements of the participating employers, beneficiaries, government, and other stakeholders and ensure they are coordinated in their reporting and communication.
- **Independence from the claims process** – As the plan sponsor, the MEG would ensure HBT effectively coordinates claims dispute resolutions. HBT would be independent of the claims process and provide the claims payor complete autonomy (based on guidelines provided by the MEG and HBT) with respect to claims adjudication. If there are claims disputes, these should include the participating employer and the respective union/employee, although an independent medical panel should exist to review disputed LTD claims.
- **Ability to accumulate contingency reserves -** The MEG would use the stabilization fund in times where claims exceed contributions[5]. This will not eliminate any potential taxation issues that could exist with the current HBT model, but will allow the building of a claims fluctuation contingency/surplus as exists currently in other benefit models. The stabilization reserve could likely grow to 25% of contributions, and could be maintained for much longer than any small, temporary surplus that could arise within HBT.
- **Choice of underwriting options for employers -** HBT would continue to be responsible for negotiating the financial and underwriting arrangements. Within the transitional model, participating employers would still be subject to the current risk sharing arrangement. As the ultimate optimal delivery model is confirmed, participating employers would be able to determine their insurance risk tolerance and develop alternative underwriting options. HBT and the MEG would work together to identify the appropriate risk sharing options in advance of finalizing the ultimate optimal delivery model.

In comparison to the current trust-only based delivery model, the relative advantages and disadvantages of the recommended transition strategy can be summarized as follows:

[5] A formal tax opinion should be obtained from CCRA, once the final legal structure of the MEG is determined; to ensure the tax implications of creating a claims fluctuation reserve have been appropriately mitigated.

Relative Advantages	Relative Disadvantages
▪ Can accumulate contingency reserves/surplus within the MEG ▪ More flexibility for employers ▪ Reduced volatility in contribution costs ▪ No additional regulatory accountability	▪ More complex than existing model ▪ New responsibility and activity for the MEG ▪ Weakening of the independence of HBT ▪ Still does not address the core claims management issues ▪ Need to address and mitigate potential taxation issues

It must be noted, however, that the MEG-based delivery model will still not address some of the fundamental issues and inefficiencies in the current delivery model. This must still be appropriately addressed in order to optimize the whole delivery model, with changes to the HBT or trust model considered secondary in importance.

5.4.2 Key Considerations for Success

In order to implement an effective foundation for improvements to the current health and welfare delivery model, the following factors and activities must be considered:

1. **Confirm the Vision** - All stakeholders will have to agree to the final vision for the ultimate optimal model, regardless whether the final vision is simply minor adjustments to the status quo or wholesale change.
2. **Legal Review of Trust Agreement –** Any changes to the current delivery model, and certainly to HBT itself, will require an appropriate legal review of the HBT Trust Agreement to ensure this is achievable with some restructuring. The legal structure of any changes to the delivery model should be determined, and the appropriate legal opinions to support the new delivery model obtained.
3. **Develop Financial, Taxation and Actuarial Projections –** If any changes are made to the model, the appropriate detailed forward-looking financial and actuarial analysis should be prepared. We have not obtained formal legal and tax opinions on the various alternatives described in this report, but have obtained assurance from our tax professionals that they can be created to appropriately mitigate any risks. In particular, attention will have to be paid to the need to mitigate tax on investment income and other potential taxation implications in an alternative or transitional model, and also the need to create a transfer pricing structure to address any commodity tax or overhead allocation issues that could arise. Additionally, given the complex tax considerations, an in-depth tax opinion from CCRA should be obtained on the final solution to ensure further tax issues are not created.
4. **Adapt Current Structure –** Once the decision to move toward a final solution is made, and the appropriate legal, accounting, actuarial and tax opinions are obtained, the formal structure and infrastructure of the MEG, or any other alternative solution, would need to be created and deployed.
5. **Determine Roles & Responsibilities –** Given the minimal nature of the proposed change to the structure of the current delivery model, HBT would remain as the primary entity for benefits administration. For continuity purposes, the task of collecting participating employer contributions on behalf of any MEG could likely be assigned to the HBT Financial Services department under a sub-contract or these employees would become employees of the MEG.

From an operational perspective, we believe HBT is best placed to continue to be responsible for all current functions, except perhaps premium administration and related activities (e.g. answering administration inquiries from participating employers, third party administration of the HSA LTD trusts, etc.) in the proposed MEG-based model. HBT would still continue with the investment management functions except for management of the MEG stabilization fund, which would remain under the control of the participating employers.

6. **Create a Stabilization Fund -** The primary purpose of the MEG would be to collect contributions from the participating employers, including a stabilization fund levy. This is essentially a claims fluctuation reserve that would be managed and administered by the MEG, outside of HBT (which currently cannot accumulate a surplus within HBT without triggering a tax liability and/or impacting HBT's Trust status, according to CCRA policy). It is imperative that the stabilization fund levy is set at a level sufficient to address current contribution rate volatility. It is also important to recognize that the contributions sent to HBT should not exceed actual claim liabilities and expense costs since contributions cannot be refunded to the MEG.

7. **Implement Integrated Disability Management Program -** As indicated throughout the report, we recommend the implementation of an integrated disability management program including mandatory early intervention services, irrespective of any structural changes to the contribution collection and administration process. To implement such a program, we understand changes will be required to plan design and collective agreements in order to deliver these services. As HBT has no control over these issues and the employer groups included in the MEG could be the parties responsible for negotiating the required changes with the unions, we believe the MEG could be a candidate to determine the most appropriate delivery of these services. A detailed review of the disability management process for the healthcare sector should, however, be undertaken regardless of who leads it.

8. **Assess Impact on Labour Relations -** Although the respective health employers' unions are not a party to HBT, we believe it would be in the interests of good labour relations practice to advise them that this change is taking place and seek their input. Certainly, where plan design and existing collective bargaining agreements are concerned, union involvement will be mandatory.

9. **Investigate Regulatory Oversight –** Under our proposed model, HBT and the MEG would continue to be unregulated entities. Given the introduction of a stabilization fund and a model that more closely resembles an insurance entity, the government might consider introducing regulatory or external oversight for the model to provide protection and accountability for all stakeholders, although this is not always considered best practice in a delivery model. Regulatory or external oversight may also bring an increased administrative burden. This may automatically be achieved, however, depending on the characteristics of the MEG (i.e. if an insurer-based solution were to be selected as the appropriate vehicle). If HBT were regulated today, however, this oversight mechanism would have likely forced the contributions to escalate rapidly as soon as an actuarial liability situation arose – a positive or negative situation depending on whose viewpoint is considered.

10. **Develop Effective Communications Strategy –** Although HBT does currently distribute a significant volume of information to participating employers, the current communication strategy should be reviewed to ensure proactive, regular interaction between all parties, including government. Furthermore, participating employers should be frequently consulted to ensure the information provided is meeting their needs.

11. **Employer-driven investment and claims management strategies** – The MEG would work through HBT to ensure that the investment strategy for the program is consistent with the participating employer's budgeting cycle. HBT would work through the MEG to ensure there is a clear, direct relationship and connection between the employer's claims management process and their contribution premium.

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6. Assessment of the Accounting Implications

To report on the most appropriate application of Canadian generally accepted accounting principles, to the facts and assumptions provided to us, in respect of the accounting for the unfunded actuarial liability in the financial statements of Fraser Health Authority and the B.C. Government;

More specifically, to make comments with respect to the following:

- ***Whether a portion of the unfunded actuarial liability of HBT should be allocated to the Fraser Health Authority for fiscal years ending on or after March 31, 2005 or whether it should continue to be pooled;***
- ***The most appropriate way for the Authority to account for the unfunded actuarial liability if it is determined that a portion of the Liability should be allocated to the Authority; and***
- ***The impact that the accounting for the unfunded actuarial liability will have on the B.C. Government's financial reporting assuming that the Health Authorities are each allocated a portion of the unfunded actuarial liability and become part of the government's reporting entity for fiscal years ended on or after March 31, 2005.***

To assess the accounting treatment of the unfunded actuarial liability within government and to facilitate the development of an accounting opinion, Fraser Health Authority has been selected by the project Steering Committee for the purposes of this review. In order to answer the questions above, we will effectively be providing a formal accounting opinion. Section 7600 of the CICA Handbook requires that we follow a defined process to do this, specifically requiring the prior consent and acknowledgement of the various facts surrounding this issue by the Fraser Health Authority ("the Authority"), the Auditor General and the Comptroller General. We have followed this process in reaching our opinion on the treatment of the unfunded actuarial liability ("the Liability") in the books of the Authority (as an HBT participating employer audited by the Auditor General) and the B.C. Government's summary financial statements. Our formal conclusions and opinion on the treatment of the Liability in the financial statements of the Authority and the B.C. Government ("the Government") is contained in *Appendix B: Accounting Treatment of the Unfunded Liability* and this should be read in conjunction with our observations and conclusions in this report.

Through discussions with the Trust's actuary and Chief Executive Officer, it was determined that insufficient information is available to allocate the plan assets to the Participating Employers. However, the Authority received correspondence (dated February 27, 2003) and an "experience rating file" from the Trust, disclosing the percentage increases in the long-term disability contributions levels under the trustees' DRP for the years commencing April 1, 2003, 2004 and 2005. The Trust Agreement gives authority to the Trustees to, in their discretion, calculate, based on actuarial advice, the amount of any Liability attributable to the Authority. It appears that the Authority can reasonably determine a liability to the extent that the Authority is informed of increases in future contribution rates that relate to a recovery of the Authority's share of the Liability under the trustees' DRP. The fact that the Authority was provided with a choice regarding the payment of these contributions i.e. either incremental rates increases over a three-year period or a higher rate increase in the first year only, could be considered to be indicative of a financing arrangement to settle a portion of the Liability.

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Based on our opinion at *Appendix B*, it would be appropriate for the Authority's financial statements to reflect a liability to the extent that the Authority is informed of, and can reasonably measure, any incremental required contributions specifically levied in order to recover the Authority's share, or a portion thereof, of the Liability. We believe that the Authority's required future contribution payments for past services under the Trustees' deficit reduction plan ("DRP") represent an existing liability that would be appropriately recognized in the financial statements of the Authority as it is probable that future economic benefits, in the form of contribution payments, will be given up. The Liability would be adjusted if one of the following events occur:

- The trustees, in their discretion, calculate, based on actuarial advice, the amount, if any, of the Liability attributable to the Authority and notify the Authority thereof; or
- The Authority ceases to participate in the Trust with respect to some or all employees, and the trustees calculate, based on actuarial advice, the amount, if any, of the total Liability attributable to the Authority and notify the Authority thereof.

Therefore, it would be appropriate for the Authority to recognize a liability to the extent that the Authority is informed of, and can reasonably measure, its future incremental contributions to the Trust under the DRP. Such liability would be determined based on the present value of these contributions and would be recognized on a prospective basis in the period in which these criteria are first met. The Authority would also recognize an expense in respect of the contribution cost for the period. For purposes of full disclosure, it is desirable that this expense be disclosed in the notes to the financial statements. Retroactive restatement would be appropriate if it was determined that either the prior periods were in error i.e. that the Authority had all the information and could have reasonably measured its share of the Liability in those periods, or if the change could be argued to represent a change in accounting policy. The final determination of whether retroactive treatment is appropriate is a matter which should be determined between the Trust, the Authority, the Government and their respective auditors.

In summary, we believe that it would be appropriate for the Authority to recognize in its financial statements a portion of the unfunded actuarial liability of the Trust to the extent it can be reasonably determined. If the Authority is informed of its share of required incremental contributions that relate solely to recovery of the unfunded Liability, then we also believe that a reasonable basis for recording the Liability would be to determine and record the present value of such incremental contributions. Finally, in the event that the Government will be required to consolidate the Health Authorities, the Government would recognize the portion of the total Liability applicable to the Health Authorities.

The Public Sector Accounting Board approved an exposure draft on Liabilities, Contingent Liabilities and Contractual Obligations in October 2003. The exposure draft provides a new definition of liabilities and identifies three essential characteristics of liabilities. The Government would need to consider the implications of the proposed new standard if and when it is released.

The ultimate responsibility for the decision on the appropriate application of Canadian generally accepted accounting principles for the Liability described above rests with your management as preparers of the financial statements of the Government and with the Authority's management as preparers of the financial statements of the Authority who should consult with the Office of the Auditor General. Our judgment on the appropriate application of Canadian generally accepted accounting principles for the Liability described above is based on the facts and assumptions provided to us, and Canadian generally accepted accounting principles as they currently exist. Should the facts or assumptions change, our opinion may change.

7. Conclusions

7.1 Overall Conclusion on HBT

The primary objective of HBT is to hold and administer a trust fund for the purpose of providing group health and welfare benefits on behalf of participating employers. Many functions and activities can fall within this service. In general, we believe HBT has effectively discharged its mandate as defined in the Trust Agreement, and certainly Trustees appear to take their responsibilities with regard to the specific mandate very seriously. The mandate to provide a vehicle for volume purchasing and centralized claims administration is also still legitimate.

Our high level review of HBT's actuarial assumptions and methodology indicate that they conform to acceptable actuarial practices. To the extent that the data used was complete and accurate and that the calculations were performed correctly, we believe that the results reported by HBT's actuaries for the liabilities, before considering the Investment Fluctuation Reserve, are within the range of acceptable actuarial practice. We do believe, however, that certain assumptions could be more conservatively applied given the size and growth rate of the current unfunded actuarial liability.

Our benchmarking of HBT's cost structure against similar private and public plans across the country indicates that the HBT cost model is very competitive. While expense charges are a factor in ensuring the cost of benefits delivery are kept to a minimum, the most significant driver is the actual cost of claims. Even a significant reduction in these overhead charges (e.g. 20% reduction or $4 million) would have a minimal impact on the overall financial position of HBT relative to reducing claims cost by the same percentage (as claims comprise 89% of the contributions). We did note, however, that HBT's LTD claims incidence rate has been consistently high in the last five years averaging approximately 19 LTD claims per 1,000 active employees over this period. This is a direct indicator of poor claims experience within some of the participating employers.

Most multi employer/multiple-employer health and welfare benefits models provide for a mechanism to build contingency reserves to stabilize claims from year-to-year. This is similar to an insurer's claims fluctuation reserve, and would be used to mitigate the volatility of claims. Unfortunately, the current delivery model does not allow for the creation of such funds or reserves within HBT without triggering taxation issues, possibly resulting in the loss of HBT's Trust status. This must be addressed.

It is open to interpretation as to whether all of the services provided by HBT are best delivered by HBT, for example, these could include the delivery of rehabilitation services, and employee and workplace health services (EWHS). Any change to HBT's role in the current rehabilitation and EWHS services delivery model, however, should only be made in conjunction with a review of the disability management process for the healthcare sector and should incorporate the investments made in this area by the individual participating employers.

In summary, although it appears that there are some operational challenges existing within HBT, it is simply the vehicle for processing and administering the health and community services sector benefits programs, and as such, we must not only look to the ability of the participating employers to repay the unfunded actuarial liability, but also for further insights as to the reasons for the rapidly escalating contribution rates and unfunded actuarial liability.

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7.2 Our Conclusions on the Overall Delivery Model

Our review of the current health and welfare delivery model indicates a number of fundamental issues exist. The two most significant concerns are the escalating unfunded actuarial liability and the increasing volatility in the employer contribution rates. These issues stem directly from a number of root causes including:

- The rapid drop in investment returns in recent years;
- Contribution rates set that are not covering current costs;
- An accelerating trend in an already high LTD claims incidence rate within some of the large participating employers;
- Lack of control over the plan design, resulting in minimal cost-containment and cost-sharing mechanisms;
- Poor LTD claims experience and inconsistent disability management processes within the healthcare sector; and
- A lack of sufficient reserves to buffer adverse investment and claims experience.

The healthcare sector in British Columbia has experienced significant change since the inception of HBT, particularly in the last two years where there has been a significant restructuring and reorganizing of the Health Authorities. Based on these recent changes in this sector, the challenges faced by HBT, and our understanding of the current needs of the stakeholders, a number of alternative delivery models could be considered. Unfortunately, simply changing the delivery model will not solve these fundamental issues of rising claims costs and the growing unfunded actuarial liability. Extensive changes to plan design, collective agreements, and the management of disability claims will need to be addressed regardless of the delivery model.

There are also a number of significant implications associated with changing the current delivery model, including financial cost, taxation issues, repayment of the unfunded actuarial liability, and opening of existing collective agreements. These implications, even considered independently, seriously impact the feasibility of considering any significant change. We believe that an alternative delivery model should only be considered if the government's mandate were to establish an entirely new benefits program for the healthcare and community services sector in the future regardless of the significant financial and political costs.

However, the dramatic change within the industry sector, the growing unfunded actuarial liability, and the current volatility of the contribution rates dictate that some measure of change must be made. We are not, however, concluding that the original purpose of the current delivery model is no longer valid, but simply that enough concern exists amongst the stakeholders that it is clear that changes will have to be made. A recommended approach with regard to HBT is to consider a transitional solution or strategy that would allow for the creation of a stabilization fund, and would provide a strong foundation for optimizing the current delivery model or implementing a new model in the future. The real challenge, however, is addressing the root issues of poor claims experience, plan design and disability management.

Improving the plan design and claims management process is likely the most significant factor in reducing the unfunded actuarial liability and the escalating cost of employee benefits. Effective disability management requires a holistic integrated approach, including an early intervention program, mandatory participation of all employers, and effective independent LTD claims adjudication. The success of the claims management process is dependent on strong communication and cooperation between all stakeholders and clear accountability to each other. A key factor in

controlling claims costs begins with more informed collective bargaining, resulting in a plan design that balances benefits with costs.

7.3 Moving Forward

Any change to the current delivery model will therefore not necessarily resolve the fundamental issues as many are beyond the control of HBT. However, we believe there are some opportunities immediately available to optimize the current delivery model. We also believe there would be significant financial, taxation, and union-related implications to changing the delivery model, so further analysis should be completed before any radical change is implemented. In the interim, we recommend that the current delivery model continue, but action be taken by following the transitional solution or strategy to address the issues outlined above and to improve the claims management process, the equitable allocation of risk, the communication with stakeholders, and to reduce the volatility of the contributions – while seeking to rapidly eliminate the existing unfunded actuarial liability.

7.3.1 Summary of Recommendations

We identified a number of opportunities to improve the existing health and welfare benefits delivery model, including a number of recommendations that could be led by, or specifically affect, HBT. Further detail has been provided throughout this report, but the key recommendations can be summarized as follows:

Communication:

1. While we recognize HBT has attempted to provide information to participating employers and government in the past, we recommend the approach to disseminating information be reviewed to ensure proactive, regular interaction between all parties regarding all aspects of plan performance. Participating employers should also be frequently consulted to ensure the information provided is meeting their needs.

Governance:

2. Earlier this year the Board expanded to include two representatives from the Health Authorities. While this expansion was designed to improve the direct participation on the HBT Board, we recommend additional Trustee(s) from areas of the healthcare and social services sector not currently represented to ensure balanced representation. Given the impact of the LTD program on the overall financial position of HBT, consideration should also be given to individuals with a strong disability management background.
3. Regardless of whether a stabilization fund or contingency reserve were to be introduced, the government might consider introducing regulatory oversight (e.g. FICOM or Superintendent of Pensions) to provide protection and accountability. If HBT were regulated today, however, this oversight mechanism would have likely forced the contributions to escalate more rapidly as soon as an actuarial liability situation arose, and certainly may have demanded a model that provided suitable claims fluctuation reserves.

Information Systems Development:

4. We recommend the participating employers work with HBT as they develop and implement their own HRIS systems. The primary objective would be to integrate and leverage the functionality of each party's system and avoid duplication of unnecessary expenditures.

Investment Management:

5. While HBT do review their investment strategy and performance on a regular basis, we do however; recommend HBT work closer with the participating employers to incorporate their risk profile and budgeting requirements in the investment review process.

Risk Tolerance:

6. We recommend a contingency or claims fluctuation reserve be established to ensure more stability in contribution levels, ideally without triggering any taxation liability.

7. The majority of benefits provided through the HBT are fully pooled by risk group, with the exception of LTD, where experience rating is applied at the employer level based on a credibility formula. We recommend increased accountability, particularly for the large participating employers. This can be achieved by setting contribution rates on each participant's claims experience for all benefits. However, the pooled approach could be maintained for the smaller participants. This approach maintains equity between participating employers, and makes employers responsible for their own employee benefit costs and also addresses the issue of cross-subsidization.

8. Currently there is no flexibility to allow participating employers to select an underwriting option that is consistent with their risk tolerance. We recommend the establishment of a HBT pool and allow participating employers to choose whether to participate in the pool or select a stand-alone underwriting arrangement within HBT. Under this approach, all participating employers would still have access to the same reduced expense charges negotiated by HBT for the entire program.

Actuarial Assessment:

9. We believe that it may be more prudent to consider the use of more conservative assumptions (e.g. interest rate) while the current unfunded actuarial liability exists, but the impact on contribution rates should still be considered.

10. We understand the practice of relying on possible investment gains above the actuarial assumption is no longer going to be utilized by HBT, and we recommend it not be reconsidered in future rate setting.

11. Although we believe the use of an IFR is acceptable for funding purposes, there is a lack of consistency in its application. We recommend a review of the continued use of this reserve and the appropriateness of its inclusion and presentation in the financial statements. .

12. While absence of margins in the determination of actuarial reserves would not be unusual for a plan like HBT, based on emerging trends, we recommend some margin in the contribution rate setting process. While we recognize over-funding will present taxation issues, the intent of the margins would not necessarily be to reduce the probability of a deficit, but could be designed to ensure the contribution rates do not significantly deviate from the anticipated LTD claims costs. In other words, there could be a lag between the experience used in determining contribution rates and the emerging experience over a period of three to five years to avoid the build up of large deficits.

13. We recommend rate setting and deficit recovery strategies be considered in conjunction with the funding policy. The current deficit recovery strategy focuses on required rate increases that will achieve a 95% funding level over a 10-year period. This funding strategy will more likely result in a deficit than in a surplus. During a period where claims costs are consistently high, as has been the case in recent years, there is a danger of continuously falling behind and, if no offset comes from excess investment performance, contribution rates could be expected to increase significantly over a prolonged period. A more comprehensive funding policy would address the following components:

    - Rate required to fully-fund the cost of new claims plus administration expenses including the approach and degree by which emerging trends are recognized in the rate setting process; and the
    - Rate required to amortize the unfunded liability over the selected period or periods.

14. There should also be a clear, direct relationship and connection between the employer's effectiveness of the claims management process and their contribution premium. In short, the employers' contribution levels should be directly related to their effectiveness in claims management and their risk tolerance.

Plan Design:

15. We recommend the government, the participating employers and the unions approach future collective bargaining and wage discussions with the intention of ensuring an equitable plan design, consistent with other similar plans in the healthcare and other related sectors. This would include cost containment and cost sharing features and benchmarking to comparative programs.

Disability Management:

16. While the analysis of the disability management program is beyond the scope of our review, we recommend an organization that has direct contact with all union representatives, is involved in all areas of absences (e.g. sick leave, WCB, and LTD), and has the authority to make participation mandatory should design and deliver this initiative. Ideally, the program would be fully supported by all the unions (if applicable) as well as the employers and should have an integrated approach with respect to sick leave/STD, WCB, and LTD claims.

    Any change to HBT's role in the current rehabilitation and EWHS services delivery model should only be made in conjunction with a review of the disability management process for the healthcare sector and should incorporate the investments made in this area by the individual participating employers.

17. To the extent it is not occurring, there should be a focus on rehabilitation and early return to work for recent LTD claims. It is generally acknowledged that early intervention and rehabilitation has a positive impact on LTD claims duration and terminations, and is most effective in the early stages of an LTD claim.

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8. Acknowledgements

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Gordon Armstrong, Trustee
Peter Speer, Trustee and Finance & Audit Committee Chair
Prof. Peter Lusztig, Chair of the Board of Trustees and Dean Emeritus, UBC Faculty of Commerce
Geoffrey Crampton, Trustee and VP Human Resources, Fraser Health Authority
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Participating Employers

David Keen, Director, Workplace Safety and Wellness, Fraser Health Authority
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Lisa Hancheroff, Manager, Payroll, Interior Health Authority
Cindy Lee, Benefits Coordinator, Interior Health Authority
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John Johnston, Vice President Human Resources, Vancouver Island Health Authority
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Judith Ray, Administrator, Pleasantview Housing Society
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Other Stakeholders

Gary Moser, Former Chief Executive Officer, Health Employers Association of BC
Lynda Cranston, Chair, Health Employers Association of BC
Peter Muirhead, Actuary

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Province of BC Project Steering Committee

Arn van Iersel, Comptroller General, Ministry of Finance
David Woodward, Deputy Minister, Strategic Initiatives and Corporate Services, Ministry of Health Services
James Gorman, Assistant Deputy Minister, Budget Services Division, Ministry of Children & Families
Annette Wall, Assistant Deputy Minister, Public Sector Employers' Council Secretariat
Brian Woods, Vice President of Corporate Services and Chief Financial Officer, Fraser Health Authority
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Shayne Gregg, Partner, Enterprise Risk
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Shirley Wolff, Senior Manager, Audit
Sheri Evans, Senior Manager, Tax
Paula Jesty, Partner, Public Sector Services
Jon Kligman, Partner and Firm Director, Audit
Dr. Peter Chant, Partner and Former Chair of the CICA
Conrad Ferguson, Partner, Actuarial Services
Bethune Whiston, Principal, Legal & Governance Consulting
Peter Gorham, Partner, Governance Consulting
Robin Pond, Partner, Investments & Governance Consulting
Ken Werker, Partner, Benefits Consulting
Ken Myck, Consultant, Actuarial Services
Kelly McKeating, Principal, Actuarial Services
Ian Thomas, Consultant, Enterprise Risk

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Appendices

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Appendix A: Tax Opinion on HBT Surplus

This opinion was developed specifically to only address key discussions in our independent assessment of HBT and should not be relied upon without first consulting Deloitte & Touche LLP.

Facts and Assumptions

Prior to completing the analysis, we provide below a listing of the facts and assumptions as we understand them. Please review these facts and assumptions and if any differ from your understanding, please advise us as a difference in the facts and assumptions may affect our analysis.

1. HBT is a Health and Welfare Trust as defined in the Canada Customs and Revenue Agency ("CCRA") Interpretation Bulletin IT-85R2 "Health and Welfare Trust for Employees".
2. HBT is currently in a deficit position (i.e. its actuarially determined liabilities exceed its assets).
3. HBT is considering establishing a surplus to provide for future experience rating and investment fluctuation risk.

Issues

1. In the context of a Health and Welfare Trust, what is a surplus and what is the difference between the term "surplus" and the term "reserve"?
2. If the HBT has a surplus, how does this affect its Health and Welfare Trust status?
3. If the surplus affects the HBT's status as a Health and Welfare Trust, what are the income tax consequences?

Analysis

Background

Health and Welfare Trusts in Canada are not expressly provided for in the Income Tax Act (Canada) (the "Act"). They are a result of a CCRA administrative policy as set out in IT-85R2. Health and Welfare Trusts enable employers to provide certain health and welfare benefits to employees (current and former) and their families. In order to qualify as a Health and Welfare Trust, the trust must meet certain requirements. For purposes of this analysis, it is assumed the HBT currently meets these requirements and is a qualifying Health and Welfare Trust.

A Health and Welfare Trust pays income tax at a combined federal and provincial rate of 43.7%. In determing the Trust's income for tax purposes, it will include only its investment income, and capital gains. The Trust can then deduct: (a) its investment expenses, (b) its administrative expenses, and (c) its insurance premiums expenses and benefits paid to its beneficiaries. The Trust is then subject to income tax on the remaining income. The trust is not required to include in its taxable income its employer or employee contributions received.

The employer may deduct all of its contributions to the Trust at the time of payment (employee contributions are not deductible).

At the time the Trust provides benefits to an employee, depending on the type of benefit, the employee may then be subject to income taxes. Trust payments to employees may arise well after the deductible employer contribution, thus resulting in an overall tax deferral.

CCRA is concerned with intentional excess contributions by employers designed to give them early tax deductions. In the case of HBT, the majority of contributions are from employers who are not taxable and thus they cannot benefit from the tax deductions associated with contributions to a Health

and Welfare Trust. CCRA should be less concerned in this situation but still may be concerned in view of the taxable employers.

In the context of a Health and Welfare Trust, what is a surplus and what is the difference between the term "surplus" and the term "reserve"?

For the purposes of discussing and applying its rules regarding Health and Welfare Trusts, CCRA has adopted a special definition of the term "surplus". In this context, a "surplus" is an amount of a trust's net assets in excess of its actuarially determined liabilities. We believe that in applying this definition of "surplus", CCRA's reference to actuarially determined liabilities is to current and future liabilities resulting from events or conditions which have already occurred or are already in existence, such as known actual disabilities and illnesses, but not to events or conditions which are reasonably expected to occur in the future. In addition, liabilities relating to the employees' health and welfare, which are not supported by an actuarial determination, are not taken into account in determining whether or not a Health and Welfare Trust has a "surplus" under CCRA's definition.

Making a "reserve" or "provision" can generally be viewed as earmarking, appropriating, or setting aside a surplus amount for a future use.

If this reserve or provision is actuarially determined and relates to known liabilities, i.e. liabilities that have arisen due to events such as disabilities, occurring prior to the year end, the making of the reserve or provision will eliminate the surplus. On the other hand, to the extent that such a reserve or provision is not actuarially determined or for some future occurrence, such as disabilities which may occur in the future, this will not reduce the surplus for purposes of CCRA's rules.

If the HBT has a surplus, how does this affect its Health and Welfare Trust status?

(i) Interpretation Bulletin 85R2

Paragraph 6 of IT-85R2 states:

"To qualify for treatment as a health and welfare trust … the employer's contributions to the fund must not exceed the amounts required to provide [health and welfare] benefits".

Paragraph 6 does not explicitly refer to the term "surplus". It only states that employer's contributions must not exceed the required amounts. On this basis, if an employer contributes to a health and welfare trust so as to fund an actuarially determined liability, the Trust should be able to take the position the employer is not exceeding the amounts required to fund the health and welfare benefits. This is taken to mean that no surplus exists.

Paragraph 14 of IT-85R2 also states:

"Although actuarial studies of the trust may recommend the establishment of "contingency reserves" to meet its future obligations, transfers to such reserves are not deductible for tax purposes by the trust".

Paragraph 14 falls under the "Taxation of Trusts" subheading and operates to deny a Health and Welfare Trust a deduction for any transfers to a contingency reserve. Paragraph 14 does not state that a Health and Welfare Trust cannot have a contingency reserve effectively reducing or eliminating its surplus. In fact, it seems to imply that it can have such a reserve, presumably where it would be reasonably required to fund the health and welfare benefits.

(ii) Jurisprudence

There is no case law on the status of Health and Welfare Trusts. As these trusts are a creation of CCRA administrative policy, this is not surprising.

(iii) Other CCRA Pronouncements

In general, CCRA's pronouncements[6] state that the existence of a surplus in any given year will not necessarily, in itself, affect the status of a trust as a Health and Welfare Trust. Where a surplus exists in any given year, a review of all the circumstances will generally be required in order to determine whether the surplus can be expected to be temporary or more or less permanent in nature. Where the surplus is seen to be relatively permanent, the most common mechanism for its reduction is a premium (contribution) holiday. Where such a step is not taken within a reasonable time, the level of annual contributions by participant employers may be seen as being in excess of that which is needed to meet their obligations under the health and welfare plan administered by the trust, and as a result may jeopardize the status of the trust as a Health and Welfare Trust.

The CCRA also indicates they expect temporary accumulations of cash to be placed in relatively liquid short term investments rather than higher risk, longer term investments so that funds will be availabe to meet the expected claims experience. The implication is that a surplus invested in longer term investments is an indication that the surplus is more permanent.

If the surplus affects the HBT's status as a Health and Welfare Trust, what are the income tax consequences?

The consequences of a loss of status as a Health and Welfare Trust are not entirely clear-cut. The deductibility of future contributions by the employers may be impacted. This would not affect the non-taxable HBT employers. The trust itself could become taxable on all of its income rather than just its investment income. In addition, the preferential tax treatment of benefits to employees could be negatively impacted.

Based on the CCRA rulings and technical interpretations to date, depending on the circumstances, an offside Health and Welfare Trust may be treated as an employee benefit plan or an employee trust. Such treatment is much less severe than discussed in the previous paragraph. Under an employee benefit plan or employee trust, employers can generally only take deductions in the year in which the employee takes the benefit into income. Although CCRA indicates this is the likely reclassification of an offside Health and Welfare Trust, the treatment depends on the whether the terms of the trust and the overall arrangement meet the requirements of the Act. A detailed discussion of these requirements is beyond the scope of this analysis, but we would be happy to provide additional analysis on this point should it be required.

[6] CCRA Rulings Document number: 9223025; CCRA Rulings Document number: 9412155

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Appendix B: Accounting Treatment of the Unfunded Liability

(Copy of formal accounting opinion provided to the Comptroller-General)

Deloitte & Touche

To the Comptroller-General,
Ministry of Finance, B.C. Government

We have been engaged to report on the appropriate application of Canadian generally accepted accounting principles to the facts and assumptions described in the attached schedule A. Specifically, we have been engaged to comment on the following:

(a) Whether a portion of any unfunded actuarial liability (the "Liability") of Healthcare Benefit Trust (the "Trust") should be allocated to the Fraser Health Authority (the "Authority") for fiscal years ending on or after March 31, 2005 or whether it should continue to be pooled.

(b) The most appropriate way for the Authority to account for the Liability if it is determined that a portion of the Liability should be allocated to the Authority.

(c) The impact that the accounting for the Liability will have on the B.C. Government's (the "Government") financial reporting, assuming that the Authority and related health authorities in other regions (the "Health Authorities") are each allocated a portion of the Liability and become part of the government's reporting entity for fiscal years ended on or after March 31, 2005.

This report is being issued to assist management to evaluate the accounting for the described Liability in the financial statements of Fraser Health Authority and the Government. Our engagement has been conducted in accordance with generally accepted standards for such engagements.

Your management has provided us with certain facts and assumptions concerning the Trust, the Authority and the Government as outlined in Schedule A to this letter.

With respect to issue (a) above, in our opinion, it would be appropriate for the Authority's financial statements to reflect a liability to the extent that the Authority is informed of, and can reasonably measure, any incremental required contributions specifically levied in order to recover the Authority's share, or a portion thereof, of the Liability. We believe that the Authority's required future contribution payments for past services under the Trustees' deficit reduction plan ("DRP") represent an existing liability that would be appropriately recognized in the financial statements of the Authority as it is probable that future economic benefits, in the form of contribution payments, will be given up. The Liability would be adjusted if one of the following events occur:

- The trustees, in their discretion, calculate, based on actuarial advice, the amount, if any, of the Liability attributable to the Authority and notify the Authority thereof; or
- The Authority ceases to participate in the Trust with respect to some or all employees, and the trustees calculate, based on actuarial advice, the amount, if any, of the total Liability attributable to the Authority and notify the Authority thereof.

Our opinion is based on the following authoritative support and other supporting rationale:

The Healthcare Benefit Trust Agreement (the "Trust Agreement") and Declaration of Trust provides that "Participating Employers are liable for payment to Trustees of the amount of any unfunded actuarial liability which may exist, from time to time, with respect to the provision of benefits under this Agreement" (section 7.01). Should a Participating Employer cease to participate in the Trust, with respect to all or certain employees or former employees, such Participating Employer is required to pay to the trustees the amounts of any Liability which the trustees, based on actuarial advice, determine the Participating Employer is liable for (section 7.03). Furthermore, the trustees may, in their discretion, calculate, based on actuarial advice, the amount of any Liability attributable to each Participating Employer (section 7.02). As such, any Liability in the Trust represents a liability to the Participating Employers under the following definition of a liability in Canadian Institute of Chartered Accountants ("CICA") Handbook – Accounting section 1000.32:

> *Liabilities are obligations of an entity arising from past transactions or events, the settlement of which may result in the transfer or use of assets, provision of services or other yielding of economic benefits in the future.*

The past transactions or events that give rise to the Liability are primarily those that entitle the employees to the benefits. Through the Trust's implementation of a DRP, it is anticipated that the obligation will be settled through future contributions by the participating employers.

CICA 1000.33 identifies the following three essential characteristics of liabilities:

(a) They embody a duty or responsibility to others that entails settlement by future transfer or use of assets, provision of services or other yielding of economic benefits, at a specified or determinable date, on occurrence of a specified event, or on demand;

(b) The duty or responsibility obligates the entity leaving it little or no discretion to avoid it; and

(c) The transaction or event obligating the entity has already occurred.

The required future contributions relating to the Liability under the DRP have all of the above three characteristics as the Trust Agreement places responsibility for the settlement of the Liability and payment of the contributions with the participating employers, with no discretion to avoid it, and the transactions or events that have given rise to the Liability and resulting additional required contributions have occurred.

In accordance with CICA 1000.44, liabilities are recognized in the financial statements (i.e. included in one or more individual statements) when the item has an appropriate basis of measurement and a reasonable estimate can be made of the amount involved and, for items involving obtaining or giving up future economic benefits, it is probable that such items will be obtained or given up.

Certain of the benefits provided under the multiemployer plan may oblige the Authority to provide benefits to an employee in future periods for service provided by the employee in the current period. The accounting for such employee future benefits is described in CICA 3461, *Employee Future Benefits*. Under CICA 3461.029, for a defined benefit plan, an entity should recognize a liability and an expense for employee future benefits, other than post-employment benefits and compensated absences that do not vest or accumulate, in the period in which the employee renders services to the entity in return for the benefits. Generally, an entity should determine its accrued benefit obligation using an actuarial valuation method. In respect of post-employment benefits and compensated absences that do not vest or accumulate, an entity should recognize a liability and an expense when the event that obligates the entity occurs.

The Trust uses a multiemployer defined benefit plan in the form of a not-for-profit health and welfare trust. CICA 3461.145 defines a multiemployer plan as a defined benefit plan to which two or more unrelated entities contribute, usually pursuant to one or more collective bargaining agreements. Multiemployer plans may be referred to as "joint trust" or "union" plans. Characteristics of a multiemployer plan include:

(i) Assets contributed by one participating entity are not segregated in a separate account or restricted to provide benefits only to employees of the entity and, thus, may be used to provide benefits to employees of other participating entities;

(ii) Participating entities usually have a common industry bond or at least have the same labour union;

(iii) A multiemployer plan is usually administered by a board of trustees composed of management and labour representatives.

In contrast, a multiple employer defined benefit plan maintains separate accounts for each entity such that contributions provide benefits only for employees of the contributing entity.

CICA 3461 further states that under a multiemployer plan, the amount for which an entity is obligated under the plan may not be quantified and that sufficient information to follow the recommendations under defined benefit plans may not be available. If the liability related to a defined benefit plan for employee future benefits other than a multiemployer plan, then under defined benefit plan accounting, the amount and full impact of the Liability would be included in the Authority's financial statements.

Through discussions with the Trust's actuary and Chief Executive Officer, it was determined that insufficient information is available to allocate the plan assets to the Participating Employers. However, the Authority received correspondence (dated February 27, 2003) and an "experience rating file" from the Trust, disclosing the percentage increases in the long-term disability contributions levels under the trustees' DRP for the years commencing April 1, 2003, 2004 and 2005. The Trust Agreement gives authority to the Trustees to, in their discretion, calculate, based on actuarial advice, the amount of any Liability attributable to the Authority. The Trustees have not formally allocated a portion of the Liability to the Authority and have not notified the Authority of their portion of the total Liability.

Under the recognition criteria for liabilities specified in CICA 1000.44, we believe that there is an appropriate basis for measurement of the total Liability of the Trust as it is determined under Canadian accepted actuarial practice. It is also considered probable that future economic benefits, in the form of future contributions by the Authority to the Trust, will be made in order to settle the obligation. It appears that the Authority can reasonably determine a liability to the extent that the Authority is informed of increases in future contribution rates that relate to a recovery of the Authority's share of the Liability under the trustees' DRP. The fact that the Authority was provided with a choice regarding the payment of these contributions i.e. either incremental rates increases over a three-year period or a higher rate increase in the first year only, could be considered to be indicative of a financing arrangement to settle a portion of the Liability. To the extent that the Authority is not informed of future contributions rate increases that relate to a recovery of the Liability under the trustees' DRP, a liability may not otherwise be reasonably measurable due to the multiemployer structure of the defined benefit plan. Under this structure, any Liability applicable to the Authority may be satisfied by a surplus applicable to another Participating Employer. In addition, it is not under the control of the Authority to determine its attributable portion of the total Liability.

Limited accounting guidance exists relating to the recognition of an irrevocable obligation for multiemployer defined benefit plans in Canada. This is also the case for the Authority's special multiemployer arrangement. EITF 90-3 in the United States, which relates to pension plans only, was adopted before the issuance of specific guidance on post employment benefits and does not take into consideration the Canadian pension regulatory context or the very specific circumstances and arrangement between the Trust and the Authority. In addition, EITF 90-3 relates to the impact of prior service costs when a participant enters a plan or the benefits under the plan are enhanced. For these reasons, we believe that it would be appropriate to refer to the basic liability recognition guidance.

In the absence of a formal allocation of the Liability to each participating employer, it can also be argued that future contribution increases under the DRP may not be a reasonable estimate of each employers' actual Liability to the extent that the additional contributions are not determined based on sound actuarial principles, are subject to change annually or do not reflect each participant's appropriate share of the Trust assets. Although the total Liability may not be fully determinable as a result of this uncertainty, the existence of the Liability has been demonstrated and the required future contributions under the DRP applicable to each participating employer can be considered as the minimum amount in a range of likely outcomes. By analogy, CICA 3290, Contingencies, provides supporting guidance when determining the amount of a likely contingent loss which should be accrued. If there is a range of possible outcomes with respect to a likely loss, and no amount within the range is a better estimate than any other, the minimum amount in the range would be used. Ultimately, the final determination of whether the Authority was adequately informed of its share of the Liability, and whether the additional future contribution increases under the DRP enable the Authority to adequately estimate its share of the Liability, rests with the Trust, the Authority and the Government. We do believe, however, that the required future contributions under the trustees' DRP represent an existing liability that would be appropriately recognized in the Authority's financial statements as it is probable that future economic benefits, in the form of contribution payments, will be given up. Of course, in the event that the trustees formally allocate a portion of the total Liability to the Authority under the terms of the Trust Agreement and notify the Authority, or if the Authority ceases to participate in the Trust with regard to some or all of its employees, and the trustees formally allocate a portion of the total Liability to the Authority under the terms of the Trust Agreement and notify the Authority, the amount of this liability would be recognized by the Authority.

With respect to issue (b), our conclusion under (a) above is that it would be appropriate for the Authority to recognize a liability to the extent that the Authority is informed of, and can reasonably measure, any incremental required contributions specifically levied in order to recover the Authority's share, or a portion thereof, of the liability.

With respect to issue (b) above, in our opinion, the appropriate accounting to be applied to the Liability described above is as follows:

It would be appropriate for the Authority to recognize a liability to the extent that the Authority is informed of, and can reasonably measure, its future incremental contributions to the Trust under the DRP. Such liability would be determined based on the present value of these contributions and would be recognized on a prospective basis in the period in which these criteria are first met. The Authority would also recognize an expense in respect of the contribution cost for the period. For purposes of full disclosure, it is desirable that this expense be disclosed in the notes to the financial statements. Retroactive restatement would be appropriate if it was determined that either the prior periods were in error i.e. that the Authority had all the information and could have reasonably measured its share of the Liability in those periods, or if the change could be argued to represent a change in accounting

policy. The final determination of whether retroactive treatment is appropriate is a matter which should be determined between the Trust, the Authority, the Government and their respective auditors.

It would be appropriate for the Authority to disclose, in a note to the financial statements, the nature and terms of any recognized liability and the basis on which it has been determined. In addition, as applicable, disclosure would be made that an allocation of the entire portion of the Liability attributable to the Authority is not determinable, together with a description of the circumstances that could result in the determination of the liability attributable to the Authority. The existence, nature, terms and total amount of the Liability reported in the financial statements of the Trust would be disclosed, together with a description of the nature and effect of the Trustees' DRP. There would also be disclosure regarding the number and relative size of participating employers in the Trust, and that a portion of the Liability attributable to the Authority would not necessarily be proportional to the size of the Authority relative to other participating employers.

Our opinion is based on the following authoritative support and other supporting rationale:

In accordance with CICA 1000.44, liabilities are recognized in the financial statements (i.e. included in one or more individual statements) when the item has an appropriate basis of measurement and a reasonable estimate can be made of the amount involved and, for items involving obtaining or giving up future economic benefits, it is probable that such items will be obtained or given up.

CICA 1000.42 states that notes to financial statements either provide further details about items recognized in the financial statements, or provide information about items that do not meet the criteria for recognition and thus are not recognized in the financial statements. CICA 1000.45 further states that "it is possible that an item will meet the definition of an element but still not be recognized in the financial statements because it is not probable that future economic benefits will be obtained or given up or because a reasonable estimate cannot be made of the amount involved. It may be appropriate to provide information about items that do not meet the recognition criteria in notes to the financial statements."

CICA 3461.016 includes in the current service cost for defined contribution plans the estimated present value of any contributions required to be made by an entity in future periods that relate to employee services rendered during the period.

With respect to issue (c) above, in our opinion, the impact that the liability will have on the B.C. Government's financial reporting is as follows:

Under the conclusions reached in (a) and (b) above, and the assumption that the Government would be required to consolidate the Health Authorities, the Government would recognize the aggregate Liability recognized by the Health Authorities. The Government would also recognize an expense in respect of the contribution cost for the period, as described above, for each Health Authority. For purposes of full disclosure, it is desirable that this expense be disclosed in the notes to the financial statements.

The Government would disclose, in a note to the financial statements, the nature and terms of any recognized liability and the basis on which it has been determined. In addition, if disclosure of the entire portion of the liability attributable to the Health Authorities is not determinable, this would be disclosed together with a description of the circumstances that could result in the determination of the total Liability attributable to the Health Authorities. The existence, nature, terms and total amount of the Liability reported in the financial statements of the Trust would be disclosed, together with a description of the nature and effect of the Trustees' DRP. There would also be disclosure regarding the number and relative size of participating employers in the Trust, and that a portion of the Liability

attributable to the Health Authorities would not necessarily be proportional to the size of the Health Authorities relative to other participating employers.

Our opinion is based on the following authoritative support and other supporting rationale:

In accordance with PS 1300.03 of the Public Sector Accounting Recommendations of the CICA, effective for fiscal years beginning on or after April 1, 2005, with earlier adoption encouraged, a government's financial statements should provide an accounting of the full nature and extent of the financial affairs and resources which the government controls, including those of its agencies and enterprises. Under CICA PS 1300.07, a government reporting entity is required to include those organizations that are controlled by the government by consolidating the financial statements of these organizations. Trusts administered by a government or government organization are specifically excluded from a government reporting entity under CICA PS 1300.40 and hence the Trust would not be included in the Government reporting entity.

CICA PS 1000.44 defines liabilities as financial obligations to outside organizations and individuals as a result of past transactions and events on or before the accounting date. They are the result of contracts, agreements, and legislation in force at the accounting date that require the government to repay borrowings or to pay for goods and services acquired or provided prior to the accounting date. They also include transfer payments due even where no value is received directly in return.

In accordance with CICA PS 1000.53, a liability would be recognized in the Government's financial statements if:

(a) It has an appropriate basis of measurement, and a reasonable estimate can be made of the amount involved; and

(b) For an item that involves obtaining or giving up future economic benefits, it is expected that such benefits will be obtained or given up.

Under consolidation accounting, the Government financial statements would reflect the impact of the allocation of a portion of the Liability for all those entities that are consolidated in the Government reporting entity.

In accordance with CICA PS 1200.42, also effective for fiscal years beginning on or after April 1, 2005, financial statements should disclose adequate information about the nature and terms of a government's liabilities.

The Public Sector Accounting Board approved an exposure draft on Liabilities, Contingent Liabilities and Contractual Obligations in October 2003. The exposure draft provides a new definition of liabilities and identifies three essential characteristics of liabilities. The Government would need to consider the implications of the proposed new standard if and when it is released.

In summary, we believe that it would be appropriate for the Authority to recognize in its financial statements a portion of the unfunded actuarial liability of the Trust to the extent it can be reasonably determined. If the Authority is informed of its share of required incremental contributions that relate solely to recovery of the unfunded Liability, then we also believe that a reasonable basis for recording the Liability would be to determine and record the present value of such incremental contributions. Finally, in the event that the Government will be required to consolidate the Health Authorities, the Government would recognize the portion of the total Liability applicable to the Health Authorities.

The ultimate responsibility for the decision on the appropriate application of Canadian generally accepted accounting principles for the Liability described above rests with your management as preparers of the financial statements of the Government and with the Authority's management as

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preparers of the financial statements of the Authority who should consult with the Office of the Auditor General. Our judgment on the appropriate application of Canadian generally accepted accounting principles for the Liability described above is based on the facts and assumptions provided to us, and Canadian generally accepted accounting principles as they currently exist. Should the facts or assumptions change, our opinion may change. We assume no responsibility for updating our opinions to reflect any changes in Canadian generally accepted accounting principles in the future.

This report is intended solely for the information and use of the Office of the Comptroller General, Ministry of Finance, B.C. Government and is not intended to be and should not be used for any other purpose. It should not be provided to other parties without the express written consent of Deloitte & Touche LLP.

Deloitte & Touche LLP

Chartered Accountants
Vancouver, B.C.
January 26, 2004

Schedule A

Facts and assumptions relevant to our conclusions on the accounting recommendations in respect of the unfunded actuarial liability in Healthcare Benefit Trust.

Facts

The Healthcare Benefit Trust (the "Trust") was established in 1979 by the Health Labour Relations Association (HLRA), now part of the Health Employers Association of BC (HEABC), as a way of providing certain collectively bargained health and welfare benefits for the employees of its members.

The Trust is a health and welfare Trust that administers employee benefits on behalf of its members. It is a not-for-profit organization, which is funded with contributions paid by participating employers. Trustees are appointed by the HEABC Board.

The Trust uses a multiemployer defined benefit plan structure to deliver benefits to the employees of its participating employers. Insufficient information is available to allocate Trust's assets to the participating employers.

The object of the Trust is to hold and administer the Trust fund for the purpose of providing group health and welfare for eligible employees, their eligible dependents and beneficiaries. The primary benefits are Group Life, Accidental Death and Dismemberment, Long Term Disability, Extended Health and Dental. Employees are not entitled to these benefits in respect of events that occur after their term of employment with a participating employer. The actuarial liabilities recorded in the Trust are liabilities relating to past transactions or events only.

Participating employers sign a Trust agreement. Under the Trust Agreement and Declaration of Trust, participating employers are liable for payment to the Trustees of the amount of any unfunded actuarial liability (the "Liability") which may exist, from time to time, with respect to the provision of benefits under the Agreement. The Trustees may, from time to time, in their discretion, calculate, based on actuarial advice, the amount, if any, of the Liability attributable to each participating employer. To date, the Trustees have not formally allocated a portion of the Liability to Fraser Health Authority (the "Authority") and have not notified the Authority of their portion of the Liability.

As of September 30, 2002, 950 organizations throughout BC and the Yukon participated in the Trust (including the six Health Authorities and some Community Social Service Employers' Association agencies). They include acute care and long-term care hospitals, community care, social service agencies, and specialty organizations within the health care and community care sectors. Over 80,000 employees participate in the Trust. Approximately 70% of these employees are employees of organizations that are funded by the Province and are, or soon will be, part of the government reporting entity.

Trust has been administered internally since 1986 through four departments under the direction of a Chief Executive Officer. In addition to charging premiums from its clients, the Trust includes an investment portfolio to meet its future benefit obligations. It is a taxable entity under the CCRA rules.

The Trust had a Liability of approximately $152 million as at September 30, 2002. At this time the Liability is only reflected in note disclosure on the Trust's financial statements. The trustees implemented a deficit reduction plan as at April 1, 2002, with the intention of eliminating the Liability over a ten year period.

Fraser Health Authority is a not-for-profit organization and applies Canadian generally accepted accounting principles for not-for-profit organizations.

In correspondence dated February 27, 2003, the Authority was notified of additional incremental long-term disability rate increases for the years commencing April 1, 2003, 2004 and 2005. In addition, the Authority was provided with an "experience rating file" that provides the deficit recovery percentages for these three years The Trust gave the Authority two options, namely either incremental rates increases over a three-year period or a higher rate increase in the first year only. The Authority agreed to the rate increases for the three year period. These deficit recovery rate increases determined by the trustees were based on a contributory payroll level for the Authority. These percentage increases for the three years referred to may vary according to variations in the underlying payroll in order to recover the targeted incremental contribution amount. Differences in claims experience and investment experience will not be taken into consideration in these three years. This agreement between the Trust and the Authority is revocable only at the discretion of the trustees. The trustees have no intention of revoking this arrangement at this time.

Assumptions

The B.C. Government (the "Government") reporting entity will elect to consolidate the Health Authorities under the new definition of control described in PS 1300 of the Public Sector Accounting Recommendations of the Canadian Institute of Chartered Accountants for the fiscal year ended March 31, 2005. Other participating employers of the Trust will not be controlled by the Government under this definition.

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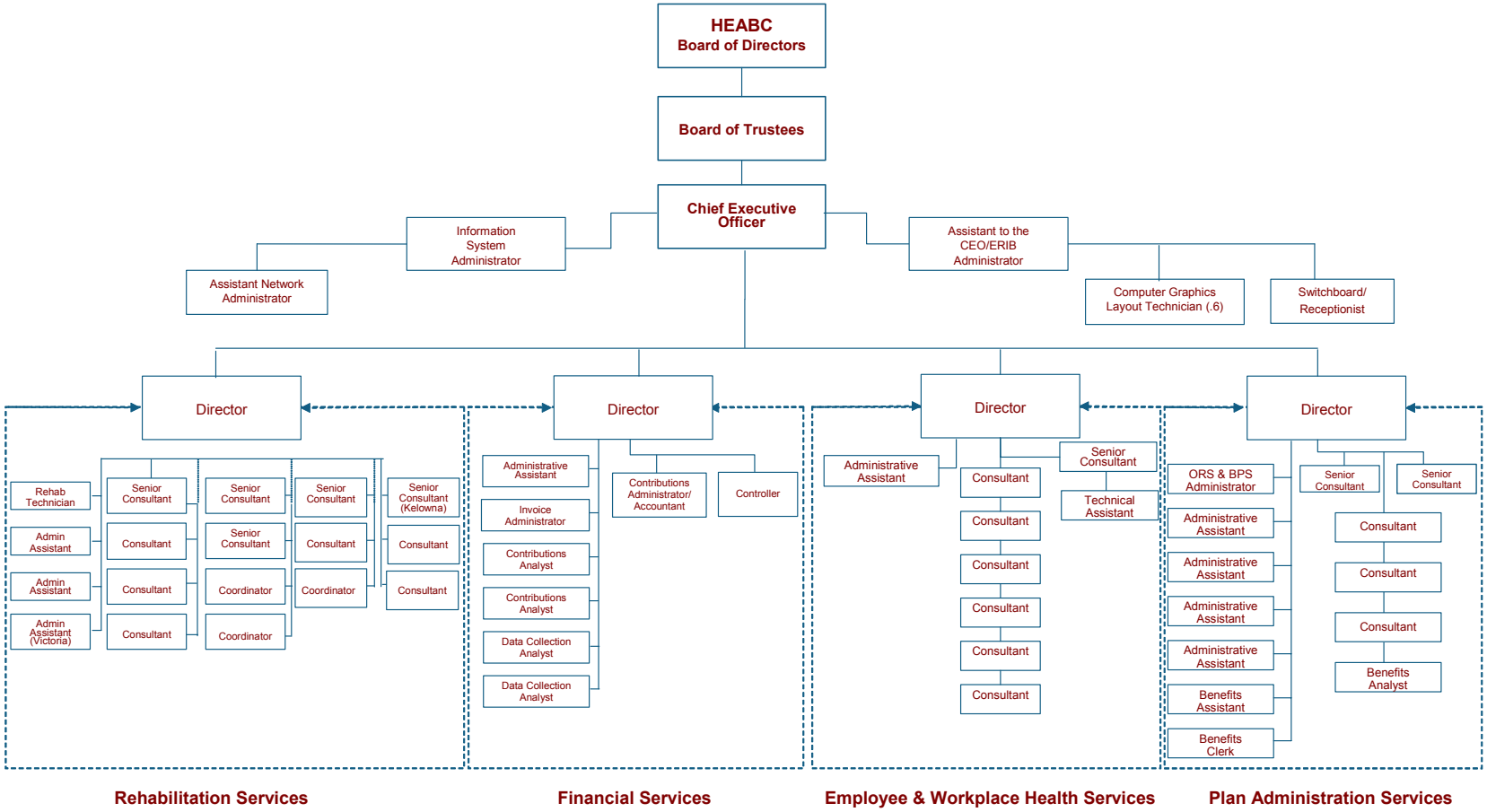
Appendix C: HBT Organization Chart

Healthcare Benefit Trust
ORGANIZATION CHART



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Appendix D: HBT Board of Trustees' Formal Response

(The attached formal response from HBT should be read in conjunction with this final report).

HEALTHCARE BENEFIT TRUST

#1200 – 1333 West Broadway
Vancouver, BC V6H 4C1
Telephone: (604) 736-2087
Facsimilie: (604) 736-8218
Toll Free: 1-888-736-2087

February 27, 2004

Private and Confidential

Mr. Arn van Iersel, Comptroller General
Ministry of Finance, Province of British Columbia
2nd Floor, 617 Government Street
Victoria, BC V1X 7X9

Dear Mr. van Iersel:

Re: Independent Assessment of the Healthcare Benefit Trust

This letter, together with its attachments, is the Trustees' Final Response to the Final Report, for attachment to the Independent Reviewer's Final Report.

When the Deloitte & Touche Review dated January 29, 2004 was received at the Trust, the Trustees met to consider it. A Trustee sub-committee was constituted to review it in detail and this sub-committee reported to the Board on February 26, 2004. This letter together with the comments attached and the reactions to the seventeen recommendations made in the Review have been approved by the complete Board of Trustees.

The Trustees and Management appreciate the opportunity to respond to the review of the Trust completed by Deloitte & Touche. We frequently seek, and always welcome, external feedback on our operations. Deloitte's assessment has highlighted some areas for improvement. Not surprisingly, many of these suggestions emanate from the recent and ongoing changes in structure and accountabilities within the health and community social service sectors. Based on the results of this review, HBT expects to:

- Strengthen the communication between all stakeholders;
- Continue the move towards broader employer representation and involvement in the Trust; and
- Expand the current underwriting and financial choices available to employers to accommodate their increased financial accountability.

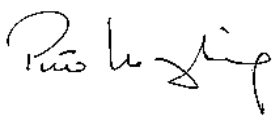
We believe the end result will better match the Trust's financial operations (underwriting, investment mix, reporting, timing) with the requirements of employers. For example, if there is, as it appears, a desire to move away from the current aggressive "lowest possible" rate-setting mandate to a more conservative rating approach to generate more predictable results, we can select from a number of actuarial solutions to realize a higher level of rate stability. The Trustees remain committed to providing the maximum level of flexibility to all participating employers, while continuing the fair and equitable delivery of benefits to the Trust beneficiaries.

Finally, the independent review provides valuable reinforcement of the two key issues that need to be addressed by all stakeholders - disability management and plan design. The need for a system-wide

integration of disability management initiatives is readily apparent. Because of its extensive database and experience, we are confident that HBT can play a major role in this initiative.
As requested, the Trustees have reviewed the "Recommendations and Possible Actions" document. Please find our comments attached. We were also invited to bring forward any errors of fact or major shortcomings and as such, our comments in this regard are attached as well. Section 6, "Assessment of Accounting Implications" was not critiqued, as the Trustees deemed this a matter for auditors and professional opinion.

Thank you again for involving us in this process. If you have any further questions, please contact Nan Bennett at 604-736-2087.

Yours truly,



Peter Lusztig
Chair, Board of Trustees

Yours truly,

E. Nan Bennett (Mrs.)
Chief Executive Officer

Attachments

cc. Board of Trustees, HBT

Comments by the HBT Board of Trustees on the
Deloitte & Touche Review of Healthcare Benefit Trust

These comments should be read in conjunction with the letter from HBT to the Comptroller General dated February 27, 2004.

1. The Trust was originally established because the contributions required from members would be less than the premiums required by an insurance company for the provision of the same benefits. A second reason was to enable the Trust to control the assets that accumulate. These advantages continue to be the main rationale for the continuation of the Trust.

The report by Deloitte & Touche does not highlight the expense and tax savings nor does it mention them as advantages in Paragraph 4.1.1. The cost savings over an insurance company are mentioned but buried in an unrelated section (Paragraph 4.2.2.6 under the heading "Commitment to Healthcare and Social Services Sector"). In fact, the Trust's actuaries estimate that contributions paid to the Trust for LTD are about 15%-20% lower than equivalent insurance company premiums.

2. Throughout the Review suggestions are made that, if implemented, would result in larger contributions being required. It would be helpful to determine whether the funding agencies for the healthcare and social services sectors in the province are receptive to increased costs of this nature.

3. There are several places in the Review where suggestions are made that would result in possible changes to the Trust Agreement itself or the tax situation of the Trust. These are always key considerations for the Trust and therefore tax and legal advisors are consulted before any changes are made. This is also the case when there is possible doubt that an extension of the Trust's activities is within its powers under the Trust Agreement.

4. The funds on deposit with claims payors, such as the dental and EHB deposits with Pacific Blue Cross, are contingency reserves and should be identified in this manner (Paragraph 4.2.3.5).

5. The Trust's investment in the HAL computer system (Paragraph 4.2.3.8) is important because there is a need for increased computerization of all processes at the Trust to improve our effectiveness and efficiency. Already there has been a substantial decrease in the amount of contributions outstanding due to introducing a computerized billing system. We have not found a commercial system that is available in the market place nor an insurance company system that will fulfill our requirements. With over 2,500 different plans in effect,the Trust must have a computer system that will allow us to properly respond to members' requirements, maintain the necessary extensive historic data base and enable retro-active amendments to the numerous benefit plans under administration.

6. Paragraph 4.2.3.10 leaves an impression that the Trust has not considered changes to its asset mix since 1996. In fact, the Trust annually reviews the composition of its assets and subsequent to 1996 has decided that no alteration to the asset mix was desirable. In other words, a decision was made not to change the asset mix but this was just as much a decision as if a change to the asset mix had been decided. Universally accepted portfolio theory has been relied on by the Trustees to consider the risk/investment return characteristics of the investment portfolio in determining their position on asset allocation. Independent professional advisors have also been employed to assist the Trustees in making their decisions.

7. In Paragraph 4.4.1.2 it is stated that "There is no indication of whether the reserving basis needs to be changed because of these losses". The actuary to the Trust meets with the Trustees annually and reviews with them the emerging experience. The actuary will only approve an actuarial valuation provided that he is able to certify that the reserving basis is appropriate.

8. In Paragraph 4.4.3 the Investment Performance of the Trust is compared to the performance of other funds. This paragraph states that a "simple comparator" is used but the effect of this simplification is that the results shown in the tables in that section are inappropriate and irrelevant. Two separate comparators should have been used - one for bond returns and one for equity stock returns. The simple comparator attempts to combine these returns but fails in this attempt. This is because the asset mix of most pension plans, to which the Trust's investment returns were compared by the Independent Reviewer, is quite different to the asset mix of the Trust's investments. The Investment Monitoring Committee of the Trustees regularly compares the investment returns on the Trust's invested assets to well-recognized investment indices. These comparisons show that HBT's investment performance has been acceptable.

Deloitte & Touche were provided with a copy of a report that is regularly received by the Trust. A copy of a relevant page from the September 30, 2003 report is attached to illustrate the type of comparison that is reviewed by the Investment Monitoring Committee.

Performance Summary

Healthcare Benefit Trust
Master Trust

Period Ending September 30 2003

	Market Value	% Allocation	One Month	One Quarter	YTD Fiscal	Annualized One Year	Annualized Two Years	Annualized Three Years	Annualized Four Years	Rolling 12 Months Ended Sep 2002	Rolling 12 Months Ended Sep 2001	Rolling 12 Months Ended Sep 2000
Total Portfolio	271,557,648	100.00	0.38	3.43	9.87	9.87	4.87	(0.75)	4.25	0.10	(11.11)	20.80
Policy			0.59	3.85	11.63	11.63	4.89	(0.81)	3.52	(1.45)	(11.30)	17.69
Canadian Equity	77,074,019	28.38	(0.78)	6.20	20.02	20.02	6.09	(9.34)	3.84	(6.22)	(33.79)	56.02
Canadian Equity Policy			(0.71)	7.22	22.02	22.02	7.19	(8.07)	4.35	(5.85)	(32.37)	52.61
S&P/TSX Comp Index			(1.00)	6.70	22.45	22.45	6.10	(9.03)	3.25	(8.08)	(33.12)	50.97
U.S. Equity	24,860,701	9.15	(3.80)	2.10	(0.39)	(0.39)	(11.63)	(16.74)	(9.37)	(21.61)	(26.10)	16.88
S&P 500 (C$)			(3.54)	2.27	5.69	5.69	(8.07)	(13.33)	(6.76)	(20.04)	(22.96)	16.07
N.N.A. Equity	34,662,737	12.76	(0.46)	6.41	5.34	5.34	4.51	(7.84)	(3.15)	3.69	(28.35)	12.40
MSCI EAFE (C$)			0.50	7.74	7.30	7.30	(4.54)	(11.90)	(7.81)	(15.08)	(24.97)	5.64
Cdn. Fixed Income	123,116,114	45.34	2.20	1.32	8.97	8.97	9.11	9.02	8.58	9.24	8.85	7.28
SC Universe			2.18	1.31	8.14	8.14	8.33	8.53	7.93	8.52	8.94	6.13
Cash & Equivalents	11,844,078	4.36	0.90	2.14	4.43	4.43	3.65	4.24	4.42	2.87	5.43	4.97
SC 91-Day T-Bill			0.26	0.81	3.02	3.02	2.83	3.65	4.03	2.64	5.32	5.16

Policy = 50.0% SC Universe + 27.0% Canadian Equity Policy + 12.5% MSCI EAFE (C$) + 10.5% S&P 500 (C$)

Final Report on the Healthcare Benefit Trust - As Issued By Deloitte & Touche
HBT's Response to Recommendations and Possible Actions
February 27, 2004

Recommendation:	HBT Board Response:
Communication:	
1. While we recognize HBT has attempted to provide information to participating employers and government in the past, we recommend the approach to disseminating information be reviewed to ensure proactive, regular interaction between all parties regarding all aspects of plan performance. Participating employers should also be frequently consulted to ensure the information provided is meeting their needs.	Some of HBT's Trustees are appointed from the healthcare industry. With their guidance HBT will review its communications strategy to reflect the changing nature of our members
Governance:	
2. Earlier this year the Board expanded to include two representatives from the Health Authorities. While this expansion was designed to improve the direct participation on the HBT Board, we recommend additional Trustee(s) from areas of the healthcare and social services sector not currently represented to ensure balanced representation. Given the impact of the LTD program on the overall financial position of HBT, consideration should also be given to individuals with a strong disability management background.	A maximum of twelve Trustees is specified in the HBT Trust Agreement. Currently there are ten. Three of them are from Health Authorities, one is from the community health sector and one is from HEABC. HEABC bears the responsibility of appointing all Trustees and HBT will ask them to respond to this Recommendation.
3. Regardless of whether a stabilization fund or contingency reserve were to be introduced, the government might consider introducing regulatory oversight (e.g. FICOM or Superintendent of Pensions) to provide protection and accountability. If HBT were regulated today, however, this oversight mechanism would have likely forced the contributions to escalate more rapidly as soon as an actuarial liability situation arose, and certainly may have demanded a model that provided suitable claims fluctuation reserves.	Whether HBT reports to a government regulator is a matter of public policy. If this change is implemented then the regulations should be specific to Health & Welfare Trusts and should apply to all Health & Welfare Trusts operating within the Province of British Columbia. It is recommended that if government regulation of HBT is to proceed, this should be through the Superintendent of Pensions rather than through FICOM.
Information Systems Development:	
4. We recommend the participating employers work with HBT as they develop and implement their own HRIS systems. The primary objective would be to integrate and leverage the functionality of each party's system and avoid duplication of unnecessary expenditures.	HBT already has agreements in force or pending with five Health Authorities concerning the development of linked information systems that are necessary for the efficient administration of the collection of contributions, enrolment data and determination of benefits provided by the Trust. HBT is ready to work with HBT members to develop information systems that will assist in the integration of computer systems between the members and HBT.

Investment Management:	
5. While HBT do review their investment strategy and performance on a regular basis, we do however; recommend HBT work closer with the participating employers to incorporate their risk profile and budgeting requirements in the investment review process.	HBT will discuss its investment strategy with its members to reflect the wishes of its members. The ability of HBT to respond will depend on the size of the member group and the exact allocation of assets requested. Risk tolerance cannot be separated from the ability to pay for a particular risk profile. Both of these features need to be considered by HBT members before relevant decisions can be made.
Risk Tolerance:	
6. We recommend a contingency or claims fluctuation reserve be established to ensure more stability in contribution levels, ideally without triggering any taxation liability.	Establishment of a contingency or claims fluctuation reserve can be considered for individual Health Authorities and other risk blocks within HBT. If such reserves are to be instituted, then the funding of them should be a prime consideration and the availability of funds will need to be considered by the funding agency.
7. The majority of benefits provided through the HBT are fully pooled by risk group, with the exception of LTD, where experience-rating is applied at the employer level based on a credibility formula. We recommend increased accountability, particularly for the large participating employers. This can be achieved by setting contribution rates on each participant's claims experience for all benefits. However, the pooled approach could be maintained for the smaller participants. This approach maintains equity between participating employers, and makes employers responsible for their own employee benefit costs and also addresses the issue of cross-subsidization.	LTD has been experience-rated by HBT for at least ten years. It is anticipated that contributions will be determined solely on the experience of a Health Authority or other large risk group for LTD benefits, effective March 31, 2004. Discussions are being held with Health Authorities concerning fully experience-rating Dental and EHB benefits. Due to the small number of claims involved, and therefore the lack of statistical significance, it is inappropriate to experience-rate Group Life and AD&D for each separate group and these benefits will continue as a separate pool within the Trust. Fully insured Dependant Life and Weekly Indemnity benefits are provided to smaller employers at present and this will continue on this basis.
8. Currently there is no flexibility to allow participating employers to select an underwriting option that is consistent with their risk tolerance. We recommend the establishment of a HBT pool and allow participating employers to choose whether to participate in the pool or select a stand-alone underwriting arrangement within HBT. Under this approach, all participating employers would still have access to the same reduced expense charges negotiated by HBT for the entire program.	This is a complex consideration even to the extent that it may be difficult to reach agreement on the meaning of the term "underwriting option". HBT is very willing to discuss with its members the implications of altering existing underwriting arrangements. However, this is another example where providing more flexibility may mean that additional funding is necessary. Inevitably this means that the funding agency will need to be involved in these discussions.
Actuarial Assessment:	
9. We believe that it may be more prudent to consider the use of more conservative assumptions (e.g. interest rate) while the current unfunded actuarial liability exists, but the impact on contribution rates	Consideration will be given to using more conservative actuarial assumptions, subject to receiving actuarial advice. If more conservative actuarial assumptions are used, the actuarial liability will be increased, and ultimately reflected in the level of contribution rates.

should still be considered.	
10. We understand the practice of relying on possible investment gains above the actuarial assumption is no longer going to be utilized by HBT, and we recommend it not be reconsidered in future rate setting.	The Trust no longer anticipates excess investment earnings in setting its contribution rates.
11. Although we believe the use of an IFR is acceptable for funding purposes, there is a lack of consistency in its application. We recommend a review of the continued use of this reserve and the appropriateness of its inclusion and presentation in the financial statements.	HBT will review the continued use of the Investment Fluctuation Reserve.
12. While absence of margins in the determination of actuarial reserves would not be unusual for a plan like HBT, based on emerging trends, we recommend some margin in the contribution rate setting process. While we recognize over-funding will present taxation issues, the intent of the margins would not necessarily be to reduce the probability of a deficit, but could be designed to ensure the contribution rates do not significantly deviate from the anticipated LTD claims costs. In other words, there could be a lag between the experience used in determining contribution rates and the emerging experience over a period of three to five years to avoid the build up of large deficits.	If margins are introduced in the contribution rate setting process, the contribution rates will be higher than if there were no margins. If this is acceptable to HBT members, a change may be made. However, this is a reversal of previous instructions from HBT members (through HEABC) that contribution rates should be kept as low as possible. Ultimately it is the Trustees, acting on advice from the actuary, who must set contribution rates.

13. We recommend rate setting and deficit recovery strategies be considered in conjunction with the funding policy. The current deficit recovery strategy focuses on required rate increases that will achieve a 95% funding level over a 10-year period. This funding strategy will more likely result in a deficit than in a surplus. During a period where claims costs are consistently high, as has been the case in recent years, there is a danger of continuously falling behind and, if no offset comes from excess investment performance, contribution rates could be expected to increase significantly over a prolonged period. A more comprehensive funding policy would address the following components: ▪ Rate required to fully-fund the cost of new claims plus administration expenses including the approach and degree by which emerging trends are recognized in the rate setting process; and the ▪ Rate required to amortize the unfunded liability over the selected period or periods.	Funding policy and deficit recovery strategies are presently an integrated part of rate setting at the Trust. The funding policy is a statement adopted by the Board to indicate the desired range of the funding ratio (that is assets/ liabilities) and what actions will be taken if the funding ratio is outside the desired range. The current funding policy states that no action will be taken if the funding ratio is within the range of 95% to 103% and specifies the corrective action to be taken if the ratio falls outside of these parameters. This is a sufficient expression of funding policy and so no change to it is necessary. When contribution rates are established at the Trust on at least an annual basis, the actuary presents to the Trustees all relevant information required to enable them to accept his recommendations in this regard. This information includes the impact of current morbidity experience, expected future changes to this experience, current and expected future investment earnings, the impact of administrative expenses, current or future expected changes to the benefits, the deficit recovery strategy and all other matters that the actuary considers significant. In summary, the changes suggested in this recommendation are already in effect.
14. There should also be a clear, direct relationship and connection between the employer's effectiveness of the claims management process and their contribution premium. In short, the employers' contribution levels should be directly related to their effectiveness in claims management and their risk tolerance.	Effective March 31, 2004, health authorities and other large risk pools will be accounted for on a self-sufficient basis for LTD, Dental and EHB benefits. This means that only the experience of each health authority will be reflected in their respective contribution rates. It should be noted that the Trust cannot provide a direct connection between the experience of a small group and the contribution rate for such a group. This is due to the fact that the experience of a small group is not statistically significant.
Plan Design:	
15. We recommend the government, the participating employers and the unions approach future collective bargaining and wage discussions with the intention of ensuring an equitable plan design, consistent with other similar plans in the healthcare and other related sectors. This would include cost containment and cost sharing features and benchmarking to comparative programs.	Plan design is outside the specific mandate of the Trust. HBT simply administers the plan presented to it by HEABC. Collective bargaining is the process within which all decisions on plan design are made. HBT recognises that plan design is one of the most important elements in controlling costs of the benefits provided by the Trust. Therefore, HBT has consistently provided input to HEABC and CSSEA, when requested, on benefit design considerations and their costs. HBT anticipates continuing to provide this service.

Disability Management:	
16. While the analysis of the disability management program is beyond the scope of our review, we recommend an organization that has direct contact with all union representatives, is involved in all areas of absences (e.g. sick leave, WCB, and LTD), and has the authority to make participation mandatory should design and deliver this initiative. Ideally, the program would be fully supported by all the unions (if applicable) as well as the employers and should have an integrated approach with respect to sick leave/STD, WCB, and LTD claims. Any change to HBT's role in the current rehabilitation and EWHS services delivery model should only be made in conjunction with a review of the disability management process for the healthcare sector and should incorporate the investments made in this area by the individual participating employers.	HBT recognises that disability management is a key component in controlling the costs of the benefits provided by the Trust. HBT will actively consider and work with any current or proposed agency to bring more effective disability management to its members, provided that their actions result in a reduction in HBT claims costs.
17. To the extent it is not occurring, there should be a focus on rehabilitation and early return to work for recent LTD claims. It is generally acknowledged that early intervention and rehabilitation has a positive impact on LTD claims duration and terminations, and is most effective in the early stages of an LTD claim.	HBT fully agrees with this Recommendation.

Appendix E: HBT & Province of British Columbia Action Plan

(The attached response prepared by HBT and the Province of BC should be read in conjunction with this final report).

Final Report on the Healthcare Benefit Trust - As Issued By Deloitte & Touche
HBT's Response to Recommendations and Provincial Action Plan
Last Updated: March 17, 2004

Recommendation:	HBT Board Response:	Government Action Plan To Implement Recommendations
Communication:		
1. While we recognize HBT has attempted to provide information to participating employers and government in the past, we recommend the approach to disseminating information be reviewed to ensure proactive, regular interaction between all parties regarding all aspects of plan performance. Participating employers should also be frequently consulted to ensure the information provided is meeting their needs.	Some of HBT's Trustees are appointed from the healthcare industry. With their guidance HBT will review its communications strategy to reflect the changing nature of our members	HBT Board: To review its communications strategy to reflect the changing nature of its members. As well to ensure the communication strategy is achieved. HEABC, CSSEA and PSEC: To ensure the communication strategy proposed by HBT meets the participating employers' needs as well as to disseminate information on plan performance.
Governance:		
2. Earlier this year the Board expanded to include two representatives from the Health Authorities. While this expansion was designed to improve the direct participation on the HBT Board, we recommend additional Trustee(s) from areas of the healthcare and social services sector not currently represented to ensure balanced representation. Given the impact of the LTD program on the overall financial position of HBT, consideration should also be given to individuals with a strong disability management background.	A maximum of twelve Trustees is specified in the HBT Trust Agreement. Currently there are ten. Three of them are from Health Authorities, one is from the community health sector and one is from HEABC. HEABC bears the responsibility of appointing all Trustees and HBT will ask them to respond to this Recommendation.	HEABC To review whether the healthcare and social service sector representation on the HBT Board is adequate according to the healthcare (MoHS and Health Authorities) and social services sectors (CSSEA). MoHS, MCFD and PSEC: To work with HEABC and HBT to ensure continuing and appropriate board membership including the possibility of government representation for an interim period.
3. Regardless of whether a stabilization fund or contingency reserve were to be introduced, the government might consider introducing regulatory oversight (e.g. FICOM or Superintendent of Pensions) to provide protection and accountability. If HBT were regulated today, however, this	Whether HBT reports to a government regulator is a matter of public policy. If this change is implemented then the regulations should be specific to Health & Welfare Trusts and should apply to all Health & Welfare Trusts operating within the Province of British Columbia. It is recommended that if government regulation of	PSEC (in consultation with MFIN and MoHS) To determine whether public policy should require HBT to report to a government regulator (either the Superintendent of Pensions or FICOM). If yes, To establish government policy requiring HBT

oversight mechanism would have likely forced the contributions to escalate more rapidly as soon as an actuarial liability situation arose, and certainly may have demanded a model that provided suitable claims fluctuation reserves.	HBT is to proceed, this should be through the Superintendent of Pensions rather than through FICOM.	and all Health & Welfare Trusts to be regulated.
Information Systems Development:		
4. We recommend the participating employers work with HBT as they develop and implement their own HRIS systems. The primary objective would be to integrate and leverage the functionality of each party's system and avoid duplication of unnecessary expenditures.	HBT already has agreements in force or pending with five Health Authorities concerning the development of linked information systems that are necessary for the efficient administration of the collection of contributions, enrolment data and determination of benefits provided by the Trust. HBT is ready to work with HBT members to develop information systems that will assist in the integration of computer systems between the members and HBT.	HEABC, Health Authorities, CSSEA, and HBT A Working Group should be established to ensure that consistent information and/or collection systems exist with minimal additional resources that are necessary for the efficient administration of the collection of contributions, enrolment data and determination of benefits provided by the Trust.
Investment Management:		
5. While HBT do review their investment strategy and performance on a regular basis, we do however; recommend HBT work closer with the participating employers to incorporate their risk profile and budgeting requirements in the investment review process.	HBT will discuss its investment strategy with its members to reflect the wishes of its members. The ability of HBT to respond will depend on the size of the member group and the exact allocation of assets requested. Risk tolerance cannot be separated from the ability to pay for a particular risk profile. Both of these features need to be considered by HBT members before relevant decisions can be made.	HBT Board Including Representatives for Participating Employers (i.e. Health Authorities and CSSEA) To ensure that HBT's investment strategy reflects members (i.e. HA CFOs and MCFD) needs on a recurring basis by providing periodic updates on performance and analysis of alternatives.
Risk Tolerance:		
6. We recommend a contingency or claims fluctuation reserve be established to ensure more stability in contribution levels, ideally without triggering any taxation liability.	Establishment of a contingency or claims fluctuation reserve can be considered for individual Health Authorities and other risk blocks within HBT. If such reserves are to be instituted, then the funding of them should be a prime consideration and the availability of funds will need to be considered by the funding agency.	HBT Board Including Representatives for Participating Employers (i.e. Health Authorities and CSSEA) To liaise with members (i.e. HA CFOs and MCFD) to determine whether each member would like to institute a contingency or claims fluctuation reserve on a go forward basis.
7. The majority of benefits provided through the HBT are fully pooled by risk group, with the exception of LTD, where	LTD has been experience-rated by HBT for at least ten years. It is anticipated that contributions will be determined solely on the experience of a	HBT Board Including Representatives for Participating Employers (i.e. Health Authorities and CSSEA) To liaise with members (i.e. HA CFOs and

experience-rating is applied at the employer level based on a credibility formula. We recommend increased accountability, particularly for the large participating employers. This can be achieved by setting contribution rates on each participant's claims experience for all benefits. However, the pooled approach could be maintained for the smaller participants. This approach maintains equity between participating employers, and makes employers responsible for their own employee benefit costs and also addresses the issue of cross-subsidization.	Health Authority or other large risk group for LTD benefits, effective March 31, 2004. Discussions are being held with Health Authorities concerning fully experience-rating Dental and EHB benefits. Due to the small number of claims involved, and therefore the lack of statistical significance, it is inappropriate to experience-rate Group Life and AD&D for each separate group and these benefits will continue as a separate pool within the Trust. Fully insured Dependant Life and Weekly Indemnity benefits are provided to smaller employers at present and this will continue on this basis.	MCFD) to determine whether other benefits in addition to LTD (i.e. Dental and EHB) should be experience rated.
8. Currently there is no flexibility to allow participating employers to select an underwriting option that is consistent with their risk tolerance. We recommend the establishment of a HBT pool and allow participating employers to choose whether to participate in the pool or select a stand-alone underwriting arrangement within HBT. Under this approach, all participating employers would still have access to the same reduced expense charges negotiated by HBT for the entire program.	This is a complex consideration even to the extent that it may be difficult to reach agreement on the meaning of the term "underwriting option". HBT is very willing to discuss with its members the implications of altering existing underwriting arrangements. However, this is another example where providing more flexibility may mean that additional funding is necessary. Inevitably this means that the funding agency will need to be involved in these discussions.	HBT Board Including Representatives for Participating Employers (i.e. Health Authorities and CSSEA) To liaise with members (i.e. HA CFOs and MCFD) and identify what underwriting options exist as well as to determine whether existing underwriting arrangements need to be altered to better meet member needs.
Actuarial Assessment:		
9. We believe that it may be more prudent to consider the use of more conservative assumptions (e.g. interest rate) while the current unfunded actuarial liability exists, but the impact on contribution rates should still be considered.	Consideration will be given to using more conservative actuarial assumptions, subject to receiving actuarial advice. If more conservative actuarial assumptions are used, the actuarial liability will be increased, and ultimately reflected in the level of contribution rates.	HBT Board Including Representatives for Participating Employers (i.e. Health Authorities and CSSEA) To ensure that HBT considers conservative actuarial assumptions that meet the members' needs.
10. We understand the practice of relying on possible investment gains above the actuarial assumption is no longer going to be utilized by HBT, and we recommend it not be reconsidered in	The Trust no longer anticipates excess investment earnings in setting its contribution rates.	HBT Board Including Representatives for Participating Employers (i.e. Health Authorities and CSSEA) To confirm that HBT will no longer rely on excess investment earnings in setting contribution rates.

future rate setting.		
11. Although we believe the use of an IFR is acceptable for funding purposes, there is a lack of consistency in its application. We recommend a review of the continued use of this reserve and the appropriateness of its inclusion and presentation in the financial statements.	HBT will review the continued use of the Investment Fluctuation Reserve.	HBT Board Including Representatives for Participating Employers (i.e. Health Authorities and CSSEA) To confirm the appropriateness of the continued use of the IFR as well as the inclusion and presentation of the IFR in the financial statements.
12. While absence of margins in the determination of actuarial reserves would not be unusual for a plan like HBT, based on emerging trends, we recommend some margin in the contribution rate setting process. While we recognize over-funding will present taxation issues, the intent of the margins would not necessarily be to reduce the probability of a deficit, but could be designed to ensure the contribution rates do not significantly deviate from the anticipated LTD claims costs. In other words, there could be a lag between the experience used in determining contribution rates and the emerging experience over a period of three to five years to avoid the build up of large deficits.	If margins are introduced in the contribution rate setting process, the contribution rates will be higher than if there were no margins. If this is acceptable to HBT members, a change may be made. However, this is a reversal of previous instructions from HBT members (through HEABC) that contribution rates should be kept as low as possible. Ultimately it is the Trustees, acting on advice from the actuary, who must set contribution rates.	HBT Board Including Representatives for Participating Employers (i.e. Health Authorities and CSSEA) To liaise with members (i.e. HA CFOs and MCFD) and determine whether margins should be introduced into the contribution rate setting process.
13. We recommend rate setting and deficit recovery strategies be considered in conjunction with the funding policy. The current deficit recovery strategy focuses on required rate increases that will achieve a 95% funding level over a 10-year period. This funding strategy will more likely result in a deficit than in a surplus. During a period where claims costs are consistently high, as has been the case in recent years, there is a danger of continuously falling behind and, if no	Funding policy and deficit recovery strategies are presently an integrated part of rate setting at the Trust. The funding policy is a statement adopted by the Board to indicate the desired range of the funding ratio (that is assets/ liabilities) and what actions will be taken if the funding ratio is outside the desired range. The current funding policy states that no action will be taken if the funding ratio is within the range of 95% to 103% and specifies the corrective action to be taken if the ratio falls outside of these parameters. This is a sufficient expression of funding policy and so no change to it is necessary.	HBT Board Including Representatives for Participating Employers (i.e. Health Authorities and CSSEA) To liaise with members (i.e. HA CFOs and MCFD) and ensure participating employers fully understand the consequences/results of the funding policy and contribution rates that are set by the Trust. In addition, the Trustees work with the actuary to ensure there are conservative assumptions, as appropriate i.e. investment rate of return. And finally, to ensure the UAL is eliminated and does not occur again in the future. In particular, the Deloitte report is not suggesting

offset comes from excess investment performance, contribution rates could be expected to increase significantly over a prolonged period. A more comprehensive funding policy would address the following components: o Rate required to fully-fund the cost of new claims plus administration expenses including the approach and degree by which emerging trends are recognized in the rate setting process; and the o Rate required to amortize the unfunded liability over the selected period or periods.	When contribution rates are established at the Trust on at least an annual basis, the actuary presents to the Trustees all relevant information required to enable them to accept his recommendations in this regard. This information includes the impact of current morbidity experience, expected future changes to this experience, current and expected future investment earnings, the impact o administrative expenses, current or future changes to the benefits, the deficit recovery strategy and all other matters that the actuary considers significant. In summary, the changes suggested in this recommendation are already in effect.	the funding policy needs to change but rather be more comprehensive. In the past HBT's actions leaned towards a 95% funding level meaning an increased likelihood of a deficit. Instead the funding strategy chosen needs to build in a more conservative margin to provide for a surplus. I.e. a more conservative discount rate from 7.5%. In addition, rating setting is inevitably connected with the funding policy in order to ensure the rates will cover a deficit. MFIN, MoHS, MCFD To require that the HBT provides regular reporting on the unfunded actuarial liability to the ministries until instructed otherwise.
14. There should also be a clear, direct relationship and connection between the employer's effectiveness of the claims management process and their contribution premium. In short, the employers' contribution levels should be directly related to their effectiveness in claims management and their risk tolerance.	Effective March 31, 2004, health authorities and other large risk pools will be accounted for on a self-sufficient basis for LTD, Dental and EHB benefits. This means that only the experience of each health authority will be reflected in their respective contribution rates. It should be noted that the Trust cannot provide a direct connection between the experience of a small group and the contribution rate for such a group. This is due to the fact that the experience of a small group is not statistically significant.	HEABC, HBT, MoHS, HAs and CSSEA To ensure the restructuring of the trust is completed by March 31, 2004 and that each health authority determines whether or not to be accounted for on a self-sufficient basis for LTD, Dental, and EHB benefits. The remaining employers in the smaller groups should be fully informed of the effects this change, if any, will have on them.
Plan Design:		
15. We recommend the government, the participating employers and the unions approach future collective bargaining and wage discussions with the intention of ensuring an equitable plan design, consistent with other similar plans in the healthcare and other related sectors. This would include cost containment and cost sharing features and benchmarking to comparative	Plan design is outside the specific mandate of the Trust. HBT simply administers the plan presented to it by HEABC. Collective bargaining is the process within which all decisions on plan design are made. HBT recognises that plan design is one of the most important elements in controlling costs of the benefits provided by the Trust. Therefore, HBT has consistently provided input to HEABC	PSEC (lead), in consultation with HEABC, MoHS, CSSEA As requested by the Minister of Finance, to undertake a cross government review of LTD plan design and case management to ensure there is affordability and flexibility in business delivery. This will include reviewing the rising cost of benefits in the broad public sector and strategies for addressing them.

programs.	and CSSEA, when requested, on benefit design considerations and their costs. HBT anticipates continuing to provide this service.	
Disability Management:		
16. While the analysis of the disability management program is beyond the scope of our review, we recommend an organization that has direct contact with all union representatives, is involved in all areas of absences (e.g. sick leave, WCB, and LTD), and has the authority to make participation mandatory should design and deliver this initiative. Ideally, the program would be fully supported by all the unions (if applicable) as well as the employers and should have an integrated approach with respect to sick leave/STD, WCB, and LTD claims. Any change to HBT's role in the current rehabilitation and EWHS services delivery model should only be made in conjunction with a review of the disability management process for the healthcare sector and should incorporate the investments made in this area by the individual participating employers.	HBT recognises that disability management is a key component in controlling the costs of the benefits provided by the Trust. HBT will actively consider and work with any current or proposed agency to bring more effective disability management to its members, provided that their actions result in a reduction in HBT claims costs.	See #15 above.
17. To the extent it is not occurring, there should be a focus on rehabilitation and early return to work for recent LTD claims. It is generally acknowledged that early intervention and rehabilitation has a positive impact on LTD claims duration and terminations, and is most effective in the early stages of an LTD claim.	HBT fully agrees with this Recommendation.	See #15 above.