Law & Governance

LegalFocus on Healthcare and Insurance

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Who Pays ? Ontario Health Premium Tax Dispute Escalates ●

Government has narrow window to clarify legislation

by Guy W. Giorno

As the dispute over whether employers are responsible for paying the Ontario Health Premium tax intensifies, employers have very little time to secure a legislative amendment that would settle the matter. At issue is whether collective agreement clauses that say employers must pay their employees' Ontario Health Insurance Plan (OHIP) premiums apply to the new Ontario Health Premium tax introduced in the 2004 provincial budget.

Unions are arguing that the clauses do apply to the premium tax; employers and the Ontario government say they do not; and three labour arbitrators have reached different conclusions. Meanwhile, the legislation giving effect to the tax, Bill 106, is still before the Ontario Legislature. [1]

The issue could be resolved by amending Bill 106 in committee to clarify that the old OHIP language in collective agreements no longer applies.

Employers who support this solution have very little time to act.

The Issue

The Ontario Health Premium tax was introduced as part of the 2004 Ontario Budget. The premium tax is calculated based on personal income and, when fully implemented, will cost each individual taxpayer up to $900 annually.

Unions argue that Ontario employers are responsible for paying the premium tax for each employee. They base this argument on collective agreements that make employers responsible for paying OHIP premiums.

1. Bill 106, *Budget Measures Act*, 2004 (No. 2). First Reading, June 21, 2004. Three days of Second Reading debate have already taken place.

(OHIP premiums have not existed since 1990, when they were abolished and replaced with the Employer Health Tax.) [2]

While the issue is directly relevant to employers whose collective agreements specifically refer to OHIP premiums, other unionized employers are facing, or soon will face, union demands to insert such language into their contracts. Some companies have already agreed to take responsibility for paying the Ontario Health Premium tax.[3]

If employer payment of the new Ontario Health Premium tax becomes widespread in unionized workplaces, then non-union employers may face similar pressure to include this among employee benefits.

At least one labour relations arbitrator has agreed with the union argument that collective agreement obligations to pay OHIP premiums automatically extend to Ontario Health Premium taxes. (See "Conflicting Decisions," page 3.)

Employers could end up paying twice: They still are subject to the Employer Health Tax, a collective burden on all Ontario employers of $3.9 billion annually. If the union argument succeeds, then many employers may end up also paying their employees' Ontario Health Premiums, the total cost of which will be $1.6 billion during this fiscal year.[4]

A Tax, Not a Premium

The new Ontario Health Premium is properly characterized as a tax and not a premium. It is imposed by the *Income Tax Act*, it is collected as a tax, and non-payment is dealt with as failure to pay income tax.

The legislation giving effect to the premium expressly refers to it as "a tax, called the Ontario Health Premium."[5]

Unlike a true premium, the Ontario Health Premium tax need not be paid in order for an individual to receive insured healthcare services. Payment or non-payment of the premium tax has no effect on entitlement to healthcare. [6]

Further, despite government statements that the Ontario Health Premium tax revenue will be used to fund healthcare, the amounts collected will simply go into general government revenue and the legislation would not restrict where the money is spent. The only requirement in Bill 106 is that the government table annual reports on how the revenue is used. [7]

2. *Employer Health Tax Ac*t, RSO 1990, c.E.11, as amended.
3. United Steelworkers of America. 2004. NewsRelease, "Employer to Pay Ontario Health Premium: Steelworkers Ratify Agreement with Canpar Transport LP" (June 23).
4. The Ontario government fiscal year runs from April 1, 2004, to March 31, 2005. The tax is being collected starting July 1, 2004.
5. Section 4 of Bill 106, enacting subs. 2.2(1) of the *Income Tax Act*.
6. *Health Insurance Act*, RSO 1990, c. H.6.
7. Section 11 of Bill 106, enacting s. 29.1 of the *Income Tax Act*.

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The legislation sets out in some detail how the tax is to be calculated. The formulae are based on the individual's "taxable income for the year," which includes all income, not just employment income. If an employer is held responsible to pay the premium tax, then it may have difficulty calculating the amount because the tax depends on more than employment income.

Conflicting Decisions

Three experienced labour relations arbitrators have reached different conclusions about employers' responsibilities to pay their employees' Ontario Health Premium taxes.

In *Re Jazz Air Inc. and Air Line Pilots Association, International* (Sept. 27, 2004), Martin Teplitsky found that the employer was not responsible for paying the premium tax. He based his conclusion on three factors: First, the parties could not have contemplated a premium tax that did not exist when the collective agreement was negotiated. Second, the premium tax is based on all income, including income from other employment; Mr. Teplitsky noted that no employer would agree to pay tax on income earned elsewhere and that the collective agreement contained no mechanism for Jazz Air to ascertain these amounts. Third, "benefits are always specifically bargained and identified," and the premium tax was not.

The Teplitsky award also noted that a "tax" is not a "premium," but the arbitrator said that this factor had the "least significance" to his decision. Jazz Air stands in stark contrast to the October 6 decision of Anne Barrett in *Re Lapointe Fisher Nursing Home and UFCW Local 175/633*.[8]

After considering extensive submissions on the history and background of the Ontario Health Premium tax, the arbitrator based her decision on where the new revenue is used. According to the Barrett award, because the government says that Ontario Health Premium tax revenue will be "invested in our healthcare system," that means that the revenue will go into OHIP, and therefore the revenue is properly characterized as an OHIP premium.

> "… at least half of the new health funding will be directed to non-OHIP health services such as long-term care, ambulances, prescription drugs, home care and public health."

Ms. Barrett based her award on findings that the Ontario Health Premium "is dedicated solely to funding OHIP" and "directed solely to the [Ontario Health Insurance] Plan."[9]

The shortcoming of this reasoning is that the new Ontario Health Premium tax is not, in fact, being directed "solely" to OHIP. The arbitrator's analysis confused OHIP with the overall budget of the Ministry of Health and Long-Term Care. The premise that money spent on healthcare means money spent on OHIP is incorrect.

The Ontario government plans to increase healthcare funding by $2.2 billion in this fiscal year, with $1.6 billion of that amount coming from the Ontario Health Premium tax.[10]

However, at least half of the new health funding will be directed to non-OHIP health services such as long-term care, ambulances, prescription drugs, home care and public health.[11]

8. Unreported (October 6, 2004).
9. *Re Lapointe Fisher Nursing Home*, at 16. See also, at 15, "The government has now decided to impose a special tax, called the Ontario Health Premium, specifically and solely for the purpose of providing additional funding to the [OHIP] plan."
10. Ministry of Finance. 2004. Backgrounder, "Ontario Health Premium: Healthier Ontarians and a Healthier Ontario" (June 21).
11. Ministry of Finance. 2004. Ontario Budget, Paper A, "Ontario's Finances," p. 43. Nine hundred forty-six million dollars of the new money will be directed to the following non-OHIP services: long-term care ($406 million), Ontario Drug Programs ($193 million), home care and community care for mental health patients ($182 million), public health ($165 million). A further $268 million is allocated for "Other healthcare services including increases for cancer care [part of OHIP] and ambulance services [not part of OHIP]." Thus, it is simply incorrect to conclude that revenue from the premium tax "is dedicated solely to funding OHIP." Further, the Ontario Government has never said that the Ontario Health Premium tax revenue will be used solely for OHIP-insured services. It promises to spend the revenue on health services in general.

The assumption on which the decision was based, that all the money collected through the Ontario Health Premium tax will go into OHIP and therefore that the health premium is really an OHIP premium, was simply wrong.

More recently, in *Re College Compensation and Appointments Council and OPSEU*,[12] arbitrator Owen Shime held that community colleges are not required to pay the Ontario Health Premium tax on behalf of their employees. In part, Mr. Shime's decision echoed the reasoning of *Jazz Air.* However, the award turned on very specific language in the community colleges' collective agreement that refers to the earlier shift from individual OHIP premiums to an Employer Health Tax and provides that the employer will resume "paying 100% of the billed premium for employees" if the government "reverts to an individually paid premium for health insurance."[13]

The arbitrator held that the government has not reverted to the old system of OHIP premiums; instead, it has added a new tax on top of the existing system. In those circumstances, the unique language in the collective agreement has not been triggered.

We understand that at least one of these decisions (*Re Lapointe Fisher Nursing Home*) may be the subject of an application for judicial review.

Government Position

Despite the Barrett arbitration award, Premier Dalton McGuinty and Finance Minister Greg Sorbara are firmly on record stating that the tax should be paid by individuals and that collective agreement references to OHIP premiums do not apply to the Ontario Health Premium tax.

The Minister of Finance has made the following definitive statements: [14]

> ... this is not a premium as contemplated by those collective agreements. ... [I]f workers and employers choose to bargain on this issue, they are perfectly free to do that. But this premium is not covered by those old provisions ... .
>
> ... I think I've made it perfectly clear that this premium does not come within the four corners of those pre-existing collective agreements.

The Ministry of Finance states a similar conclusion:[15]

> Q. If a collective agreement states that the employer would cover OHIP premiums, must the employer pay for the Ontario Health Premium?[16]
>
> A. Unlike the old OHIP premium, the new health premium would be a tax on individuals under the *Ontario Income Tax Act*. Unless employers have bargained to pay employees' taxes, we would not expect that this charge has been anticipated in collective bargaining agreements.

Ontario Premier Dalton McGuinty has been even more definitive: "Our intention is that taxpayers have to pay," he told the media a few days ago. "We'll be watching things very closely, but our intention remains the same, and it's been very clear from the outset: this is a tax provision found within the *Income Tax Act*, and our intention is that taxpayers will pay this new premium."

> "A solution that would eliminate the uncertainty might be to amend Bill 106 at the committee stage, following Second Reading."

12. Unreported (October 29, 2004).
13. The complete text of the provision is as follows: "The parties recognize that the method of funding OHIP has been changed from an individually paid premium to a system funded by an employer paid payroll tax. If the government, at any time in the future, reverts to an individually paid premium for health insurance, the parties agree that the Colleges will resume paying 100% of the billed premium for employees."
14. Ontario Legislative Assembly, *Debates* (June 24, 2004).
15. Ministry of Finance. 2004. "Ontario Health Premium: Frequently Asked Questions." Retrieved October 28, 2004. <http://www.gov.on.ca/FIN/english/healthfaqemp.htm>.
16. Canadian Press. 2004. "Taxpayers Must Pay Premium: Premier" (Oct. 25).

Despite the government's pronouncements, two conflicting arbitration awards (and several more pending decisions) leave employers' obligations unclear.

A solution that would eliminate the uncertainty might be to amend Bill 106 at the committee stage, following Second Reading. For example, MPPs might be persuaded to pass an amendment clarifying that responsibility for paying the Ontario Health Premium tax shall not shift to employers. Perhaps such an amendment could distinguish between collective agreement provisions negotiated before and after May 18, 2004, the date that the premium tax was announced.

What Can Employers Do?

Faced with the prospect of contributing to healthcare twice, employers are justifiably anxious to have the issue resolved.

One option is to await the outcome of multiple arbitration and judicial review proceedings. This approach will not necessarily resolve the matter with certainty, because the award of one arbitrator is not binding on another and differences in wording among collective agreements mean that each arbitration award has direct application only to that particular contract.

Neither is there any guarantee that judicial review will settle the matter province-wide. On such an application, the issue is not whether the Divisional Court agrees with the arbitrator but whether, having the regard to the specific facts and contract language of each case, the arbitrator's decision falls within the bounds of reasonableness. It is definitely possible for two awards reaching opposite conclusions both to be upheld on judicial review.

An alternative is for employers to urge the government to hold public hearings on Bill 106 and then to ask for a clarifying amendment in committee.

However, the window for employers to make these representations is extremely tight. Three days' Second Reading debate has already occurred. The conclusion of the debate and a decision about whether to send the bill for public hearings could occur at any time.

To ask for Bill 106 to be sent to public hearings, employers may call the Hon. Dwight Duncan, Government House Leader (416-325-7754), Official Opposition House Leader John Baird (416-325-6351) and NDP House Leader Peter Kormos (416-325-7106).

While not the only solution, a clarifying amendment to Bill 106 would be the surest way to achieve the government's stated objectives: ensuring that individual taxpayers bear responsibility for paying the premium tax and ensuring that the premium tax is not subject to pre-existing collective agreement provisions. L&G

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Calendar

Medical Imaging
February 12–17, 2005
San Diego, CA
Contact: http://spie.org/conferences/calls/05/mi/

Annual HIMSS Conference and Exhibition
February 13–17, 2005
Dallas Boards Convention Centre
Dallas, TX
Contact: http://conference.himss.org/ASP/index.asp

4th Anuual Obstetric Malpractice and Perinatal Risk Management Forum
February 22–23, 2005
Toronto, ON
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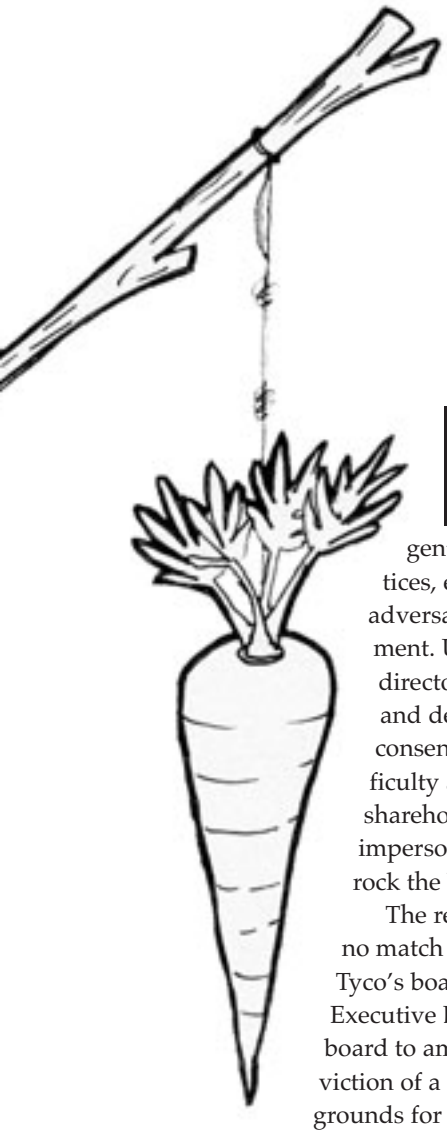

Strong Boards, Weak Managers

Directors must be empowered to stand up to management.

by B. Espen Eckbo

Directors of corporate boards today are expected to implement stringent corporate governance practices, even if this means playing an adversarial role vis-à-vis management. Unfortunately, while most directors are intelligent, honorable, and dedicated, they also tend to be consensus builders. Many have difficulty asking tough questions. And shareholders are a distant and impersonal constituency, so why rock the boat?

The result is a weak board that is no match for a superstar CEO. Take Tyco's board. In 2001, then Chief Executive Dennis Kozlowski asked his board to amend his contract so that conviction of a felony would not constitute grounds for termination. In the words of governance activist Nell Minnow, someone might have said, "Dennis, we're sorry: Are you planning to knock over a bank? Is there something you want to tell us?" Instead, the board signed the contract.

There are ripple effects. After Jack Welch – perhaps the best CEO of the last 30 years – got GE's board to sign off on a retirement plan that included lifetime dry cleaning, Knicks tickets, and catering, IBM chairman and CEO Lou Gerstner persuaded IBM's directors to agree to a similar plan.

How do we empower board members to stand up to management? There is a carrot and a stick. The stick is the loss of reputation, increased director turnover, and increased director liability that goes along with the types of scandals we have seen lately. Moreover, there is now an increased focus on the performance of board members.

The carrot includes a compensation package that makes directors think like shareholders.

That means payment in company stock, with a sizable lockup period after a director leaves the company. Companies should also consider requiring directors to invest a non-negligible amount of their personal wealth in the company's stock.

Moreover, it is important to reduce the CEO's formal influence over the board. New directors must know who hired them: shareholders, not the CEO. Splitting the CEO and the board chairmanship functions sends the right message: Directors are ultimately responsible for the governance of the corporation.

Finally, although legislation such as the *Sarbanes–Oxley Act* of 2002 helps empower the board, our system of corporate governance depends on shareholders being active participants. After all, shareholders have voted to approve most of the bad governance provisions found in today's corporate charters and bylaws. Their vote has been largely passive, with support of management-driven governance proposals as a default. Shareholder passivity is due to a combination of factors, ranging from ownership dispersion (small shareholders have no incentive to expend resources to oppose management) to legal constraints on institutional investor activism.

The good news is that institutional shareholders have started to play more of an activist role. The most important governance changes will come when shareholders as a group insist on better corporate governance and have economic incentives to take action. Reforming the rules for director election is necessary in order to level the playing field. Only then will we establish the right balance of power between the CEO and the board. L&G

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This article first appeared in the Corporate Board Member's 2004 Academic Council Supplement, Emerging Trends in Corporate Governance.

B. Espen Eckbo is the Tuck Centennial Professor of Finance and founding director, Center for Corporate Governance, at Dartmouth College.

Newsworthy

Findings in a recent report released by the Center for Studying Health System Change in the U.S. include:

- A decrease in the growth of spending for hospital inpatient care (from 6.4% in the second half of 2003 to 5.1% in the first half of 2004).
- Hospital outpatient care spending held constant at its 11.4% growth and remains the category of healthcare spending that is growing the fastest.
- The combination of inpatient and outpatient hospital utilization continues to grow at the slow rate of 0.8%.
- Hospital prices, however, grew at a rate of 7.7% in the first half of 2004 – primarily due to increased wage rates resulting from workforce shortages.
- Growth in spending on prescription drugs has slowed from 9.6% in the second half of 2003 to 8.8% in the first half of 2004.

Source: Center for Studying Health System Change

The HHS Office for Civil Rights has issued its answers **to nine new frequently-asked-questions about the disclosure of protected health information** (PHI) during judicial and administrative proceedings. Questions include whether PHI can be disclosed for a subpoena or discovery request absent a court order (the answer is yes but only under certain conditions), and when covered entities must track disclosures made during the course of litigation in their accounting of disclosures. To view the questions and their answers, go to http://answers.hhs.gov.

According to Forrester Research:

- FDA aims to make RFID tags required for drug tracking by 2007.
- 80% of eligible U.S. seniors, Forrester predicts, will not be enticed by Medicare drug discount cards in 2005.
- 9% of U.S. adults who regularly take prescription medication have gone online to purchase a prescription in the past year.
- 40% of U.S. businesses Forrester surveyed take 18 months or longer to put portals into production.
- 23% of the uninsured U.S. residents are actively researching or applying for health coverage.

Source: Forrester Research

In a telephone survey of almost 1,350 respondents, 80% of healthcare **consumers want their physicians to use "established best-practice guidelines for treatment and diagnosis."** In other findings:

- 68% of respondents favored health plans rewarding physicians with a track record of using best-practice guidelines;
- 68% also reported that they'd choose a physician based on how well he or she applied the guidelines in his or her practice; and
- 74% of respondents would be likely or fairly likely to choose a hospital based on whether or not it uses guidelines.

The survey was conducted during November by Peter D. Hart Research Associates on behalf of the Blue Cross Blue Shield Association.

Source: Modern Physician STAT, December 14, 2004

Two percent of e-mail messages sent by employees at payer and provider organizations contain protected health information (PHI), according to a recent study conducted by Zix Corp. The Dallas-based e-communication vendor analyzed 5 million incoming and outgoing messages from 50 healthcare organizations from April through October 2004. The volume of e-mails containing PHI at the organizations studied ranged from 1 to 9%.

Source: Health Management Technology December 2004 Governance, at Dartmouth College.

A recent article in *Business Week* highlights some of the **privacy concerns associated with the emerging use of computerized medical record systems** and other related technologies in healthcare. The author advises patients to ask about protective security measures, segregation of psychiatric records, and access for insurers and other non-medical entities, but misleads readers to believe that federal law gives them the right to know who has viewed their medical information, to "opt out of the system," or to "have some information excluded." http://businessweek.com/magazine/content/05_05/b3918155_mz070.htm

Abstracts

Coming Soon to a Health Sector Near You: An Advance Look at the New Ontario *Personal Health Information Protection Act* (PHIPA)

By John P. Beardwood and J. Alexis Kerr

This is Part I of a two-part article that provides a broad overview of the new health sector privacy legislation in Ontario, and compares this legislation to personal health legislation in other provinces. It discusses the objectives, structure and scope of, as well as the substantive rights and obligations created by, the Ontario Act. The article also discusses the approach to the protection of personal health information taken by other provinces, including Alberta, Saskatchewan and Manitoba, which have already enacted legislation that is similar in many respects to the Ontario Act.

http://www.longwoods.com/hl/art.php?ID=152&view=1

Bill 8 – Accountability and Control

By Simon Chester, Maureen Quigley and Graham Scott

The Ministry of Health and Long-Term Care (MOHLTC) and the hospitals of Ontario have for some time agreed that there has been little clarity as to their respective expectations in accounting to each other for their responsibilities in the delivery of healthcare. Bill 8, introduced in the Ontario Legislature in November 2003, provides the vehicle the government proposes to use to introduce formal accountability processes for hospitals. One major area of disagreement between the Ministry and the OHA concerns Sections 26 and 27, which would permit the Minister to intervene directly with a hospital's CEO. The authors believe that the Minister can exercise effective operational accountability without bypassing the hospital board, and thus avoid clouding accountability.

http://www.longwoods.com/hl/art.php?view=1&ID=147

Taking the Next Step to Privacy Compliance for Hospitals: Implementing the OHA Guidelines

By John Beardwood

Released in July 2003, "Guidelines for Managing Privacy, Data Protection and Security for Ontario Hospitals," prepared by the Ontario Hospital eHealth Council Privacy and Security Working Group ("the Guidelines"), are useful in that they provide a comprehensive overview of the types of issues raised for hospitals by existing and pending privacy legislation, and a very high-level framework for addressing same. However, the Guidelines are, as stated, high-level guidelines only – leaving hospital management to grapple with the next big step towards privacy compliance: how to operationalize the Guidelines within their particular hospital.

http://www.longwoods.com/hl/art.php?view=1&ID=134

Coming Soon to a Health Sector Near You: An Advance Look at the New Ontario *Personal Health Information Protection Act* (PHIPA): Part II

By John P. Beardwood and J. Alexis Kerr

This is Part II of a two-part article that provides a broad overview and comparative study of the new Ontario health sector-specific privacy legislation. The article discusses the administrative obligations created by the Ontario Act, as well as the provisions relating to its enforcement and the remedies available under it.

http://www.longwoods.com/hl/pdf/HQ81JBeardwoodJKerr.pdf

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