

HEALTH WEALTH CAREER

**REPORT TO THE CANADIAN MEDICAL
ASSOCIATION ON POTENTIAL
RETIREMENT SAVINGS OPTIONS FOR
CANADIAN PHYSICIANS**

JULY 19, 2019

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BACKGROUND AND CONTEXT

The Canadian Medical Association (CMA) represents the interests of more than 72,000 of Canada's physicians. Recently, a number of physicians have signed a petition, asking CMA to consider implementing a national pension plan for Canadian physicians. We have been asked by CMA to identify potential options to improve physicians' retirement income security, as individuals or as a group, within the confines of the existing Canadian pension system, as well as those that could be implemented with realistic changes to current legislation and/or innovations in plan design.

It is important to note that Canadian pension plans are exclusively offered through employers. Most plans are sponsored directly by employers, and even in the situations where this is not the case, employers virtually always contribute to the plans. This premise pervades the entire system at a very deep level, making it impossible for a third party (like CMA or a provincial government) to contribute directly to a pension plan for self-employed or incorporated physicians. Based on information supplied by CMA, we understand that for those physicians who are not self-employed or incorporated (only about 5%), a number of different pension arrangements already exist across the country, depending on location. Currently, however, the majority of Canadian physicians do not participate in a pension plan. For the purpose of this report, we will focus on this majority, unless otherwise specified.

While they may not participate in a pension plan, physicians do have the ability to save and invest their money as they see fit, including for retirement. To assist them with this, there are a number of services available in the marketplace, including:

- Investment and financial planning advice;
- Advice on debt management, incorporation, and estate planning;
- Access to professionally managed investment funds, with lower fees for larger amounts invested;
- Discount brokerage firms;
- Individual pension plans for professional corporations; and
- Insurance offerings

It appears that these services are not currently fully meeting the needs of all Canadian physicians, based on the petition, which asks for CMA to set up a pension plan for Canadian physicians, in order to increase their retirement income security, thereby reducing the stress arising from financial concerns. In theory, there are various ways to increase retirement income security, all of which are variations on the following two concepts:

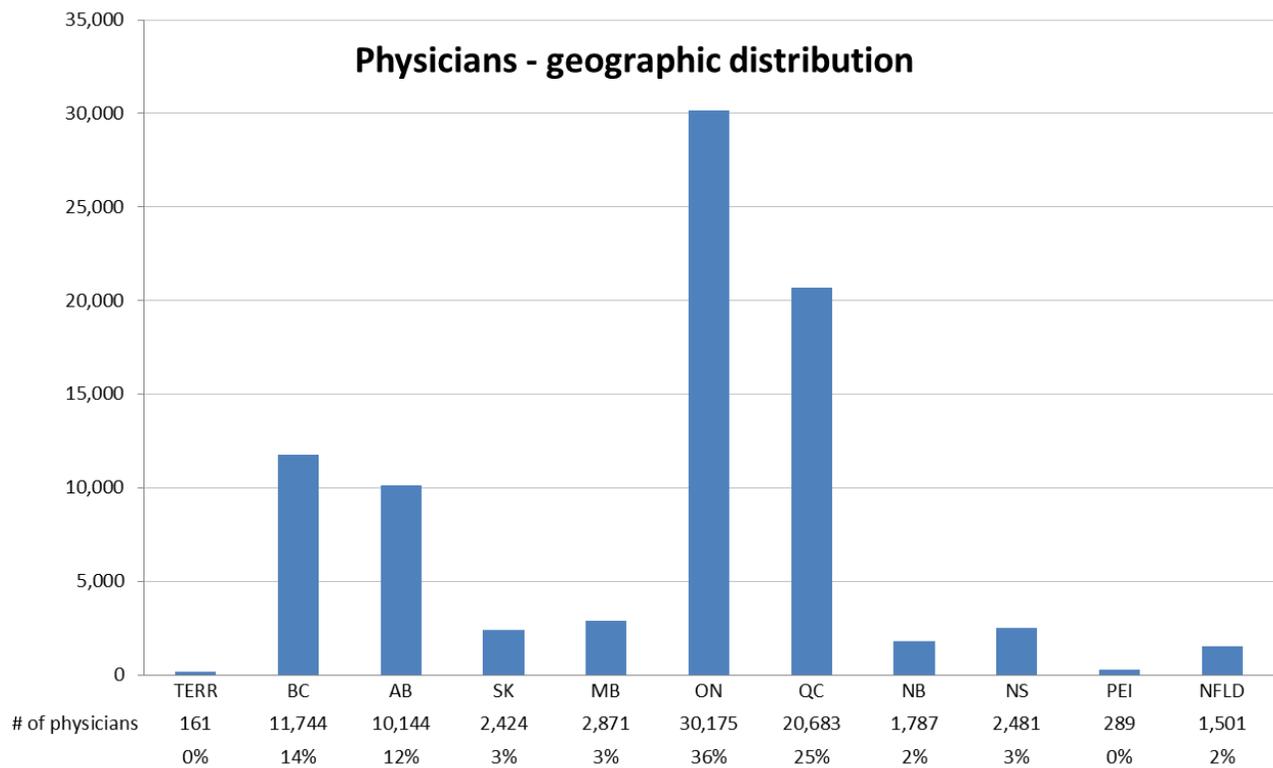
- Greater certainty of retirement income; and
- Greater levels of retirement income, to achieve reasonable replacement of pre-retirement income

The analysis contained herein will focus on these goals, to the extent they are achievable within the constraints of the Canadian retirement system.

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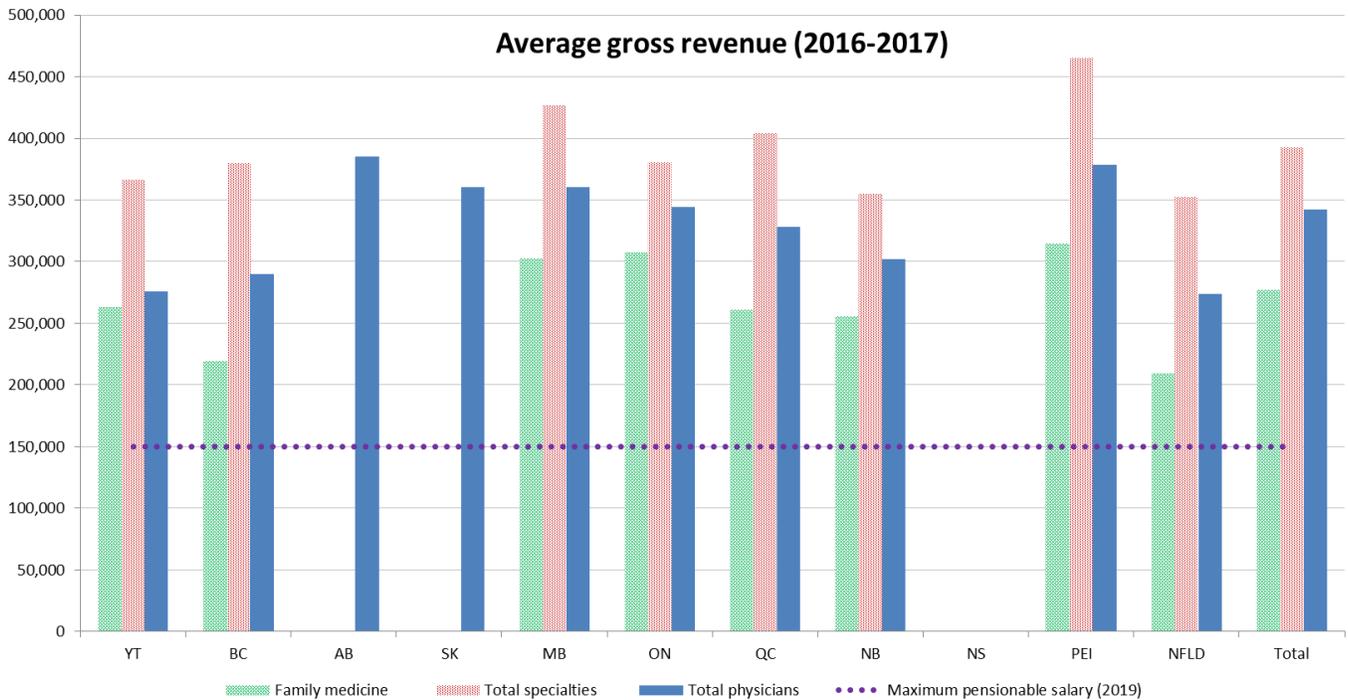
CURRENT STATUS OF CANADIAN PHYSICIANS

Canada’s 84,000 physicians are distributed across the country, with the highest concentration (over 60%) in Ontario and Quebec, as shown below:



Source: Canadian Medical Association

The following graph shows the average gross revenue (before overhead¹) of physicians across the country, split by family medicine and specialists, where available. For reference, the graph also indicates the approximate salary on which maximum pension contributions and benefits are based under the *Income Tax Act*, as described later in this report.



Source: Canadian Medical Association (information not available for all regions)

From an employment/incorporation perspective, physicians are approximately distributed as follows:

- Employees: 5%
- Self-employed: 30%
- Incorporated: 65%

Based on information supplied by CMA, we understand that the average retirement age of a Canadian physician during the period 2014-2017 was 68.

¹ Based on information supplied by CMA, we understand that typical overhead costs for a family physician are 25%-35% of revenue, with lower levels of overhead paid by most specialists.

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BACKGROUND ON CANADIAN RETIREMENT SYSTEM

The Canadian retirement income system is often described as having three pillars:

PILLAR 1: OLD AGE SECURITY (OAS) AND GUARANTEED INCOME SUPPLEMENT (GIS)

Pillar 1 benefits, provided by the government from general revenues, are intended to reduce poverty through a fairly low, basic benefit. For this reason, benefit eligibility is related to income. Given their income level, physicians would not generally be eligible for any GIS benefits, and may not receive the full amount of OAS benefits either². Eligibility for OAS and GIS benefits is also based on Canadian residency criteria, and both programs begin payouts at age 65.

PILLAR 2: CANADA/QUÉBEC PENSION PLAN (C/QPP)

C/QPP benefits provide a basic benefit, linked to employment income. Benefits are funded in equal shares by employees and their employers. Self-employed workers pay both the employee and employer share of the costs. Basic C/QPP benefits provide a maximum benefit of 25% of indexed career earnings, up to a maximum earnings level (\$57,400 in 2019); in 2019, the maximum C/QPP benefit payable at age 65 is about \$13,900 per year. Recent changes to the C/QPP will result in a 14% increase in this maximum earnings level, and a higher benefit accrual rate (33 $\frac{1}{3}$ %), as well as higher contribution rates. The transition to this new design began in 2019, but will take about 40 years to take full effect; following this transition, the maximum C/QPP benefit payable at age 65 will be about \$21,000 per year (in 2019 dollars), about a 50% increase over the original maximum benefit. C/QPP benefits can begin at any time between age 60 and 70, at the individual's option, with benefits being reduced if they start before age 65 and increased if they start after age 65.

PILLAR 3: PRIVATE EMPLOYMENT-BASED PENSION PLANS AND PERSONAL SAVINGS

The purpose of this pillar is to provide Canadians with an opportunity to increase their retirement income beyond the basic level. Through the tax system, Canadians and their employers are encouraged, although generally not forced, to save for retirement.

² OAS benefits are clawed back during retirement, depending on the recipient's income. In 2019, benefits begin to be clawed back for incomes of \$77,580 or more. Recipients with income of \$125,696 or more in 2019 will receive no OAS benefits.

Retirement income under this pillar comes through one or more of the following vehicles:

- *Registered Pension Plans (RPPs)*: These are employment-based plans, which are highly regulated by various Canadian jurisdictions. RPPs include Defined Benefit Pension Plans (DB), which deliver a guaranteed pension, and Defined Contribution Pension Plans, which provide accumulation balances like Registered Retirement Savings Plans (see next section for more detail).
- *Registered Retirement Savings Plans (RRSPs) and Tax-Free Savings Accounts (TFSA)*: Canadians can contribute to individual investment accounts, and then can withdraw the balance, subject to legislation.
- *Non-registered savings*: The savings vehicles described above are given advantages under our tax system; for this reason, they are subject to limits specified in the *Income Tax Act*, as described more fully later in this report. Canadians who wish to save additional funds for retirement, in excess of those limits, can do so, but this type of savings will not have any tax advantages.

All of the savings vehicles above, except for DB RPPs, are types of Capital Accumulation Plans (CAPs), which are covered in more detail in Section 4.

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CANADIAN RETIREMENT SAVINGS PLANS (PILLAR 3)

Canadian retirement savings plans have traditionally been grouped into one of the following two categories:

- Defined Benefit (DB) pension plans
- Capital Accumulation Plans (CAPs)

DEFINED BENEFIT PENSION PLANS

A traditional DB plan is an RPP that delivers a lifetime monthly benefit to the member upon retirement, according to a set formula. The most common types of formula for the retirement benefit are as follows:

- Final average earnings (e.g., annual lifetime benefit = 2% × best 5-year average earnings × years of service)
- Career average earnings (e.g., annual lifetime benefit = 2% × sum of career earnings)
- Flat benefit (e.g., annual lifetime benefit = \$480 × years of service)

An RPP must be registered under pension legislation (provincial or federal, as applicable) and the *Income Tax Act*, and must meet the following governance conditions:

- There is a plan sponsor, either an employer or a governing body
- There is a trustee, either a recordkeeping company or a group of individuals
- Furthermore, in Québec, a separate entity must be set up to administer the plan (Pension Committee), which must include members representing plan participants

DB plans are funded by employers, with members sharing a portion of the cost in many cases. However, the employer is generally the party with ultimate responsibility for the plan funding (i.e., will need to pay for a deficit). Therefore, the existence of DB plans would not be possible without the participation of an entity responsible for the financial viability of the plan. It is important to note that RPPs are based on employment income, and therefore require an employer/employee relationship.

The costs are determined by periodic actuarial valuations, as required under the relevant jurisdiction, and can vary over the life of the plan, depending on the characteristics of the plan membership and the assumptions used, which in turn depend on the prevailing economic environment. In addition to

the annual funding of additional service accruals, minimum standards legislation may require additional contributions, typically by the employer, to fund deficits over a number of years.

In addition to lifetime retirement income, DB plans may offer other benefits subject to eligibility, such as a temporary pension (or bridge) from retirement to age 65, lump sums on termination, survivor benefits, and indexation.

Besides the governance requirements noted above, pension legislation provides for a number of other requirements, including the following:

- Minimum benefits to be provided;
- Disclosure requirements; and
- Minimum funding rules

For the most part, if an RPP contains members employed in more than one province, the province containing the largest number of members will have jurisdiction over the plan³.

Tax rules for DB Registered Pension Plans

The tax rules surrounding Pillar 3 of Canada's retirement savings system are designed, in part, to achieve a degree of "equity" between members of DB plans and those participating in various types of tax-sheltered CAPs.

For DB pension plans, contributions are tax-deductible, subject to certain limits:

- Employer contributions are tax-deductible, as long as they are made based on an actuary's recommendation, to ensure that the plan has sufficient assets to pay benefits under the plan.
- Member contributions are tax-deductible, generally up to the lower of the following:
 - 9% of total compensation; and
 - \$1,000 + 70% of the PA (as defined below)

There is no taxation of investment earnings within the plan, but all benefits are considered taxable income in the year they are received by the member.

Each year, as part of the annual tax reporting, the administrator of a DB RPP must report a Pension Adjustment (PA) to CRA and the plan member, for each individual plan member. The PA reduces the RRSP contribution room created in the following year, in an effort to equalize opportunity for tax-assisted savings across pension plan members and non-members. Under a DB RPP, the PA

³ For workers in certain defined industries (e.g., banking, interprovincial transport, telecommunications), the federal government has oversight over pension plans, rather than the provinces.

calculation is based on the deemed value of the defined benefit accrued in that year, following rules provided in the *Income Tax Act*.

Benefits payable under a DB RPP are also limited by the *Income Tax Act*. Generally, the annual lifetime retirement income payable from a DB RPP, per year of service accrued in the plan, is limited to the lesser of:

- 2% of highest 3-year average earnings; and
- a dollar limit (\$3,025.56 in 2019)

If a member accrues the maximum benefit allowed under a DB RPP in a given year, the maximum DB PA will be generated, leaving only \$600 of new RRSP contribution room in the following year.

It is important to note that the only parties who may legally contribute to an RPP are plan members and their employers, who must pay their employees some form of employment income (i.e., dividend-only income would not be permitted for an RPP participant).

CAPITAL ACCUMULATION PLANS

Capital Accumulation Plans (CAPs) include Defined Contribution (DC) RPPs, Registered Retirement Savings Plans (RRSPs) and Tax-Free Savings Accounts (TFSA)⁴. While these different sub-types differ in terms of the applicable regulatory environment and tax treatment, they are largely similar, in that members and/or employers contribute amounts to individual accounts, and each individual's balance is invested, with the proceeds payable from retirement. In most cases, the investment decisions are made by the individual members, who are provided with a range of investment options.

The contribution structure, defined in advance, can vary (e.g., compulsory or voluntary, flat percentage of pay or varying by age/service, employer partially or fully matching a portion of member contributions, etc.). Details on the various CAP types are given below.

RRSPs

The maximum amount of tax-deductible RRSP contribution room available in a year is 18% of the taxpayer's earned income in the previous calendar year, up to a dollar maximum (\$26,500 in 2019). Each year, CRA determines the maximum dollar amount that each taxpayer can contribute to his/her RRSP. If the individual participates in a registered pension plan, the contribution room is reduced by the pension adjustment calculated for the previous year, as explained above. Unused contribution room is carried forward indefinitely. Contributions to an RRSP are tax-deductible in the year they are

⁴ Capital Accumulation Plans also include Deferred Profit Sharing Plans (DPSPs). However, since these plans would not be available for physicians, we have not considered them further in our analysis.

made or any year thereafter. Investment earnings are not taxed as they accrue. Withdrawals from an RRSP are taxed as retirement income in the year they are made.

Group RRSPs are often set up to cover multiple members. However, such plans are simply a collection of individual RRSPs, offering streamlined operation and lower cost due to scale.

In recent years, legislation has been enacted permitting Pooled Registered Pension Plans (PRPPs). Despite their name, PRPPs are essentially Group RRSPs as described above, and are intended to permit multiple employers to join together to offer a retirement savings plan to their employees at lower costs due to economies of scale. So far, there has been little interest in PRPPs, as the design itself is not new in the marketplace, and the cost savings have not been significant.

DC Registered Pension Plans

In a DC RPP, total contributions from members and employers are subject to the same annual limits as for RRSPs, offset by one year⁵. Just as for RRSPs, investment earnings are not taxed until withdrawal, and all withdrawals are taxed in the year they are made.

As explained above for DB RPPs, the administrator of a DC RPP must report a Pension Adjustment (PA) to CRA and the member each year. In a DC RPP, a member's PA represents the total contributions (member + employer) made to the member's DC account in a given tax year, and reduces the new RRSP room that would otherwise be made available the following year. If the DC RPP contributions were made to the maximum allowed level, no additional RRSP room would be created for the member in the following year.

Through the PA mechanism, the government creates a level playing field for the retirement income tax assistance available for members of DC RPPs and those who save through RRSPs.

As noted above, the only parties who may contribute to an RPP are plan members and their employers. Pension legislation (provincial or federal, as appropriate), as noted above, also applies to DC RPPs.

DC RPPs do not offer any broad advantages over RRSPs for Canadian physicians, as they are virtually identical in structure and tax treatment. There are, however, some minor differences, which could be significant for certain individuals:

- One advantage offered by a DC RPP, compared to an RRSP, is that during certain periods of leave (such as disability) during which a member is receiving no income, a DC RPP can still

⁵ Contributions are limited to 18% of the current year's earnings (vs. the prior year's earnings, for RRSPs), and the dollar limit differs by one year (e.g. the dollar limit for DC RPP contributions for 2019 is \$27,230, which will become the 2020 dollar limit for RRSP contributions).

receive contributions based on deemed earnings (whereas RRSP room is based on “earned income”, which does not include deemed earnings for periods of temporary absence).

- DC RPPs include some protection of spousal rights to benefits in case of death, which are not a feature of RRSPs.
- In addition, DC RPPs may offer more protection from creditors than RRSPs, depending on the circumstances.

Tax-Free Savings Accounts (TFSAs)

In a TFSA, contributions are not tax-deductible, so contributions are made with after-tax dollars. However, investment earnings are not taxed, nor are withdrawals. Like RRSPs, new TFSA contribution room is created each year (beginning in 2009), with the 2019 limit being \$6,000. Contribution room is not related to earned income or employment income, and no employer relationship need exist. There is unlimited carry-forward of unused contribution room, and when amounts are withdrawn in a year, the same dollar amount is added to the contribution room for the following year.

Non-registered savings

The *Income Tax Act* limits the amount of tax-assisted savings available to Canadians through RPPs, RRSPs, and TFSAs. Savings outside of these vehicles would be on a non-registered basis. Contributions to such savings are not tax-deductible, and investment income would be taxable in various ways, depending on the nature of the investment (e.g. interest income, capital gains, etc.). Having paid tax through the life of these investments, there is no additional tax on any withdrawal from them.

ADVANTAGES AND DISADVANTAGES

Neither of the above categories (DB vs. CAP) is inherently more or less expensive than the other, which depends more on the design of the specific plans. The most important differences between the categories are with respect to certainty of the costs and benefits, and how significant risks are handled.

DB plans and CAPs are subject to many of the same inherent risks, such as interest rate risk, equity market risk, inflation risk, and longevity risk (the risk of living longer than expected). Most plans are invested with some degree of risk, in order to increase the chance of achieving reasonable investment returns. Because of this, the future investment experience of a plan’s assets cannot be predicted with certainty. In addition, when providing for income during retirement, it would be helpful to know how long a person is expected to live; of course, this cannot be predicted for any one person with any certainty.

DB plans

DB plans have the highest certainty of a particular benefit being provided. As recent events have shown (e.g., Nortel, Sears), these plans are not completely risk-free for members, but in the overwhelming majority of cases, DB plans deliver the promised benefits. This high degree of benefit predictability comes with increased cost uncertainty and volatility. In particular, if experience is worse than assumed (e.g., low investment returns, greater longevity), any resulting deficit may need to be funded, depending on the rules in the applicable jurisdiction. This cost is most typically paid by the employer. On the other hand, if experience is better than assumed, this could result in surplus, which can be used in various ways.

Setting aside the relatively small risk to members mentioned above, it is fair to say that the risks in a typical DB pension plan are borne by the employer.

DB plans (with the exception of IPPs, discussed below) are group plans, with a sponsor (or group of sponsors) holding ultimate responsibility for funding. Because investment risk is pooled and borne over time, DB sponsors are typically willing to take more risk than most CAP members, in order to reduce costs (since greater risk should be expected to result in greater returns over the long term). Also, due to their greater size, DB plans often have access to more asset classes and better investment advice than individual investors, as well as lower investment fees. In addition, the pooling of longevity risk across a group of members better distributes retirement income.

For these reasons, numerous studies have shown that in many cases, for a given level of contributions, DB plans provide a greater average retirement income than would be expected from a CAP (i.e., DB plans are a more efficient retirement savings vehicle).

CAPs

In capital accumulation plans, cost levels are defined in advance by the parties providing the funding (which, depending on the specifics of the design, could be members, employers, or a combination), but the eventual benefit cannot be predicted. In such plans, all risks (particularly investment and longevity risk) are borne by individual members. The upside of this risk may be attractive (e.g., a member may benefit from superior investment returns), but the downside risk can be substantial.

For example, if an individual's investment returns are extremely poor in a given year (or for a few years in a row), this would have a direct impact on the amount of retirement income that the CAP could provide for that individual. Without pooling the investment risk across groups of members, or across time periods, it is generally difficult for an individual to bear this risk alone.

Ideally, retirement income will last throughout an individual's remaining lifetime. However, since this is inherently unpredictable, CAP members can only use guesswork to decide how quickly to draw down their retirement savings. Members who live longer than expected may run out of money. On the other hand, if a member is very conservative in drawing down his/her savings during retirement in order to

protect against long life, there is a risk that an earlier death will result in significant funds being left to the member's beneficiaries, rather than used for the member's own benefit during retirement.

OTHER OPTIONS

While most discussions of pension plans focus on the two basic types described above, there are a number of other options that are either currently available, or at least theoretically possible. These designs combine the features of DB and CAP approaches, typically resulting in less benefit certainty than a typical DB, but with some of the beneficial risk pooling features that CAPs lack.

DB-DC hybrids

A typical hybrid plan has two separate DB and DC components, both of which are relatively modest. The eventual benefit is simply the sum of the two, with a defined lifetime pension benefit payable from the DB component, plus a lump-sum balance accumulated in the DC component. This design brings all of the advantages and disadvantages of the DB and DC models, although each is reduced.

Adjustable benefit plans

There are a number of plan designs in which benefits are defined by a formula (as in traditional DB plans), but without the high level of guarantees associated with traditional DB plans. This type of plan, which must also be registered under pension legislation and the *Income Tax Act*, can take various forms, depending on the legislative jurisdiction, the governance structure, and the goals of the stakeholders.

For instance, some of the largest DB plans (e.g. Ontario Teachers', HOOPP) use contingent benefits to manage cost volatility, while still providing predictable defined benefits to members. In such plans, the primary lifetime retirement benefit is guaranteed, but certain ancillary benefits (most typically, indexation) are only provided when the plan's financial status is sufficient, as defined by the plan terms.

Other plans, such as Multi-Employer Pension Plans (MEPPs), define both benefit and contribution levels in advance. However, if current contributions and investment earnings are deemed to be insufficient to provide the benefits, one or both of the benefits or contributions can be adjusted. These plans are typically governed jointly by participating employers and member representatives, although some are set up by unions. In plans such as these, it is important that the roles and responsibilities of all parties (employers, members, unions, trustees, etc.) be fully clarified, so that all involved understand the risks when adverse experience (e.g., poor investment returns) occurs, and the consequences.

A number of Canadian jurisdictions have recently put in place, or are in the process of considering, provisions for various forms of Target Benefit Plans. Such plans vary in their details across jurisdictions, but generally allow benefits to be adjusted (particularly, to be reduced if necessary), possibly with the criteria for such adjustments to be defined in advance.

Individual Pension Plans (IPPs)

Canadian tax legislation makes special provision for IPPs, which are a particular type of DB pension plan providing benefits for business owners and incorporated professionals. While an IPP is, strictly speaking, a DB plan, it is often used as a type of CAP plan in order to provide greater tax-advantaged contribution room than an RRSP. It is worth noting that, being an individual plan, an IPP does not provide the pooling of investment and longevity risks obtained from a large scale DB plan.

IMPLICATIONS FOR HIGH EARNERS

The limits on tax-assisted savings have important implications for Canadians who have above-average earnings levels. Even with the maximum 18% contribution to an RRSP or DC RPP in 2019, or with the most generous DB formula permitted (2% of earnings per year of service), the dollar limits on these plans (as shown above) would be reached at incomes of around \$150,000. As shown in Section 2, many physicians make much more than that amount. Furthermore, no contributions or benefits can be paid with respect to dividends, which may be a serious concern for incorporated physicians who prefer distributing dividends to themselves rather than paying salaries.

For these reasons, it would not be possible for many physicians to use the tax-assisted retirement system alone in order to replace a reasonable proportion of their pre-retirement income during retirement. In order to reach their income replacement goals, these physicians will likely need to supplement any tax-assisted savings with substantial additional personal, non-registered savings.

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OPTIONS FOR CANADIAN PHYSICIANS

Based on the current Canadian legislative environment, and the specific characteristics of most physicians' situations, we have assessed the available options for enhancing physicians' retirement savings. In evaluating available options, we have considered the two primary methods of achieving greater retirement income security: greater certainty of benefits, and greater level of benefits.

In this section, we have considered the plans that are currently available in Canada. In addition, we have identified options that could be feasible, with some industry innovation and/or reasonable changes to the current legislation.

First, it bears repeating that, since most Canadian pension legislation is geared toward employment-based plans, and most physicians are self-employed or incorporated, the applicability and/or effectiveness of most pension plan solutions are limited. Please note that we do not think it is reasonable to expect that the requirement in the current system that pension plans be offered through employers and employment income will be changed, as this assumption is so pervasive in the system; therefore, we have assumed this requirement will remain in place.

TRADITIONAL DB PLANS

Traditional DB plans are offered by employers, and provide benefits to multiple employees. However, as explained above, given the employment structure of the majority of Canadian physicians, these plans are not likely candidates for this population.

CAPs

Currently, the majority of Canadian physicians are saving for retirement using CAPs. We do not believe that CAPs, as currently structured, can offer much to physicians to achieve their goals, compared to what they already have access to.

By their nature, CAPs offer very little certainty of their eventual benefit level. It is possible to increase benefit certainty in a CAP by taking less investment risk, both before and after retirement, but this invariably brings with it decreased expected returns, with the result being greater certainty of a lower benefit.

The proceeds of a CAP can be used, on retirement, to purchase an annuity from an insurance company, which would pay out guaranteed lifetime benefits in the form chosen by the individual. While this option provides a high degree of certainty (for a given purchase price), the high cost of such purchases would be expected to result in a lower lifetime benefit.

Physicians already have the ability to contribute to RRSPs, like all Canadians. Given their typical level of income, we would assume that most physicians are likely using all of their available RRSP room, and there is no way to significantly improve this method of retirement savings.

We understand that, for some physicians in some areas of Canada, provincial governments contribute a percentage of each physician's earnings to a group RRSP. While this arrangement could conceivably be expanded to other areas of Canada, we would expect that the provinces would not be willing to add such contributions without a commensurate decrease in other forms of earnings, resulting in no net benefit to physicians.

While there are technical differences between RRSPs and DC RPPs, they are very similar in terms of cost, benefit, risks, and tax-effectiveness. Therefore, we do not believe DC RPPs offer any particular advantages that need to be explored further.

In short, assuming physicians are already making maximal use of RRSP and TFSA contribution room, we do not believe that other CAP solutions exist in the current legislative environment that could improve on these, as these would not add to the level of benefits that physicians already have access to. However, we do have some ideas of ways that CAPs could be improved, to provide for somewhat greater benefit levels and greater degrees of certainty, as explained below.

Longevity pooling during CAP decumulation

As discussed above, one of the biggest problems with CAPs is that members are exposed to individual longevity risk during the decumulation phase (i.e., while drawing retirement income).

In theory, it should be possible for a group of CAP members to pool their longevity in some way, to reduce this risk. This concept could take a number of forms, but we will describe one such form in more detail below.

Physicians who choose to participate in the pooled program could allocate some portion of their retirement assets to it (i.e., they would not necessarily have to commit all of their assets to the longevity pool). Each year, the assets related to pool members who died during that year would be re-allocated to the surviving pool members. The specifics of such re-allocation would need to be designed carefully, based on actuarial probabilities and each participant's proportion of the total assets in the pool, in order to be fair to all involved parties (e.g., impact of survivor benefits, if any).

Currently, we are not aware that such longevity pooling exists, and understand it may not be permitted under current rules. However, as governments wrestle with ways to improve retirement security for a growing population of CAP members, such options will likely be explored and legislation may be adjusted to accommodate them.

Other types of support during CAP decumulation

Financial institutions supporting CAPs (e.g. banks, insurance companies) have developed sophisticated tools to help members during the accumulation phase (i.e., while asset balances are being built up). However, we have not yet seen the same level of innovation applied to support during the decumulation phase (while the assets are being drawn down during retirement).

For example, many CAPs offer target-date funds or life-cycle funds, which automatically adjust their relative risk exposure over time depending on a member's age. We believe that such auto-adjusting funds could be developed specifically for members who are in retirement, to vary the amount of investment risk taken across a range of older ages.

It may also be beneficial to CAP members to have access to more favourable pricing to convert their CAP balances into lifetime income through the purchase of an annuity from an insurance company, either at retirement, or at a later date (e.g., age 75) with the remaining CAP balance.

We note that these ideas are not specifically beneficial just for Canadian physicians, but would likely be of benefit to CAP members in general. However, due to the expected size of their savings, physicians are well positioned to negotiate favourable decumulation solutions, including annuity purchase pricing on a group basis.

INDIVIDUAL PENSION PLANS (IPPs)

An IPP is a DB plan set up for a single member, through that person's employer. For the most part, IPPs are used by owners of incorporated companies and incorporated professionals, who have high levels of earnings. The primary use of an IPP is to provide greater tax-assisted savings than is possible through CAPs such as RRSPs and DC RPPs.

An IPP is typically set up to provide the maximum DB benefit permitted under the *Income Tax Act* for such plans (i.e., 2% of indexed career average earnings, times years of service). However, upon retirement, the plan member can choose between:

- The lifetime pension described above, or
- The value of the pension as a lump-sum

Regardless of which of the two options is chosen, IPPs offer the chance of generating greater retirement income than can be done under an RRSP. For this reason, contributions to an IPP are greatly limited under the *Income Tax Act*, but the advantage of an IPP still persists in most cases.

As has been noted for other options presented in this paper, IPPs would not be available to self-employed physicians, but only to those who are incorporated. While it appears that IPPs may be a good option for many physicians, we understand that very few have such a plan.

Group Individual Pension Plan

One major impediment to Canadian physicians adopting IPPs more broadly may be the relatively high administrative costs (both for initial set-up and on an ongoing basis).

We think it may be worthwhile to explore the feasibility of a “group” IPP. Under this approach, a central agency (e.g. an insurer or bank) could offer IPP services on a one-stop-shopping basis (set-up, investments, annual government filings, administration, periodic actuarial valuations, and even help for the decumulation though favourable group annuity pricing as mentioned above for CAPs) to physicians. The design options could be very limited to allow for lower fees through standardization (e.g., choice between three different pre-set designs), and all such participating IPPs would use the same service provider(s) for the required services. The participating IPPs would not pool their risks (e.g., investment, longevity), but would stand alone as individual IPPs. However, it is possible that reduced fees and streamlined operations could be possible through such a grouping.

This concept would require further exploration, to determine if significant savings could actually be achieved, and if so, what agency would be best positioned to offer it.

ADJUSTABLE BENEFIT PLANS

The greatest degree of benefit certainty is provided through DB plans. However, in the current Canadian system, with very limited exceptions, most or all of the ultimate funding responsibility for these plans needs to be taken by employers, making them difficult to implement for Canadian physicians.

Those physicians who are incorporated are both employees and employers; in theory, a single, broad-based pension plan for incorporated physicians could be set up as an adjustable benefit plan, such as a Multi-Employer Pension Plan (MEPP), Jointly Sponsored Pension Plan (JSPP), or Target Benefit Plan (TBP). This type of design brings together some of the advantages of a DB plan (greater benefit predictability, albeit with lower guarantees; risk pooling across members and across time) and those of CAPs (particularly cost certainty).

This type of plan can form a good compromise between the traditional DB and CAP extremes, and has some potential to work for Canada’s physicians. However, we have identified a number of challenges to the successful implementation of such a plan, as detailed below. These challenges do not necessarily mean that this option will not work for physicians, but they should be considered carefully.

Regulatory challenges

As mentioned earlier in this report, adjustable benefit plans can take many forms, and various rules apply in different provincial jurisdictions. For example, until the recent Ontario budget, MEPPs in that province were only permitted for unionized workforces. The Ontario budget has removed this restriction, although the relevant regulations have not yet been published, so many details still

remain unknown. It will be very challenging to design and implement such a plan for physicians that will work within the rules as currently set out.

In all likelihood, incorporated physicians would be the sole contributors to the plan, through their personal corporations). CMA would not be permitted to contribute directly to the plan, since there is no employer/employee relationship with CMA. Self-employed (non-incorporated) physicians would not be eligible to participate, for the same reason.

Administration

The ongoing administration of an adjustable benefit plan for Canadian physicians poses significant challenges. Even if this plan only covered the majority of incorporated physicians in the two largest provinces (more than 60% of physicians are in Ontario and Quebec), such a plan would have approximately 35,000 participating employers. The plan would need to work with each of these employers to verify eligibility and register participants, exchange data, collect contributions (including dealing with cases of delinquent contributions), communicate with participants, and administer benefit payments.

It may be useful to consider, as a relevant comparison, the Ontario Teachers' Pension Plan (OTPP), which provides defined benefits to over 300,000 active and retired teachers in Ontario. This plan is jointly sponsored by employers and members (represented by the government of Ontario and the Ontario Teachers' Federation, respectively). These sponsors appoint independent Board members to oversee the governance and administration of the plan. The OTPP is a large, sophisticated, well-run pension plan, which exchanges information with, and collects contributions from, 170 separate employers (mostly school boards).

Another comparator plan is the Healthcare of Ontario Pension Plan (HOOPP), which provides defined benefits to about 350,000 active and retired healthcare workers in Ontario. Like the OTPP (with various differences), HOOPP is jointly sponsored and governed. HOOPP interacts with more than 570 employers.

It can be seen that a Canadian physicians' pension plan would involve over 50 to 200 times as many employers as in these examples (with "employers" being, in most cases, the physicians themselves), while serving fewer members. The administrative complexity and cost of this structure would likely prove to be significant, both for the plan and the individual employers.

It may be possible to establish a streamlined system to assist with plan administration tasks. Such a system would need to be simple for physicians (or their staff) to use, but its use would be required for participation. Costs could be spread over the potentially large group of participating employers (physicians' personal corporations).

Governance

In a traditional DB plan, the employer is usually the plan sponsor and administrator, and has ultimate responsibility for choosing the plan design, setting the investment policy, operating the plan properly, and ensuring that plan funds are sufficient to meet benefit promises. In a CAP, virtually all of the responsibilities fall on the individual plan member.

In an adjustable benefit plan, these roles are typically handled differently. In the case of a broad-based MEPP/JSPP for Canadian physicians, who would serve on such a Board, and how would those members be selected? What sort of actions would be taken in periods of adverse experience (e.g., poor investment returns, increasing longevity), and who would decide? How will this Board communicate effectively with all participants?

Equity

Every DB plan operates with a certain amount of cross-subsidization between various groups of employees (male vs. female, old vs. young, past contributors vs. current contributors vs. future contributors, etc.), which is a natural consequence of risk pooling. While all plan members in a typical adjustable benefit plan pay the same contribution rate, the actual value of the benefit accruing in a year will vary widely between members. For example, for a young member, his/her contributions would exceed the value of his benefit for that year, while an older member's value would far exceed his/her own contributions. In this way, young members subsidize older members' pensions; in theory, eventually younger members become older members, and receive a similar benefit.

In a typical adjustable benefit plan, each employer has a range of employees with different characteristics (age, gender, etc.), but there is typically a high level of homogeneity between employers on average. In the case of Canadian physicians, each employer would likely only have one employee, so employers' "true" costs would vary substantially, while their cash costs would not. It is possible that this could result in conflict and/or even litigation among plan participants.

For related reasons, a plan for Canadian physicians would be much more effective if participation were mandatory. In the absence of mandatory participation, it is possible that certain groups would have a higher participation rate than others, which could have a significant impact on the plan cost. For example, if younger physicians chose not to participate (possibly for reasons like that described above), and the plan contained mostly older physicians, the plan could become dramatically more expensive. This could lead to a vicious cycle, with the average age of plan members getting older and older over time, and costs rising accordingly.

Equity between active and retired participants can also be difficult to achieve. Active participants would contribute to the plan (through their personal corporations), including making contributions to fund any deficits. Retired members would not be able to contribute, although some portion of plan deficits could reasonably be attributed to their portion of the plan. This type of intergenerational

inequity can be difficult to manage, depending on the attitudes and cultural preferences of the covered workforce.

The challenges we have raised are not necessarily insurmountable, but we believe they should be carefully considered before any commitment might be made to any particular course of action. Further additional research could be performed, depending on the parties' level of interest. In the course of such research, it is possible (even likely) that other challenges will be identified.

SUMMARY

The chart below summarizes the options presented above.

	CAP DECUMULATION SUPPORT	GROUP IPP	ADJUSTABLE BENEFIT PLAN
Improvement relative to status quo	<ul style="list-style-type: none"> Increased benefit certainty through longevity pooling and/or more favourable pricing for annuity purchase Risk reduction through more appropriate targeted fund line-up Greater level of income through lower fees 	<ul style="list-style-type: none"> Lower costs and product simplification may increase interest among physicians Greater level of retirement income than can be achieved through CAPs 	<ul style="list-style-type: none"> Greater benefit certainty (DB-like design, with high degree of risk pooling) Greater level of retirement income than can be achieved through CAPs
Challenges	<ul style="list-style-type: none"> Potential legal impediments to longevity pooling More research needed to determine detailed design options Willingness of providers to develop appropriate products at competitive cost 	<ul style="list-style-type: none"> Further research needed to identify reasons for current low utilization rate, and develop specific solutions Willingness of providers to develop appropriate products at competitive cost 	<ul style="list-style-type: none"> Legislative/regulatory Administration/communication complexity Governance Equity Implementation

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PRELIMINARY CONCLUSIONS

Currently, most Canadian physicians' only options for retirement savings are Capital Accumulation Plans (primarily RRSPs, TFSAs, and non-registered savings), and we understand that some members of the profession are asking CMA for more assistance in improving their retirement income security. The Canadian retirement income system offers many options, but there are particular challenges in implementing these options for physicians:

- The tax advantages offered in the system are limited, and Canadian physicians would likely need to save additional money on a non-registered basis in order to provide themselves with an acceptable level of income replacement during retirement.
- Much of the Canadian retirement income system is built around employer/employee relationships and employment income, which is not naturally well suited to the situation of most physicians. This basic premise, which underlies current pension taxation law, is unlikely to change.

It is important to note that, due to the lack of an employer/employee relationship, CMA would not be permitted to contribute directly to funding a pension plan for physicians. Therefore, in every option presented herein, all funding would come from the physicians themselves.

In this report, we have focused on ways to work within this system, with consideration of potential industry innovations or changes to the legislative environment, to identify solutions for Canadian physicians, as follows:

- For physicians who are incorporated, an employer/employee relationship does exist, which could theoretically be used to establish a broad-based multiple-employer adjustable benefit plan. Such a plan would provide greater benefit certainty than can be achieved through CAPs, with a low degree of cost volatility. However, we have identified a number of significant challenges that would need to be addressed for the successful implementation of any such plan, due to the large number of participating employers.
- Greater support during CAP decumulation, including longevity pooling; and
- Streamlined group Individual Pension Plans.

Depending on CMA's interest in these options, further analysis can be performed to identify and clarify the risks and benefits.

We would be pleased to discuss this report, and our analysis, with you at your convenience.



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July 19, 2019

Date



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