



# BENEFIT *Advisor*

## In This Issue

*In this third issue of the McGrawWentworth Benefit Advisor for 2006, we will revisit Consumer Driven Health Plans. Several years ago, these plans were touted as the “silver bullet” to solve the problem of rising health care costs. However, only a few employers have jumped on the CDHP bandwagon.*

*This Advisor discusses the current state of the nation when it comes to Consumer Driven Health Plans. While many aspects of these plans make sense, many employers are reluctant to embrace them as the strategy for better managing health care costs.*

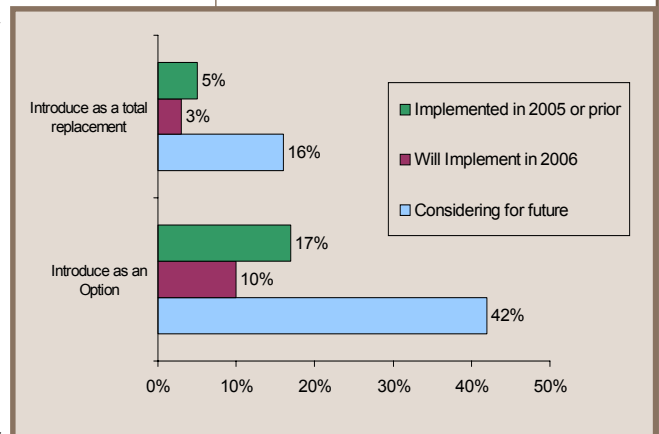
*We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at [www.mcgrawwentworth.com](http://www.mcgrawwentworth.com).*

## “The Latest on Consumer Driven Health Plans”

Consumer Driven Health Plans or CDHPs have been a hot topic in the benefits industry for the last several years. These plans are designed to encourage employees to consider cost when they seek health care. While plan designs vary, the general idea is to offer the employee some money in an “account” to help offset the increased cost of a high deductible health plan. The plans also offer participants tools to help evaluate cost, quality and treatment options in order to become better “consumers” of health care.

Conceptually, these plans should save employers money in several ways. First, and most definable, is the cost savings associated with the plan design changes. Most organizations will see significant savings because of increased deductibles. The amount employers will save will depend on the plan design changes they make. The other areas that should reduce costs are less definable. Organizations hope implementing CDHPs will improve their participants’ buying habits. If participants have to pay more of the cost, they may seek less expensive care. In addition, some participants may decide not to seek unnecessary care. Employers also hope employees will

try to negotiate the best price for services. Finally, the hope is that because employees will have to pay more for health services, they will work to improve their health and make better lifestyle choices.



Although the buzz on CDHPs has been significant, not many companies are offering them, yet. According to the 2006 Towers Perrin Health Care Cost Survey, the chart above shows the number of survey participants who adopted a CDHP or plan to implement a CDHP.

The Towers survey shows many organizations are interested but have yet to implement a CDHP strategy. This Advisor examines CDHPs, including:

- Overview of CDHP plan designs
- Which account - HRA, HSA or neither?
- Communication is key
- Savings potential

Although some organizations have implemented CDHPs, many more are taking a “wait and see” attitude to determine whether these plans will really help reduce health care cost.

### Overview of CDHP Plan Designs

CDHPs are plans designed to increase the participant’s portion of health care costs. These plans have been called many things such as “consumer-directed”, “e-health” and “self-directed.” These plans may differ widely, but all of them are intended to compel employees to use health care services more responsibly.

A critical concern for employers is the rising cost of health care coverage. In many organizations, health care cost has a significant impact on profitability. While employers struggle to manage cost, employees and plan participants are, in many cases, woefully unaware of the true cost of health care benefits. Participants are really not aware of health care cost beyond copays or deductibles. They also do not have a realistic idea of the cost of many health care services (see table below).

Even though health plan cost increases have slowed over the last couple of years, the cost continues to increase well above the inflation rate. The Towers Perrin survey participants expect the average gross cost for each employee’s medical plan options to be \$8,448 in 2006. As a flat dollar amount, these costs are 75% higher than the cost in 2001.

One of the problems employers have when attempting to manage cost, is the attitude of participants. Since most participants don’t pay the full cost of care, they don’t have a realistic view of the true amount. Because the cost is hidden by the health plan, plan participants tend to assume the cost sharing elements of their health plan represent the actual cost of care.

Employers have looked at many options to involve their employees with the rising cost of their health care benefits. Any change requiring employees to pay more for health care could be viewed as consumer-

ism, even if the change is something as simple as increasing the gap between the copays for generic and brand name drugs. If organizations increase the gap between generic and brand name drugs significantly, employees will seek generic treatment options. In other words, if brand name drugs cost significantly more, patients will insist on

generic alternatives. While this option is consumer oriented, it is not a full blown CDHP.

CDHPs typically are designed with a core catastrophic health

plan. The health plan has a high deductible and possibly significant copays for various types of care. The high deductible health plan pays medical expenses only after the individual meets the deductible and any out-of-pocket maximums. It is a safety net for those who need significant medical services. Most plans also offer more comprehensive coverage for well visits to encourage routine preventive care.

Currently, most employer plans offer more complete coverage than catastrophic plans provide. Therefore, many employers choose to offer employees tax-preferred accounts to help pay for certain expenses. Account options include Health Reimbursement Arrangements (HRAs) or Health Savings Accounts (HSAs). The CDHP plan design depends on the type of tax-preferred account the employer offers. The next section discusses account options and their impact on employers and the CDHP plan design.



Employee Estimated Average	Procedure	Average Actual Cost*
\$10,639	Hip Replacement	\$25,000
\$6,145	Birth via C-Section	\$13,500
\$1,058	Day/Night in Hospital	\$3,600
\$476	Ambulance Trip	\$550
\$143	Blood Chemistry Test	\$300
\$153	Blood Pressure Rx (months supply)	\$93**
\$97	Primary Care Visit	\$80

\*Average billed charges for products and services as calculated by Milliman USA.

\*\*Average cost for Pfizer’s Lipitor and Tenormin, a beta-blocker made by AstraZeneca.

Source: Wall Street Journal Online/Harris Interactive Health-Care Poll, Vol. 3, Issue 13, July 19, 2004. Great West Healthcare (2005)

The plan should also provide tools participants can use to help them make the best choices when they seek care. Most people simply choose providers their friends and family members recommend. Few people consider cost. Because these new health plans increase the participants' share of the cost, plan participants will want to choose their providers and medical services more carefully. Unfortunately, most individuals don't ask about cost and most physicians do not publish a list of fees for their services. In fact, most individuals would feel awkward discussing fees with their physicians. With the increased financial responsibility, however, individuals will need to ask about cost, quality and care information to make reasonable decisions about their medical treatments.

Most CDHPs offer the following tools to help plan participants improve their health and become more knowledgeable consumers:

- **Wellness and disease management initiatives.** These programs work with plan participants to improve health and help manage chronic conditions.
- **Cost comparison tools.** In many cases, these tools are incomplete but are getting better. Tools for comparing prescription costs are readily available, but tools for comparing doctor and hospital costs are still incomplete.
- **Quality information.** Health care providers do not always agree on how to measure



quality. The quality tools generally report simple outcome information.

Although every plan offers some tools to help plan participants, many tools are not developed enough to be useful to plan participants. In addition, quality, cost and outcomes data is not readily available. Federal and state governments are pushing physicians to disclose this information to help individuals make better decisions.

### HRA, HSA or Neither?

One of the most attractive aspects of the Consumer Driven Health Plan is the tax-favored account designed to accompany the high deductible

health plan. Today, many health plans require participants to pay a deductible. However, typically, these deductibles are much lower than the deductibles in a high deductible health plan. An employer

trying to help employees pay these substantial deductibles could offer an account to help with initial expenses. These accounts can roll over to encourage employees to use their health care dollars wisely.

The two primary accounts available are:

- Health Reimbursement Arrangements - HRAs
- Health Savings Accounts - HSAs

Both of these account structures are fairly complicated. Each offers different advantages and disadvantages. Your organization should choose the account structure that works best with your consumer driven health plan strategy.

Each of these accounts is explained in detail below. However, employers are not required to offer either of these accounts as part of a consumer driven health plan. In fact, some employers do not find either account arrangement attractive. Instead, these employers choose to launch a consumer driven plan with a lower deductible and allow individuals to establish a medical flexible spending account to set aside pre-tax dollars for medical expenses. These employers do not fund accounts for their plan participants. In this way, they provide benefits only for employees who incur claims under the plan.

### **Health Reimbursement Arrangements**

HRAs were created several years ago by Revenue Ruling 2002-41. The ruling outlined a few basic requirements for these accounts, including:

- Only employers may deposit non-taxable money into an account for an employee; employee contributions are not permitted.
- Employees may use an HRA to pay for non-covered health services with tax-free dollars. The expense must be a Section 213(d) expense and the plan document must consider the expense to be eligible.
- Any unused account values may roll into future years if permitted by the employer.
- HRAs are meant to be paired with a "catastrophic health plan"; however, the ruling does not provide any specific health plan requirements.
- The employer or the health insurance carrier determines whether employees can continue to use funds after

**Continued on Page 4**

they leave the company (most require forfeiture).

These accounts are not really “accounts” but are considered an unfunded employer liability. HRAs are treated just like self-funded medical plans. They are subject to all the regulations and requirements of self-funded medical plans, including:

- ERISA requirements, including requirement to distribute SPDs
- COBRA
- Non-discrimination requirements of Section 105(h)
- FMLA and USERRA requirements

Employers have a great deal of flexibility with HRAs. Employers determine:

- Catastrophic health plan parameters.
- Amount the account will be funded.
- Eligibility provisions for plan participants.
- Rollover provisions for funds remaining in account at year end; options include forfeiture, rollover to the next year or rollover subject to dollar limits.
- HRA covered expenses; the only limitation is the expense must be a Section 213 (d) eligible expense.

HRAs also require claims paid by the account to be substantiated. The plan administrator must verify the funds were used to pay for a qualified medical expense. It is generally believed a plan could include premium payments for health plans as a covered expense of the ac-

count; however, this point is not particularly clear in the Ruling.

A plan cannot permit any payments to be made for any expenses that are not considered Section 213(d) eligible medical expenses. The following transactions are prohibited under an HRA:

- Cash
- Death Benefits
- Non Code 213(d) medical expenses
- Long term care expenses
- Balance transfer to 401(k)
- Valid medical expenses that were deducted in a previous plan year
- Improperly coordinated benefits also covered by FSA



Expenses employees incur after they leave the company are an issue. Initially, these accounts were designed with the thought that if employees managed their care wisely, they could accumulate a significant account balance that could be used to help supplement health care costs while unemployed or retired. However, the Revenue Ruling allows treatment of terminated employees to be handled as a plan design issue. The accounts could remain open to ex-employees or a plan could require them to forfeit their account balances. As a practical matter, most plan designs require all employee account balances to be forfeited when they leave the company. If the organization is subject to COBRA, the plan must extend COBRA rights for the health plan and the HRA.

HRAs are attractive to many employers because they allow a great deal of flexibility. Employers control plan design, eligible expenses, funding levels and rollover provisions. In addition, they do not need to fund these accounts until the employee incurs an eligible claim.

Another appealing aspect of HRAs is their ability to co-exist rather easily with a medical flexible spending account. The HRA guidance does not address FSA coordination directly, so the requirements of Section 125 must be met. Section 125 states an expense is only eligible if it is not reimbursable from any other health plan or benefit arrangement.

Therefore, an employer needs to determine which account pays first. Most organizations with HRAs require the medical flexible spending account to pay first. When employees exhaust their FSA funds, they can use their HRA funds.

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### **Health Savings Accounts**

The Medicare Modernization and Improvement Act created Health Savings Accounts (HSAs). HSAs allow individuals to set aside tax-favored funds in an interest-bearing trust account. Interest accumulates tax-free as well. Account funds used for qualified medical expenses remain tax-favored.

While the general HSA guidelines were outlined in the Medicare Act, the IRS and Department of Treasury have released numerous clarifications on how the accounts operate. HSAs are individually owned, fully funded trust or custodial accounts that may be invested to generate

yield. The following summarizes the key HSA guidelines:

- In order to contribute to an HSA, an individual must be covered by a qualified High Deductible Health Plan (HDHP), with no other comprehensive health coverage (limited opportunities for dual coverage). To be a qualified HDHP, a plan must meet the following requirements:
  - For 2006, a minimum annual deductible of \$1,050 Single/\$2,100 Family (annually indexed, based on "In-Network" plan benefits).
  - Special rules apply if individual deductible is embedded in family deductible.
  - For 2006, the out-of-pocket maximum cannot exceed \$5,250 for self-only and \$10,500 for family coverage.
  - Preventive care is the **only** first dollar benefit allowed.
- Both employees and employers can contribute pre-tax money.
- Contributions may be made through a cafeteria plan.
- Contributions are limited to lesser of:
  - Annual deductible, or
  - For 2006 - \$2,700 individual/\$5,450 family



- For 2006, \$700 of catch-up contributions can be made by individuals 55 or older.
- Accounts may be established either by the individual or as part of the employer health plan.
- Unused balances at year-end roll forward and the individual owns the account so it is fully portable.
- Individuals may use account to pay for non-covered health expenses tax-free.
- Funds can be used to pay non-health care related expenses but these funds become taxable income and are subject to a 10% penalty under certain circumstances.
- If an employer offers to contribute, the employer must provide comparable funding for other employees selecting an HDHP with an HSA
- HSAs cannot coordinate with a traditional medical FSA. FSAs are treated as self-funded medical plans. If an employee has a traditional medical FSA along with an HDHP, the

individual would not be qualified to contribute to an HSA because it would result in dual coverage. An employer-established

FSA limited to covering dental, vision, preventive care and other services once the deductible is satisfied is not considered comprehensive health coverage and would be permitted.

HSAs are complex and the government is still confirming some of the administrative details. HSAs will be attractive to a certain segment of employees. This segment includes high wage earners looking for a tax-deferred savings vehicle, self-employed individuals, partners in a partnership, more than a 2% shareholder in a subchapter S corporation, and anyone looking to start a tax-deferred savings account to pay health care costs during retirement.

The plan design for an HSA compliant HDHP is very restrictive and very different from plans traditionally offered in many organizations. Therefore, most organizations will use HRAs to launch a consumer driven health plan approach. With an HRA, an organization:

- Has significantly more flexibility with plan design.
- Can offer a medical flexible spending account to offset the financial pain of the increased out-of-pocket costs for employees.
- Does not need to fund the accounts until point of claim.

Organizations choosing HSAs:

- Must meet the specifications of the high deductible health plan.
- Cannot offer a comprehensive medical FSA to assist with the added financial burden of a high deductible health plan.
- Must fund the account according to their established funding schedule. Once account is funded, money belongs to employee.

- Must allow the participant to request a disbursement for any reason. An employer cannot limit the covered expenses or permissible disbursements under an HSA.

The account options for assisting plan participants with necessary expenses under a consumer driven health plan are complex. Organizations must consider the impact of using either account to assist participants in meeting the deductible. In some organizations, an employer may offer an employee the choice between plans that are paired with either an HRA or HSA, and allow employees to determine which arrangement best meets their current and future health care needs.

Other organizations are embracing the concept of consumerism but are not necessarily sold on the value of either account. These organizations are adopting wellness and disease management initiatives, launching employee research tools, and increasing employee cost at the point of service. These organizations permit their employees to set aside funds in a medical flexible spending account to offer tax savings on their anticipated out-of-pocket costs.

### Communication is Key

Consumer driven health plans are substantially different from traditional health care plans offered by most employers. In these arrangements, your organization is asking your employees to take greater responsibility for their health care costs and their overall health. Employees are not used to taking responsibility for their health care decisions. In the past, their buying decisions consisted of determining whether their office visit copay

warranted a visit to the doctor. In fact, the low cost of health care probably encouraged doctor visits.

With Consumer Driven Health Plans, your organization will bring your plan participants directly into the middle of the problem of escalating health care costs. Employees will become acutely aware of the cost of services because they will need to pay for them. This approach will compel employees to make better health care purchasing decisions.

The big question is "how?" What steps can employees take to better manage their health and health care purchasing decisions? Com-

munication is very important. Your employees will not be comfortable with accepting more responsibility regarding their health care. Most people do not regularly question their doctors about the necessity of various tests, treatment options and effectiveness as compared to the cost. They avoid asking because they feel they are at an information disadvantage. They tend to think their doctor knows best.

Employees need to understand how to speak with their physicians and research cost information. Review the information tools your health plan vendor offers and look for other resources, especially if the ones available through your vendor are less than adequate. Provide relevant examples on how to use various tools. Teach your employees how to speak with their physicians. Employees will accept your new Consumer Driven Health Plan if they feel comfortable using the plan and using the tools to help

them make informed health care decisions.

Although very few people discuss these issues with their physicians today, attitudes can change. For example, as employers increased employees' share of prescription drug costs, most plan participants began to ask about potential generic alternatives when the doctor prescribed a medication. Health is a very sensitive subject. People with severe conditions will probably be uncomfortable asking about alternative treatments. The more severe the condition, the less likely an individual will be inclined to question a doctor's recommendation.



Increase your employee's comfort level with reviewing cost, quality and necessity of treatment options. Communicate with your employees before you launch a CDHP. The communication should occur throughout the year, not just during open enrollment. However, communication will only take you so far; individuals with serious health conditions are likely to follow their physician's recommendations as their expenses will far exceed their out-of-pocket maximums. Serious health conditions will probably fall outside your employees' comfort zones for making their own health care decisions.

If you launch a plan with an HRA or an HSA, you must clearly communicate the details of these accounts.

In addition, be honest about your reasons for implementing these plans. Some employees in your

workforce will benefit from these arrangements and others will pay more out-of-pocket when they receive services.

### Savings Potential

The savings potential of these plans is hard to gauge. You need to understand how to structure your plan properly. Your organization should be very careful in the following areas:

- **Setting Employee Contributions:** Many employers are offering a CDHP as a plan choice along with more traditional health plan options. In order to encourage participation, they are pricing the plans with little or no employee contribution. This approach has two major considerations:

- If you offer a very low cost option, you may be inviting employees that previously waived coverage to elect the new plan. This increased enrollment will result in increased cost.
- You need to be aware of the impact of enrollment patterns on your overall net cost. Contributions can be viewed as income to your plan. If a sizable number of your low or no claim individuals move to the CDHP, your experience under your other health plan options will not change significantly, yet you have reduced your plan income because many



of your employees elected CDHP and are paying less. This could result in an unexpected increase in net cost.

- **Account Funding:** If your organization chooses to fund an HRA or HSA for any employees electing coverage under a CDHP, you should consider the following in setting your contributions:
  - Your plan's claim distribution is an important consideration. Not all health plan participants use the plan at the same rate. In fact, if you review your plan's claim distribution, you will find a high percentage of employees probably incur less than \$500 in claims a year. If your organization funds an account at \$1,000 when launching a CDHP, you will be giving a sizable part of your population a benefit they were not using under your more comprehensive health plan. If you have a sizable number of participants, you could end up paying more for a consumer driven plan if you do not set your contribution levels reasonably. In addition, if you set employer funding too high, it will be difficult to reduce that funding level in the future because your employees will view the reduction as a benefit cut.
  - Funding an account may change the cost savings

estimates of your CDHP. For example, your organization will estimate the expected savings for launching a CDHP. This estimate will come from actuarial documents that show what savings should occur, for example, if a plan increases a deductible from \$100 to \$1,500. The savings estimate is based upon the actuarial evidence of savings produced by a change of that magnitude. However, if you then offer to offset the increase by funding \$500 in an HRA or HSA, you have changed the differential between your low deductible and higher deductible plan. Funding the account can change the cost savings estimates that are made for your underlying health plan.

- **Estimating Effects of Consumerism:** Most employers expect a CDHP plan to reduce costs because their plan participants will make better purchase decisions. Participants will have a strong financial incentive to make better health care decisions. The impact of these behavior changes is commonly called "consumerism." Consumerism savings can come from a number of behavioral changes, including:
  - Seeking generic prescriptions whenever they are available.
  - Negotiating a lower price from a health care provider.
  - Researching quality and cost data to choose the

most effective provider for your health care needs.

- Using your health care plan only when necessary and for preventive services.

Be wary of suggestions that consumerism will have a substantial impact. Estimating the impact of behavior changes is difficult at best and many factors can influence an individual's willingness to change behavior.

Unfortunately, we still do not have independent actuary support that these plans are a long-term strategy that will help better manage health care cost. Actuaries need a large enough sample size and enough claim data to support their conclusions. This type of analysis is still several years away.

Many health plan vendors offering CDHPs have their own studies to support the effectiveness of these plans. Deloitte recently released their "2005 Consumer-Driven Health Care Survey." This is the third year Deloitte has conducted the survey. Of the 316 participants:

- 77% thought CDHPs would change employee purchase patterns; only 7% disagreed
- 56% thought CDHPs would result in immediate employer cost savings, interestingly 27% of respondents did not think these plans would result in immediate employer cost savings
- 43% felt CDHPs would reduce long-term health care cost trends, 24% thought they would not. Interestingly, early adopters (companies that have a CDHP in place for over a year) were more likely

to think CDHPs would reduce long-term health care cost with 65% agreeing.

These plans may decrease costs for many employers. However, these plans are very complex and savings will depend on a number of plan design decisions, including contribution levels, account funding and utilization.

### Conclusion

CDHPs are gaining some momentum, especially among large employers. The cost of providing health care benefits still challenges employers, and rising costs will continue to affect profits. Increasing your employees' share of the costs when they seek health care services is not a bad idea; in many circumstances the increased burden will result in better purchasing decisions.

Reducing drug benefits illustrates how financial incentives can affect treatment choices. When organizations began offering two and three tier copayment strategies, in most cases, employees began to switch to generic drugs. As a result, individuals feel comfortable discussing their prescription costs. However, applying this logic to all health care services may be a leap.

The jury is still out on the effectiveness of CDHPs. The basic components of these plans make sense and involving participants more in the cost of care is not a bad idea. Offering wellness, disease management and tools to help individuals make better health care decisions all should impact claim cost. However, the majority of plan cost is generally driven by a small percentage of individuals with critical or chronic health conditions. It will not be easy to change the care patterns of these individuals because on some level, your organization loses the financial push to change behavior. The very sick are going to meet the out-of-pocket maximum, regardless of how high it is set.

These plans have merit, but how much merit is the question. Be cautious, be cynical, and don't be fooled if someone claims these plans are the answer to all your health care problems. Consider carefully every aspect of your CDHP plan during the set-up phase to make sure you do not inadvertently set your plan up for failure.

If you have any questions regarding Consumer Driven Health Plans, please contact your McGraw Wentworth Account Director. **MW**

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