



BENEFIT *Advisor*

In This Issue

In this second issue of the McGraw Wentworth Benefit Advisor for 2010, we take another look at Consumer Driven Health Plans. The prevalence of these plans has been growing slowly and steadily over the last few years. Economic conditions are forcing many employers to consider these plans as a cost control strategy.

These plans are complex. However, some employers are having success with them.

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 McGraw Wentworth website at www.mcgrawwentworth.com.

“The Latest on Consumer Driven Health Plans”

Consumer driven health plans seem to be here to stay. Just five years ago, consumer driven plans were being touted as the solution to ever-increasing health plan costs. Simply put, consumer driven plans increase the cost to members so that they will consider cost when they seek medical care. Typically, these plans are paired with some type of tax-favored account to help members offset the increased expense. The two predominant accounts typically paired with consumer driven health plans are Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs).

Consumer driven health plans started picking up steam in 2005. They were a dramatic departure from the plans Michigan employers had been offering. The severe economic challenges for many businesses in Michigan and nationally are compelling many employers to consider these plans as a way of controlling costs.

Now that these plans have a foothold in this marketplace, it makes sense to reexamine the following key issues associated with them:

- Health Savings Accounts
- Health Reimbursement Arrangements
- CDHP Results



Some employers are still weighing the advantages and disadvantages of these plans. Many struggle with the idea of passing such high costs on to employees. Others are concerned that their employees may not have enough information to make good decisions about their care. What’s more, employees sometimes have catastrophic, unexpected health challenges and struggle to afford their out-of-pocket responsibilities.

On the other hand, employees enrolled in CDHPs do take a more active role in managing medical care by looking for cost-effective treatments. CDHP enrollees also participate in wellness and disease management programs at a higher rate because they know they will be paying more for care relating to poor lifestyle choices.

- Current Statistics on the Plans
- Overview of the Plans

Current Statistics on the Plans

The percentage of employers offering CDHPs varies depending on the survey. The McGraw Wentworth Mid-Market Group Benefit Survey, for example, shows 19% of employers in Southeast Michigan offer consumer driven health plans. We expect this percentage to increase in 2010. In West Michigan, 33% of employers offer consumer driven health plans.

The Mercer 2008 national survey showed that 20% of large employers (employers with 500 or more employees) offered consumer driven plans. Early reports of Mercer's 2009 survey show 24% of large employers offered them last year.



The percentage of employers offering these plans isn't the only statistic employers find interesting when it comes to consumer driven health plans. The Employee Benefit Research Institute or EBRI recently released a report providing the following insight on tax-favored accounts and employer funding:

- The number of employers contributing to an HRA or HSA has dropped. In 2008, 67% of employers contributed to these accounts. In 2009, only 63% of employers contributed.

- The amount employers contribute to these accounts has changed as well. In 2008, 37% of employers contributed \$1,000 or more to a single coverage account. In 2009, only 32% contributed \$1,000 or more. For family coverage, the percentage of workers receiving \$1,000 or more in employer contributions increased from 59% in 2008 to 73% in 2009.
- Employees with either of these accounts are saving money.

The percentage of employees reporting a rollover of \$1,500 or more increased from 13% in 2006 to 31% in 2009. This good news means more employees will have money

available to pay their deductibles if they need care.

Some survey sources show a third to even half of employers offer consumer driven health plans. Typically, surveys of employers with more than 1,000 employees show a higher percentage of employers offering these plans.

Regardless of the numbers, year over year these plans have grown steadily and over time, more employees are choosing this type of coverage when it is offered with other plans.

Overview of the Plans

Consumer driven health plans are high deductible health plans that provide the information tools employees need to help them decide on quality and cost-effective care. The amount of the deductible is not formalized under the definition of a high deductible plan. Your organization can choose the appropriate amount for your employees. You can increase your deductible from \$100 a person to \$750 a person. Any plan that increases responsibility for paying for care and offers resources to help employees make better care decisions is considered a consumer driven health plan.

Most employers pair their high deductible health plans with tax-favored accounts. These accounts give employees a tax advantage savings account to help offset any possible increased expenses. Relatively few employers offer only a medical flexible spending account as permitted under Section 125 of the Internal Revenue Code. These accounts do offer a tax-favored method for paying medical expenses that insurance carriers do not cover. However, employees using these accounts must predict what their unreimbursed health expenses will be before the beginning of the plan year. These accounts are also subject to the "use it or lose it" rule which requires employees to make their annual elections carefully. Health Savings Accounts and Health Reimbursement Arrangements, on the other hand, offer more favorable tax advantages. Both of these accounts are fairly complex. The next two sections will explain each of these accounts in detail.

NOTABLE THOUGHTS

**YOU CAN'T SEE THE FUTURE THROUGH
A REARVIEW MIRROR.**

PETER LYNCH

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Consumer driven health plans force health plan members to consider the cost of medical services. Studies show when people have to pay more, they seek fewer services. This issue is widely debated in the press; many people have difficulty with the idea of considering cost when they make health care decisions. They feel health services are not like consumer goods and cost should not be a factor. They simply rely on their physician's judgment—very few will question a physician's recommendations. What's more, when insurance carriers are paying most of the bill, patients have no real financial reason to discuss cost.

Consumer driven plans must, therefore, provide usable information and resources on health conditions, the cost of various procedures and provider quality. Health care decisions are complicated and even with good information resources, many people are uncomfortable making these decisions on their own. These plans require employees to be more involved in their care and they offer employees the tools they will need to help them discuss reasonable options with their physicians.

Employer communication is essential with these plans. Organizations can't launch successful consumer driven health plans if they don't keep their employees informed on health care issues. A consumer driven plan won't work if your organization communicates with employees only during open enrollment. Communication can be simple pieces that:

- Remind employees of the information resources available to them and teach them how to use the resources.
- Teach employees how to find less expensive prescription drugs. Remind them to

always look for generics or therapeutic alternatives.

- Provide regular reminders about how the HRA or HSA works.
- Encourage employees to get the preventive exams recommended for their age and gender.

Regular communication is an important step that will help employees accept these plans and manage their care effectively.

Because these plans differ from traditional plans, employers considering them need to calculate potential costs carefully. Often in an attempt to make the plan attractive to employees, employers design plans that fail to meet their own financial goals. For most traditional plans, employers predict cost and then set contributions to meet their overall net cost goals. However, with consumer driven plans, a third element can affect cost and plan selections: whether to encourage enrollment by funding

part of the tax-favored account, the HRA or the HSA. These funds add to plan cost. At the end of the day, employers may end up paying more for employees in the consumer driven plan. Also, employers need to take into account that people selecting consumer driven plans are often healthy and do not use many health care services. If your organization self-funds its benefit plans, you should consider that your high utilizers will probably stay with the most comprehensive health coverage regardless of cost while your low utilizers will try the consumer

driven plan. If you fund an account to pair with the consumer driven plan, for some employees (low utilizers), you may spend more funding an account than you would have paid in claims under a more comprehensive plan option.

Setting up your plan is a very important consideration when you offer employees a consumer driven health plan in a choice environment. It becomes less of an issue when the consumer driven health plan is the only option. However, offering just a consumer driven plan is a very aggressive approach and not many employers are embracing it.

Health Savings Accounts

Health Savings Accounts are tax-favored, individually owned trust accounts. Anyone can contribute to these accounts. Employees can use



an HSA to pay unreimbursed medical expenses or to save for future medical expenses. Funds are tax-favored when they are contributed and when they

are used for qualified medical expenses. Funds can be withdrawn for any reason, but if they are not used for qualified medical expenses, they are taxable and in most cases subject to a 10% excise penalty as well.

These highly regulated accounts must meet many requirements including the following:

- The account holder must have a qualified high deductible health plan. The IRS sets the parameters for the high deductible plan and they are indexed annually. For 2010, the parameters for the high deductible health plan are:
 - Single deductible: \$1,200
 - Family deductible: \$2,400
 - Single maximum out-of-pocket limit: \$5,950
 - Family maximum out-of-pocket limit: \$11,900
- The deductible applies to all expenses the plan covers including office visits and prescription drug costs. The plan may, however, cover preventive care services before the deductible limit is reached. These services include annual physicals, mammograms, well-child care, preventive prescription drugs, and so on.
- Fourth quarter carryover deductibles can affect the maximum HSA contribution allowed; therefore, most plans do not allow fourth quarter carryover deductible credits.
- To receive tax-favored contributions to the HSA, account holders must file taxes using the 1040 Form and not the E-Z Form.

Account holders with high deductible health plans and no other comprehensive medical coverage are eligible to contribute to HSAs under the following rules:

- Individuals covered by any part of Medicare cannot contribute to an HSA. Anyone receiving Social Security

income benefits is automatically enrolled in Part A of Medicare.

- Account holders or their spouses cannot set aside funds in a comprehensive medical FSA and still contribute to an HSA because medical flexible spending accounts under Section 125 are considered comprehensive health coverage. In fact, if your medical FSA includes a grace period, your employees may not be able to contribute to an HSA during that period. For more details on this situation, please read our third *Special Alert* in 2007 at: http://mcgrawwentworth.com/Special_Alert.html.



Some account holders have family coverage. In those cases, the spouse and children can have other comprehensive coverage; that coverage, however, does not affect the account holder's family contribution to the HSA. The dual coverage restriction applies solely to account holders, not to their dependents.

- The IRS sets annual contribution limits to HSAs. The limit for 2010 is \$3,050 a year for single coverage and \$6,150 a year for family coverage. These limits assume the employee is covered for the entire year. If the employee is covered for only part of a year, the limit is prorated for the appropriate number of months. Anyone covered by a qualified high deductible health plan as of the

first of month is eligible to contribute to the HSA for that month. In some situations people covered for only part of the year can still set aside the full annual election. For more details on these situations, please read our fifth *Special Alert* in 2008 at http://mcgrawwentworth.com/Special_Alert.html.

- Employers may contribute to an employee's HSA. Overall, employers contributing to one employee's HSA must contribute a comparable amount to all employees' HSAs. That is the simple concept, but there are a number of

reasons why employers can vary the amounts they contribute. The IRS does say, for example, that if employers allow employees to contribute to HSAs through a Section 125 plan, the comparable coverage rules do not apply. However, the employer must be able to pass the Section 125 non-discrimination test to show the contributions are not discriminatory.

Employers do not have a lot of control over HSAs. Most employers have contracts with vendors to provide HSAs to employees and allow their employees to contribute to the HSA through the employers' Section 125 plan. Employers don't get to determine the expenses the HSA will

cover. The government determines the types of expenses that can be considered tax-favored. These expenses include:

- Section 213(d) qualified medical expenses.
- Premiums for health insurance when the person is not employed, including COBRA premiums.
- Over age 65, the following are tax-favored:
 - Medicare premiums (Part A, B or D).
 - Medicare Advantage plan premiums.
 - Retiree contributions for employer-sponsored retiree health plans.

These are not qualified if you became eligible for Medicare before age 65.

Medigap plan premiums are not tax-favored.

HSA vendors sometimes offer debit cards along with HSAs so accountholders can access funds immediately. Vendors do not track expenditures to determine if the funds are used for tax-favored expenses. Employees, not vendors, are responsible for proving their HSA funds were spent for qualified medical expenses if the IRS decides to audit them.

High deductible health plans must meet IRS requirements. Employers can't control how the HSA funds are spent. HSAs are not considered an ERISA health benefit plan, even if an employer contributes to the account. Since these accounts are not considered group health plans, they are not subject to COBRA or many other federal benefit laws that affect group health plans.

NOTABLE THOUGHTS

THOUGH NO ONE CAN GO BACK AND MAKE A BRAND NEW START, ANYONE CAN START FROM NOW AND MAKE A BRAND NEW ENDING.

CAROL BARD

Although they are complicated, HSAs do offer people a long term, tax-favored saving alternative. Accountholders have an attractive incentive to save for current and future medical expenses.

Health Reimbursement Arrangements

Health Reimbursement Arrangements (HRAs) are self-funded medical plans. They are much more flexible than HSAs and employers have much more control of these accounts.

HRAs must meet the following requirements:

- Only employers can fund HRAs. The employer commits a certain dollar amount to the HRA and the employee can use those funds for eligible medical expenses.
- Employers have full control over which expenses their HRAs can cover so long as they are Section 213(d) medical expenses. Employers can also cover a subset of Section 213(d) expenses. The plan document must list all covered services.
- Because HRAs are treated like self-funded medical plans, they are subject to all federal laws

affecting group health plans. For example, COBRA, ERISA communication and claim review and Section 105(h) non-discrimination rules apply to HRAs.

- Employers have great flexibility when it comes to HRAs. Some employers require a front-end deductible and the HRA funds become available once the employee meets the deductible. Other employers make the HRA funds available as soon as an employee incurs an eligible expense. Once the HRA funds are exhausted, employees must pay any additional expenses until they meet the deductible.



- Employers can also decide what happens to the funds left in the account at year end. Employers can require unused funds be forfeited at year end, allow year end balances to roll over or put a limit on the amount of funds that can be rolled over. In any case, employers should budget for their potential liabilities as funds roll over to the following year and think carefully about how they

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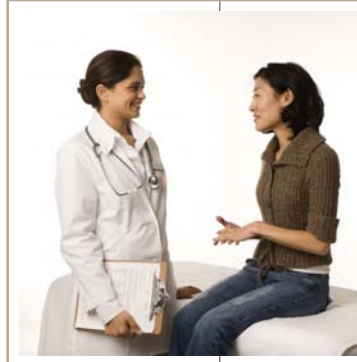
handle rollover funds. If employees must forfeit funds at year end, they may decide to use the money before they lose it. A rollover encourages employees to spend their HRA funds wisely.

- Medical FSAs and HRAs can co-exist. The employer needs to determine which account will pay first and explain the payment order in plan documents. Many employers require the medical FSA to pay first because FSA funds are subject to the “use it or lose it” rule.

Part of the savings with a consumer driven plan comes from substantially increasing the deductible. Actuaries determine savings by assuming some of the cost will shift to the member, but additional savings are calculated because members use fewer services when they have to pay more of the cost. In HRA arrangements, the deductible is high, but plans do not see the change in behavior when if the HRA pays a significant part of the deductible.

Blue Cross Blue Shield of Michigan has noticed on their insured block of business that the high deductible plans paired with HRAs have much higher utilization than high deductible plans that are not paired with HRAs. This year BCBSM has made a change to how they will offer high deductible plans. For their Community Blue products, they offer two high deductible plans. These plans will assume the employer pairs the plan with an HRA account. Blue Cross is introducing two additional Community Blue high deductible plan options that will be available for employers that do not have HRAs. The rates for the plans with the HRA will be 6–8% higher.

Employers need to choose the account that makes most sense. HSAs are currently more popular than HRAs. HSAs require significant plan design changes. All expenses require a substantial deductible, but employees have no office visit copays, no prescription copays, no emergency room copays and so on. On the other hand, these accounts are very complex and may be difficult to understand in some cases. HRAs are a less aggressive step into consumer driven health plans. Employers have more flexibility and the plan design can allow for office visit copays, prescription copays and so on. With Blue Cross Blue Shield applying a rate load on high deductible health plans paired with an HRA, the savings may not be as significant as they may be with an HSA.



3. Employees can make informed choices. By using information resources, employees will be more likely to ask their physicians about treatment options. Employees will also consider the provider's quality ratings.

To develop a statistically valid amount of savings associated with consumer driven health plans, actuaries will need to compile data over many years and with a sizable population. These plans are relatively young and few employees enroll when given the choice.

However, each year more and more employers are offering consumer driven health plans and more and more employees are enrolling in them.

In lieu of an independent actuarial result, health plan vendors are evaluating consumer driven health plans. CIGNA, a national health insurance carrier, released the key findings of its “Choice Fund Experience Study” in December 2009. CIGNA has conducted this study the last four years. The study compares CIGNA's Choice Fund consumer driven health plan participants with members in its traditional HMO and PPO plans.

CDHP Results

One of the reasons employers have been reluctant to adopt consumer driven health plans is that the Academy of Actuaries has not released data on the impact of CDHPs. Savings are expected from the following:

1. The cost shift from the increase in deductible.
2. The change in behavior. With more financial responsibility, employees make different decisions. Employees may choose not to seek care at all or they may seek a less expensive treatment, for example, a generic prescription instead of a brand name prescription.

Some of the key findings of the study are as follows:

- Medical cost trend for consumer driven health plans continues to be less than traditional HMO and PPO plans. In fact, for the first year in a Choice Fund consumer driven health plan, the trend differential was 14% and that continued in subsequent years.
- Choice Fund participants use preventive care services more often. In the first year, preventive care visits increased and in subsequent years the number of preventive care visits was significantly higher than traditional plans.
- Medical cost was 15% to 27% less for CIGNA Choice Fund members with hypertension, joint disease and diabetes.
- Choice Fund participants were more engaged in managing their health. Disease management program participation and completion rates are 22% higher in Choice Fund than traditional HMO and PPO plans.
- Medication compliance improved while pharmacy cost decreased. This means more members complied with their prescription drug treatments but looked for generic alternatives.



The CIGNA study also looked at how often Choice Fund members used their health care programs. Choice Fund members:

- Adopted myCIGNA.com at a rate 34% higher than traditional HMO and PPO participants.
- Were more likely to use CIGNA's online information tools at least once a month.
- Were seven times more likely to complete a Health Risk Assessment.
- Were 22% more likely to participate in and complete a disease management program.

The CIGNA study is one of the more comprehensive vendor studies and has compared Choice Fund participants with traditional HMO and PPO participants over four years. The results show participants in consumer driven health plans are more focused on their health and make more cost-effective purchase decisions.

Other vendor studies tend to mirror the CIGNA results. Some employers hesitate because they are concerned that employees will not just reduce unnecessary care in a consumer driven arrangement, but also reduce necessary care because they cannot afford it. However, employers with consumer driven plans report participants tend to participate more in wellness programs, use generics whenever they can and work on improving their health.

Concluding Thoughts

Consumer driven health plans have grown slowly and steadily over the last five years. According to Mercer in 2008, one fifth of all large employers offered consumer driven plans. These plans are here to stay.

As the economy continues to struggle, these plans are becoming more popular with employers. The potential savings as well as the increased responsibility these plans place on members are appealing. These plans, however, are complicated. Employers need first to explain the concept to employees and then continue to communicate with them if they expect their employees to become more informed purchasers of health care.

If your organization is struggling to manage health plan costs, it makes sense to look at offering a consumer driven health plan.

If you have any questions about consumer driven health plans, please contact your McGraw Wentworth Account Director. **MW**

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