Employee Benefits Report

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Consumer-Driven Plans: Ten Years Later

Consumer-driven health plans (CDHPs) came on the scene about ten years ago to help employers take control of their employee healthcare costs. At first, employers and employees were slow to adopt them, but in the last couple of years, their popularity has grown. What are the different CDHP types and what features do they offer?

What is a "consumer-driven health plan"?

Consumer-driven health plans combine a high-deductible health insurance plan with some form of health savings account. The high deductibles in these insurance plans (a minimum of $1,200 for employee-only coverage in an HSA-qualified plan) force insureds to pay for a greater share of healthcare expenses than under other types of insurance plans. However, plans include a tax-favored savings or spending account that insureds can use to pay at least some of their out-of-pocket expenses.

CDHPs rely on a simple idea: If people spend their own money, they will become more frugal

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This Just In…

Starting September 1, health insurers that want to increase rates for small group or individual policies by an average of 10 percent or more must explain and justify those increases in writing, as required by the Affordable Care Act. Oversight of the private health insurance industry is primarily the responsibility of states. Rate increases will be reviewed by state insurance departments or, in states that lack the infrastructure to do this, by federal reviewers.

The U.S. Government Accountability Office reviewed state health insurance rate review procedures for 2010. Respondents from 38 states reported that all rate filings were reviewed before

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consumers of healthcare. They will think twice before running to a specialist for a minor complaint and compare costs whenever possible. In theory, consumers will take their business to providers who give better care at lower cost. In this way, CDHPs will allow providers, instead of insurers, to set prices for their services and reap the benefits of innovation. And that, proponents argue, will significantly lower healthcare costs.

In reality, however, consumers often lack easy access to the cost and effectiveness data they need to make informed healthcare decisions. When employees have had a choice of health plans, traditionally the employees who opted for CDHPs tended to be more educated and have higher incomes, because these plans require employees to assume more financial risk than other types of plans.

As employers pass along more of their healthcare costs to employees, this could be changing. The Employee Benefit Research Institute (EBRI) recently released a survey that found the income differences between enrollees in CDHPs versus traditional health insurance plans has begun to narrow. In 2006, CDHP enrollees were more likely than traditional plan enrollees to have household income of $150,000 or more, but by 2010 this was no longer the case. In 2010, CDHP enrollees were more likely to have a household income of $50,000 to $100,000, but not more likely to have incomes of $100,000 or more.

Despite the narrowing of income differences, CDHP and high-deductible health plan enrollees have consistently reported higher education levels than traditional plan enrollees. In addition, they consistently have reported better health status and health behaviors (lower rates of smoking and obesity and higher rates of regular exercise) than individuals with traditional coverage.

What does this mean to employers? CDHPs appeal to those who are healthier because they know their out-of-pocket health expenses are unlikely to exceed their account balances. The plans' tax advantages also mean more to higher income individuals. Finally, more educated individuals have greater resources to research and discuss prices with their healthcare providers.

If you offer a CDHP, consider the following actions to help your employees get the most out of their plan:

- Look for a plan that offers first-dollar coverage for preventive care services, and encourage your employees to take advantage of these services. The law permits an HSA-qualified HDHP policy to cover certain preventive care services, such as prenatal care, immunizations and cancer screenings, before insureds meet their deductible. Most plans now offer preventive care service coverage at 100 percent and not subject to the high deductible.
- Implement disease management programs to help your employees control common chronic conditions. This might vary by employee population, but common—and costly—controllable conditions include asthma, high blood pressure and diabetes.
- Consider supplementing your health plan with wellness benefits.
- Offer free health information resources. Many insurers provide online health information or free health counseling services by trained nurses. If your insurer offers these services, make sure employees are aware of them.
- Provide resources that allow employees to compare costs for common services and, when possible, costs for procedures at area hospitals.
- Educate your employees on how their plan works. Most insurers will offer enrollment materials. You can supplement these with information showing the tax advantages of various plans and how account balances can grow (for health savings accounts), as well as the costs involved.

For an overview of various types of CDHPs, please see the chart on Page 4. And for more information on CDHPs and their advantages, please contact us.

the rates took effect, while other respondents reported reviewing at least some rate filings after they went into effect. Some survey respondents also reported conducting comprehensive reviews of rate filings, while others reported reviewing little information or conducting cursory reviews.

Outcomes of states' rate filing reviews varied. Survey respondents from five states reported that more than 50 percent of the rate filings they reviewed were disapproved, withdrawn or resulted in rates lower than originally proposed, while survey respondents from 19 states reported these outcomes occurred less than 10 percent of the time.

Your Changing Fiduciary Responsibilities

Two rules affecting participant-directed individual account plans, such as 401(k)s, originally due to become effective January 1, 2012, have been delayed until April 1, 2012. Following is an overview of these rules.

Nearly 483,000 participant-directed individual account plans, including 401(k)s, cover an estimated 72 million participants and hold almost $3 trillion in assets. These plans allow participants to direct the investment of all or a portion of the assets held in their individual plan accounts, making participants increasingly responsible for making their own retirement savings decisions. This has raised concerns that participants and beneficiaries may not have access to information needed to make informed decisions about their accounts, particularly when it comes to investment choices, fees and expenses.

New Regulations Increase Disclosure

To address some of these concerns, two new rules governing your retirement plans were scheduled to become effective on January 1. However, the U.S. Department of Labor delayed the effective date until April 1 to give plan providers more time to comply. The final rule applies to plan years beginning on or after November 1, 2011 and requires plan administrators to provide initial disclosures to participants no later than 60 days after the plan's applicability date or 60 days after the effective date of the regulation. In other words, for calendar year plans, your initial disclosures will be due no later than May 31, 2012.

The first rule will require retirement plan service providers to provide specific disclosures of their services and related fees and expenses, including compensation, both direct and indirect, to plan sponsors. If your service provider compensation exceeds $1,000, the new rules likely apply and your plan service provider(s) must provide this information. Plan fiduciaries must review this information to ensure that fees are reasonable. Employers should plan to review service provider information at least two months before April 1 to ensure their providers comply with the law and to give them time to take any necessary corrective action.

The second rule requires plan administrators to regularly and periodically make plan participants and beneficiaries aware of their rights and responsibilities with respect to the investment of their account assets. They must also provide sufficient information on the plan and its designated investment alternatives, including plan fees and expenses, to allow participants and beneficiaries to make informed decisions on the management of their accounts.

The Department of Labor estimates costs of compliance at $425 million in 2012 (in 2010 dollars), including legal compliance review, time spent consolidating information for participants, creating and updating websites, and the costs of preparing and distributing annual and quarterly disclosures. However, it also says the regulation will reduce the amount of time participants spend collecting fee and expense information and organizing it in a way that allows them to compare key information. This will save plan participants nearly 54 million hours, valued at nearly $2 billion in 2010.

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Your Fiduciary Responsibilities

Employers have reason to look at their retirement plan fiduciary responsibilities aside from complying with these new rules. A souring economy increases the likelihood that employees dissatisfied by the performance of their retirement investments will sue their plan provider or sponsor for breach of fiduciary liability.

The year 2009 — the year after financial markets collapsed — brought a huge increase in the number of breach of fiduciary duty cases arbitrated by FINRA, the independent regulator of securities firms. Cases arbitrated jumped 48 percent, to 4,206, up from 2,836 in 2008.

What exactly do employers' fiduciary responsibilities consist of when it comes to employee retirement plans?

1. Ensure plan participants have a range of funds to invest in.
2. Monitor fund performance to ensure adequate performance. Many plan sponsors use an outside advisor to regularly analyze fund performance, at least quarterly. To avoid potential conflicts of interest, an advisor should have no financial relationship with the fund provider.
3. Track the performance of your third-party administrator.
4. Track all fund-related expenses, including administrative fees, advisor's fees, broker's commissions or fees, and auditors' fees.
5. Perform due diligence of plan providers to ensure fees and expenses are reasonable.
6. Buy fiduciary liability insurance to protect your firm from liability.

For more information on administering a 401(k) plan, please contact us.

Does Your Sick Pay Plan Need a Checkup?

On January 1, 2012, Connecticut will become the first state to mandate paid sick leave for employees. The law will apply to employers with 50 or more employees in the state. Although other states do not mandate paid sick leave, Connecticut's experiment could prompt other states to follow suit, making this a good time to give your organization's sick pay plan a checkup.

No federal law requires employers to provide paid sick leave. However, failure to do so might be a bad business decision for several reasons. First, many employees regard paid sick time as a "basic" benefit and expect to receive at least some paid sick days, even if their employer doesn't provide paid vacation. Second, failure to provide paid sick days can lead to problems with "presenteeism."

"Presenteeism"—when sick employees come to work—can spread disease, affect productivity and contribute to accidents.

Evidence suggests the recession has worsened the presenteeism problem. In a 2008 poll by NPR, the Kaiser Family Foundation and the Harvard School of Public Health, "…about half the people reported that in at least a number of cases they go to work when they're sick and believe they should stay at home because of the financial issues that are involved," said researcher Robert Blendon, of the Harvard School of Public Health.

Are your paid leave programs working for your firm and its employees? Options include:

Traditional plans. For years, employers have provided workers a set number of paid sick leave and vacation days per year. The amount varies by company and industry, but new employees get an average of 17 or 18 paid days off per year, allocated evenly between sick and vacation days. Professional, long-term employees may accrue 30 or more days off annually.

This type of leave plan is easy to administer. Simply decide how many sick and vacation days to give employees per year, put it in writing—your employee manual is a good place to start—and let everyone know.

This system works well for many companies, but alternatives can give your employees more respect and autonomy, without costing your company considerably more.

Paid time off programs. Some companies combine different types of leave into one unified bank of "paid time off" (PTO) hours. A survey of employers with 100 or more employees found that 42 percent of respondents offered paid time off "banks." Instead of a set number of vacation and sick days per year, these employers provide an equivalent amount of PTO hours for workers to use as they see fit, whether vacation, personal time or illness.

Leave accounts can be more equitable: childless employees won't feel cheated out of parental leave, and those with elderly dependents can use time off to care for them. PTO banks can reduce unscheduled absences by allowing employees to use paid time off, rather than sick leave, to take care of personal business. You can make them more flexible by allowing employees to redeem unused days off for cash or to accumulate unused sick days from year to year, or match it with a short-term disability program.

In constructing your program, consider whether it encourages employees to take leave when needed. Cash-out programs and attendance incentives could send the wrong message about taking time off, which has become increasingly important in today's high-stress work environment. If workers perceive that the employer discourages using leave, employers risk increased presenteeism and encouraging employees to overwork to the point of serious illness.

Examine current policies, leave trends and your firm's management style, and then establish a program that meets your needs. For questions about leave policies that make sense for your employees and your business, please contact us. ■

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Consumer-Driven Health Plans: A Comparison

Type of account	Pretax employee contribution allowed	Employer contribution allowed	Rollover allowed	Investments allowed?	Must the account be linked with a HDHP?	
					Yes/No	Limits for Qualified HDHPs
Health Savings Account (HSA)	Yes	Yes	Yes	Yes. Participants may invest funds in any IRA instrument.	Yes	Min. deductible: Self $1,200, Family $2,400. Max. annual out-of-pocket: Self $5,950, Family $11,900.
Health Reimbursement Arrangement (HRA)	No employee contribution allowed.	Yes	Yes	No. Funds for qualified medical expenses only.	No	
Flexible Spending Account (FSA)	Yes	Yes	No	No. Funds for qualified medical expenses only.	No	Beginning Jan. 1, 2013, contributions to FSAs will be capped at $2,500 per year.

Archer Medical Savings Accounts (MSAs) allowed self-employed individuals and employees of small businesses with qualifying high-deductible health plans to have tax-advantaged savings for medical expenses. The HSA has largely supplanted MSAs and no new accounts can be created; however, Congress grandfathered existing accounts. Employees who hold an MSA can roll their balances into an HSA; please contact us for information.

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