For employers that bear the heaviest burden of steadily rising health care costs, finding solutions to reduce their expenses has been a critical mission. Regulatory changes, coupled with innovative and integrated consumer-driven health care options, have proved a key remedy to their needs. Chief among these options are new hybrid health reimbursement account/health savings account plans.

Innovative, Integrated Approaches in *HSAs* and *HRAs* Yield Optimum Results

by J. Scott Bradley

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Health care represents a $2 trillion industry—17% of the gross domestic product. For many employers that bear health care's heaviest cost burden, adopting innovative, consumer-driven health options is a way to improve the overall health of their employees as well as reduce costs.

In 2000, the first consumer-driven health plans were introduced. *Health reimbursement accounts (HRAs),* allowed under Section 105 of the Internal Revenue Code (IRC), enabled employers to reimburse employees for out-of-pocket medical expenses not covered by insurance. They combined a high-deductible plan with an employer-funded account, were employer owned and were therefore not portable for departing employees. In 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), which paved the way for employers to offer *health savings accounts (HSAs)*—portable medical expense reimbursement accounts linked to qualified, high-deductible health plans and funded with tax-deductible contributions by employees alone or employees and employers. Over the past three years, new hybrid HRA/HSA plans have emerged to give employers and employees even more options.

Understanding the history of consumer-driven health plans (CDHPs), the forces at work driving broader use of these plans and the latest innovations in CDHPs is critical for all professionals whose mission includes protecting their employees' and their company's fiscal health.

Consumer-Driven Health Plans—A Historical Perspective

In the mid-1990s, after the inception of managed care, a disturbing trend in

health care started to emerge. Health care costs began a steady climb at a rate of 10% per year, and it became apparent to governments and businesses alike that vital steps were needed to curtail the upward spiral. Solutions were needed to shift some of the burden of these costs from employers to their employees and to educate employers and employees regarding health care costs and the impact of their decisions on the cost of care.

Bursting on the scene in 2000, CDHPs were the first step toward regaining control of health care costs. On average, annual premiums for CDHPs cost about $800 less per employee than for preferred provider organization (PPO) coverage and $600 less per employee than for health maintenance organization (HMO) coverage.[1]

Since the introduction of HRAs and HSAs, many more coverage options have emerged, including an innovative hybrid HRA/HSA plan that warrants a closer look. Understanding the history behind CDHPs, the new forces at work driving broader use of these plans and the effective new strategies now available to help control health care costs is critical for all individuals charged with serving employees' health care interests, as well as an employer's fiscal health.

It's 2007 and the nation is still experiencing double-digit health premium increases. This trend has forced employers of all sizes to address the inherent issues of a third-party-payer managed care system, which has reduced competition and resulted in rising costs for both the insured and uninsured. Fortunately, over the past several years, major strides have been made enabling employers to deliver successful CDHPs that focus on engaging and empowering employees to consider costs when making health care decisions. Although new, these programs are already making a positive impact on the rate of health care inflation.

HRAs were the first step. They allow employers to reimburse employees for out-of-pocket medical expenses not covered by insurance and are usually combined with high-deductible health plans (HDHPs).

MMA presented the next step by introducing HSAs, often referred to as medical IRAs or medical 401(k)s. Unlike HRAs, HSAs are portable, employee-owned accounts that can be funded by employers, employees or both, as well as by third parties. Both employee and employer contributions are tax-deductible, but neither party can make a contribution to an HSA unless the employee has health coverage with a qualified HDHP. Employer contributions to HSAs and HRAs are not subject to taxes, including income taxes and taxes related to Medicare, the Federal Insurance Contributions Act (FICA) and the Federal Unemployment Tax Act (FUTA).

Both HRAs and HSAs have increased in usage over the past few years. Enrollment in CDHPs of various types will increase to six million by January 2007.[2] It is predicted that in 2007 one-third of all large employers will move to CDHPs,[3] and the number of HSA enrollees will increase to 30 million by the end of 2009.[4]

Pricing trends for HDHPs—to which HRAs and HSAs are linked—vary depending upon the type of plan. Despite their tax-favorable status and favorable pricing trends, HRAs, HSAs and HDHPs are not without their challenges. However, recent legislation removed the remaining obstacles, further expanding the potential for these and other CDHPs to hit their stride.

Legislation Drives More Opportunities

On December 20, 2006, literally in the 11th hour of the 2006 legislative session, President George W. Bush signed into law the Tax Relief and Health Care Act (HR 6111), also referred to as the Health Opportunity Patient Empowerment Act of 2006. This "Hail Mary pass" and the president's signature introduced important changes to HSAs and the associated HDHPs.

In general terms, the law expands annual limits and funding sources for HSAs, in addition to increasing flexibility for employers that elect to fund the accounts. Specifically, the law enables deposits up to the annual contribution limits, regardless of the qualified health plan deductible. Prior to the law's enactment, contributions were limited to the health plan deductible if it was below the annual contribution limit. Now the limits are $2,850 for individual coverage and $5,650 for family coverage. When the Treasury Department releases its HSA limits for 2008, the maximum HSA contribution—not including catch-up contributions—will be $2,900 for individuals and $5,800 for families. These changes will minimize the potential risk that a person will exhaust his or her HSA dollars for the current year before the out-of-pocket expense maximum is reached under the HDHP. Still in force is the requirement that the qualifying HDHP meet the minimum annual deductible (i.e., $1,100/ $2,200 in 2007) and the maximum out-of-pocket requirements (i.e., $5,500/$11,000 in 2007).

Another positive outcome of the legislation is the ability to now make HSA contributions to the full annual limit, even when an individual's health plan coverage is for a partial year plan. This option is of importance to individuals who begin coverage midyear and for whom the full deductible now will still apply. In the past, the contribution was based on a prorated limit tied to the number of months of HSA-qualified coverage. The new law does, however, require that coverage in the qualified HDHP be maintained for a full year beginning in the month the HSA is opened. Failure to do so results in tax and penalties.

Also introduced by the Tax Relief and Health Care Act of 2006 is the one-time option for employers and employees to roll over unused funds from an existing HRA or a flexible spending account (FSA) into an HSA. The one-time transfer is tax-free as long as the money is used for qualified medical expenses and the transfer is made prior to January 1, 2012. The amount of funds that can be transferred is the lesser of the cash balance in the HRA or FSA as of September 1, 2006 or the balance as of the date of distribution. A waiting period is also required, during which an individual must remain covered under the HDHP that starts the month of the transfer and ends on the last day of the following 12th month. A 10% penalty on excess contributions as well as income tax is incurred for those who fail to maintain their HDHP coverage, with an exception for individuals who die or become disabled.

It should be noted that transfers from HRAs and FSAs are recognized as rollover transactions. Therefore the amount transferred is not considered to be part of the covered individual's annual statutory HSA contribution limit, which is an important advantage.

Another important element of the Tax Relief and Health Care Act of 2006 is the elimination of the FSA 2½-month grace period conflict. The former IRS guidelines

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(Notice 2005-86) enabled an employer to provide that FSA funds be available for reimbursement during an additional 2½-month grace period. An unfortunate consequence of this was that employees who used all of their FSA funds prior to the grace period were treated as having disqualifying coverage and prevented from making HSA contributions during the 2½-month grace period. Even if employers wanted to do away with the 2½-month grace period requirement, they were prohibited from doing so. The new law eliminates this disqualification for employees without FSA balances.

Also introduced by the legislation is an earlier cost-of-living adjustment for HSA limits. The law amended Code Section 223 and now requires that indexing of applicable limits be completed by June 1, 2008 rather than later in the year, as was previously the case. Employers and insurance carriers benefit from more time to develop communications materials that include accurate contribution amounts for programs that become effective in the following calendar year.

Additionally, the legislation permits individuals to make a one-time, tax-free and irrevocable rollover from an individual retirement account into an HSA, as long as the money transferred does not exceed the annual contribution limit and the eligibility for HSA contributions is maintained for the 12-month period following the transfer. Failure to do so results in income tax and a 10% penalty on the transfer. This feature is especially beneficial to individuals who enter into an HDHP and incur high out-of-pocket expenses in the beginning of the year before they have had a chance to fund their HSA using payroll deductions or nonrollover contributions.

Finally, the Tax Relief and Health Care Act of 2006 eliminated the requirement that prohibited higher contribution limits for nonhighly compensated employees, thereby enabling employers to provide HSA contributions up to the statutory maximums for these individuals. This feature is expected to be most helpful for small businesses that do not offer cafeteria plans, which have more flexible rules than HSAs.

The Tax Relief and Health Care Act of 2006 is not alone in increasing the appeal of CDHPs; there are other important forces underway.

Other Forces Driving Broader Use of HSAs and HRAs

The greater flexibility introduced by the new law notwithstanding, efforts to make all parties in the health care equation better informed on the costs of providing care is perhaps the other most important factor driving broader use of HSAs and HRAs. Price transparency is a new initiative to make the total costs for health care services available to anyone who has a stake in these costs—including consumers, employers, health care providers, hospitals and government agencies, among others. Total costs include consumers' out-of-pocket expenses as well as expenditures by health care providers, plans and insurers.

Price transparency is at the core of consumer-driven health care, and its primary goal is more cost-effective consumption of health care services. It is believed that this goal can be achieved when informed consumers understand the financial ramifications of their health care choices. With consumers now absorbing more of the costs for health care coverage, it is expected they will be more interested in the prices they are paying for services.

Studies to date have shown that consumers are sorely lacking in knowledge of health care costs. This was evidenced in a recent Harris poll that asked consumers to estimate the cost of a four-day hospital stay. The majority of those polled missed the accurate figure by $8,100. Even more revealing of the need for price transparency was the finding that 63% of consumers surveyed who had received health care in the past two years did not know the cost of their treatments until seeing the bills, and 10% had never read their bills.

Price transparency has become the subject of an executive order that President Bush signed in August 2006. It required the four federal agencies providing health care services, as well as their contracted vendors, to implement price-transparency plans by January 2007. For their part, the states are also initiating price-transparency programs.

Some examples include California's health care reform program, Florida's Compare Care Program, the Massachusetts Health Care Quality and Cost Council, and Pennsylvania's Health Care Cost Containment Council.

Employers are also getting aboard, believing that while price transparency may not lead to lower costs in the short term, it will help their employees make more informed health care purchases, which will ultimately reduce spending. The ERISA Industry Committee, National Business Coalition on Health and the National Business Group on Health are among those groups with workplace price-transparency initiatives underway. Additionally, many businesses are spearheading proactive disease-management and wellness programs in which price transparency is part of the core curriculum.

All proponents of price transparency expect the Internet will play a major role in making health care service pricing more accessible to consumers. Easy-to-use Web-based tools, which present specific prices for various health care services and comparative pricing, will raise awareness and arm consumers with the data they need to make more informed choices. In particular, managed-care Web sites will have a critical role in supporting the success of consumer-driven health care. Much money has been and will continue to be spent making insurance carrier Web sites useful and user-friendly.

To further motivate better choices and employee participation in preventive care and wellness programs, many businesses are offering incentives. These are often provided in a "benefits reward program" that offers a wide range of enticements, from discounts on vacations and health clubs to merchandise, airline miles and tickets to entertainment venues.

While price-transparency initiatives and incentives are advancing the application of CDHPs, so too are new and innovative approaches like the new HSA/HRA postdeductible plans, also known as hybrid HSAs.

Hybrid HSAs— The New Frontier in CDHPs

A hybrid CDHP uses the stacking of HSA and HRA accounts. This approach enables an employer to transition from a managed care program to a full-replacement CDHP by limiting the employees' out-of-pocket exposures to no more than what they were under the prior managed-care plan. In transitioning to a full-replacement CDHP, an employer can lower overall premium costs, make contributions to its employees' HSAs, limit em-

ployees' financial exposures after they meet their deductibles and offset any coinsurance exposure through the HRA. In this hybrid approach, the employer is able to retain premium dollars and distribute them among existing employees rather than to insurance carriers, begin to impact future renewal costs, encourage employees and their families to change behaviors and embrace wellness and disease-management programs, and develop a culture of wellness. Tying in a wellness program with financial incentives is critical for engaging and motivating employees in the fight to control costs and improve value.

One Company's Approach

Smart Design, a product design and development company with 75 employees in New York, San Francisco and Barcelona, has a 30-year history of designing products that address the unmet needs of consumers. The company is most recognized for the OXO line of kitchen tools and for introducing Universal Design to mass retail.

After experiencing annual increases of 15% to 20% in the cost of health care—despite having a relatively young workforce—the company decided it was time to take action and contacted an independent insurance and risk-management advisor to help design a new health care plan.

Smart Design was open to a wide variety of ideas, including crafting a plan that would address the unique needs of two types of health care users within the organization—the "extreme" and the "average."

Extreme users were defined as employees with large families and those who had had difficulties with health care coverage in the past. These individuals are the outliers—represented on the far edges of a bell curve because their characteristics and/or experiences are uncommon compared to those of other employees. The *average users,* on the other hand—who include most of this particular workforce—are typical in characteristics like family size and health care utilization.

This approach helped the company make several critical decisions. For example, it was decided that (1) the company portion of the HSA would be funded entirely at the beginning of the year to avoid hardship for unlucky employees; (2) the company would offer health advocacy services to employees to help them navigate through any difficulties they experienced when accessing health care services; and (3) the company would hold monthly workshops for employees and their spouses to keep them informed on the plan's benefits throughout the year. At the end of the year, the workshops would be evaluated to determine whether they should be offered again—and at what frequency—during the next plan year.

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Finally, in addition to training personnel on the intricacies of HSAs, the company would also undertake an initiative to educate health care providers on behalf of its employees. Specifically, it would inform providers that in-network claims would be repriced by the managed-care organization and that an explanation of benefits and bill would be sent directly to the patient for payment to the provider. Most provider offices are accustomed to taking a copayment at the time of service, which is not the case with HSA plans.

Since the plan has been implemented, it seems to have met the needs of extreme users. Two babies have been born, and one employee was involved in a major vehicle accident that required a hospital stay. While staff members aren't entirely happy about the work entailed in educating doctors and getting the billing department to amend bills, they understand the benefits and protections offered. Further, these employees are no worse off financially under the current plan than they would have been under an HMO.

The average users, on the other hand, are receiving financial benefits from the plan, with about one-quarter of last year's premiums now earning interest in HSA accounts. These benefits will increase over time since premiums are expected to increase only 8% next year. But even more significant are the changes that will come as employees become more savvy consumers. Some of this has already occurred. For example, several employees reduced their pharmaceutical costs by playing one supplier against another, and one employee prenegotiated a service rate with an out-of-network doctor.

Although the jury is still out, all indications point to a more transparent, competitive health care plan that comes with significant economic benefits.

Taking the Lead

Centers for Medicare and Medicaid Services (CMS) estimates that total health care expenditures will reach $4 trillion in 2015.[5] CMS projects that by 2020 health care will represent 21% of U.S. gross domestic product.[6]

Many employers recognize that they must lead the way in transforming health care by embracing creative HDHPs, HRAs, HSAs and hybrid plans. They are creating cultures of wellness by integrating financial incentives for employees to embrace disease and chronic health care management programs. And they are engaging employees to become more responsible in managing their health and purchasing health care services. These steps are critical to breaking the cycle of double-digit health care inflation. **B&C**

Endnotes

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