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Session 104PD
HSAs, HRAs and LMNOPs

Track: Health

Moderator: JOHN C. LLOYD

Panelists: VICTORIA C. ARNDT
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Summary: Consumer choice and consumer-driven health plans (CDHPs) are being implemented in combination with a variety of financial mechanisms, including health savings accounts (HSAs), health reimbursement accounts (HRAs) and flexible spending accounts (FSAs). In addition to financing mechanisms, these plans require special consideration in areas such as consumer communication tools, network, and administrative systems. Panelists discuss important elements from this alphabet soup of acronyms, including the current state of regulation, design and delivery of these products.

MR. JOHN C. LLOYD: This is a session on HSAs and HRAs. We have a really fine panel of speakers today. First is Robert Stahnke. Robert is second vice president at Trustmark Life, in charge of their consumer center health strategy section. The consumer center health strategy group is organized at Trustmark to focus on CDHP products. In that capacity, he's been a frequent speaker at employers', brokers' and employee groups and the Chicago Actuarial Association.

Second we're going to have Vicki Arndt. She's an actuarial associate at the health-care section of CIGNA in Bloomfield, Connecticut. Her focus has been on developing pricing and methodology for CIGNA's choice funds, which are its CDHP products.

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† Ms. Kismet Toksu, not a member of the sponsoring organizations, is senior consultant at Reden & Anders Ltd., in McLean, Va.

Note: The chart(s) referred to in the text can be downloaded at:
http://handouts.soa.org/conted/cearchive/neworleans-june05/104_bk.pdf.

This includes HSAs, HRAs and other offerings. She also supports the underwriting sales and customer strategies for those products.

Lastly we have a non-actuary. We try to find one occasionally if we can. Kismet Toksu has been with Reden & Anders since 2004. However, she's been on the ground floor of HSAs, HRAs and all the consumer-driven initiatives as a president of Candor Consulting, where she works with employers and businesses on consumer-driven strategies. Before that, she was with Lumenos as a vice president in charge of business development strategic alliance, clearly one of the early participants in the launch of consumer-driven movement.

MR. ROBERT P. STAHNKE: I'll give the background on HSAs and HRAs. My goal today is to provide an introduction. The introduction is going to focus primarily on the regulation behind it. I hope to present it in a way that it doesn't make it seem like I'm sharing the regulations directly from the laws themselves. Hopefully this sets the stage for later speakers who will get into issues that sort of rely on this background.

What I'll be doing is comparing HRAs and HSAs and talking about what the differences are. So to start off, HRAs are health reimbursement arrangements, and as such, they are set up to be owned by the employer. The type of account is really a notional account. It's really another way of establishing a self-funded benefit plan that's under the employer's control. The idea of a notional account means that because of your participation in an HRA, you're given a balance at the beginning of the year, and you may draw down that balance through eligible medical expenses after submitting them to your HRA administrator.

So how is a person eligible for an HRA? That's defined by the employer. There's a discrimination test that says you have to cover all eligible people. But in particular, there are no legislative requirements on what kind of insurance plan has to accompany an HRA. On the other side, we have HSAs, or health savings accounts. The ownership for the HSA is by the employee, so the employee physically owns the account. It is a real account, meaning that it exists at some bank or insurance company or other HSA custodian. A person is eligible to open and contribute to an HSA by participating in a qualified high-deductible health plan (HDHP). I'm going to get into what a qualified HDHP is, as can be seen in Stahnke Slide 4.

There are two major points here. One is that all expenses must be subject to the deductible with some exceptions. I'll go into those in a second. The second major point is that all of the in-network cost sharing has to accumulate to the in-network out-of-pocket maximum. So going back to the idea that all expenses have to be subject to the deductible, when HSAs were set up the idea was that only the HSAs should provide tax-favored reimbursement of the deductible. You shouldn't be able to get expenses that go to the deductible reimbursed from any other tax advantage source. Now they did set up some exceptions, recognizing that there are certain things that people want to get every year, and those are things like preventive care

benefits and maintenance drugs. I think the definition for maintenance drug has not been established sufficiently yet to do much with it, because it defines the maintenance drug as any drug for an individual's disease or symptoms, where disease or symptom has not manifested itself. That becomes a problem in terms of saying "Well, you can use this beta blocker for everybody." No, it's only for the people which don't have a condition at this point.

We do have a couple of items that are grandfathered in, the prescription drug co-pays, as well as some state mandates. But those go away January 1, 2006. To move on to the in-network cost sharing, again, certain items are exempted, such as preventive care benefits, co-pays and the like and any amounts above reasonable and customary (R&C) or whatever your inside plan limits are. So the expenses of going to a chiropractor above a $1,000 limit do not accumulate to this out-of-pocket maximum. And the out-of-pocket cost sharing has to accumulate. It doesn't matter how you set it up. It can be a coinsurance; it can be an access fee; it can be a per day deductible. It doesn't matter how you set it up, as long as that particular expense gets accumulated to this out-of-pocket maximum. In a minute I'll talk about what those maximums are, but first let me just go through a list of what preventive care benefits are as allowed by the IRS. They include periodic health exams, including tests and diagnostic procedures ordered in connection with routine examinations, such as routine annual physicals; routine prenatal and well childcare; immunizations; tobacco cessation programs; weight loss and obesity programs; and screening services. But preventive care generally doesn't include any service or benefit that's intended to treat an existing illness, injury or condition. So it's a pretty wide range of services that can be covered at a first dollar basis.

Going back to the idea that all expenses have to be subject to the deductible, Stahnke Slide 6 shows that in 2004 there was a minimum deductible of $1,000 for individual coverage and $2,000 for family coverage. The terms " individual" and "family" are how these are defined in the regulations. It's sort of different than how this is defined in the employer marketplace, which is where I come from, where you have the employee-only tier and the employee-plus-spouse, employee-plus-child, and so on. Well, the employee-only tier is here the individual coverage, and employee- plus-anybody-else then falls into the family coverage requirements. So with this minimum deductible for your plan design, interestingly enough, the $2,000 family coverage represents either an aggregate deductible, meaning that all the family members have to reach the $2,000 deductible before the plan can take, or a minimum embedded individual deductible for a family plan. And in the interest of time, I'm not going to get into it.

The second part of this is what the maximum cost share is, and the maximum cost share is $5,000 for individual coverage and $10,000 for family. And that includes the deductible. Importantly, out-of-network costs aren't necessarily included. So you can have separate and higher out-of-network cost sharing, and those do not accumulate. In 2005, as can be seen in Stahnke Slide 7, thanks to a CPI index thing, the annual out-of-pocket maximum was raised $100 for individual and $200

for family coverage. This is for effective dates in 2005, so if it's a 12/1/05 plan, these particular limits can be applied to that plan throughout its time in 2006, until the 12/1/06 renewal when some new cap is going to be in place.

The regs also allow a person to have other coverages that would not invalidate the HDHP status of an HDHP plan. Those other coverages can take the form of accident coverage, disability, dental, vision, long-term care, some specified disease or a per-diem-type hospital reimbursement. Then there are other kinds of coverage that are non-insurance that are also allowed. These include an employee assistance program (EAP), if they don't provide significant benefits. I know that there are EAP programs that may pay for 10 or 12 visits to a behavioral health provider or counseling. But self-funded workers' comp or workers' comp generally doesn't count. Very important is that discount or pre-negotiated pricing cards are allowed, so you can actually get a discount at whichever provider you happen to attend. And this is obviously key when you're talking about the drug benefit, because you don't want to pay retail for the drug; you want to get whatever pharmacy benefit manager (PBM) discount you can arrange for.

Finally, a cafeteria plan is allowed. But the health FSA has to be designed in a way such that it's for specified coverage only, like dental or vision. Or it has to be set up so that's it a post-deductible FSA, meaning you can't use the FSA monies to reimburse the HDHP's deductible.

Going back to comparing HRAs and HSAs, as can be seen in Stahnke Slide 9, I'll start again with the HRA column. The HRA and the account, or the arrangement, is totally funded by the employer. The employer cannot in any way get employee monies to contribute, whatever the HRA balances are. The funds in an HRA are held by the employer or their administrator or third-party administrator (TPA) designator, as they call it here. The account can pay for those things that the employer defines. So the employer sets what it's going to pay for, and you have to substantiate that it's an eligible expense. So, there's a certain amount of paperwork there involved in getting the HRA to reimburse.

For the funds that are available, the employer defines how they're available. So they can follow the uniform coverage rule of the FSA. You can say the entire amount is available at the front of the year, or you can say let's say for a $1,000 HRA balance you only get $250 a quarter. The employer defines how that money is available over the course of a year. The employer also defines the size of the fund. So there's a common theme here that the employer really controls exactly how the HRA is defined, what it's used for, when it can pay and how much it will pay, and it will be reiterated later as well. Contrast that to the HSA where the account can be funded by anyone, although practically speaking, the employer will fund or the employee will be adding their own monies to the account. The funds are actually held by an HSA custodian, which can be a bank, insurer or IRA type of administrator. But even though they're holding the funds, they're in an account that the employee owns, so they are also accessible to the employee based on whatever

the custodian rules are. The account will pay for anything that the employee wants to use it for. And presumably here, the account holder is going to keep records on what they actually use that money for or they're going to keep records for the expenses that they're going to say the monies were used for at the time that they do their income tax return.

The funds are available based on the amount in the account. So if you have $2,000 in the account, that's how much money you can take out, depending on what the custodian's rules are for maintaining minimum balances. How much can be deposited each year? Well, there's a cap. And it's defined based on the HDHP and some IRS caps.

Under the HSA contribution cap, an individual can contribute 100 percent of the HDHP deductible up to $2,600 for account year 2004 or $2,650 for 2005. And again, here's where the indexing comes into play. And I expect that number to go up again for 2006.

A family can contribute 100 percent of the HDHP deductible up to $5,150 in 2004 and $5,250 in 2005. So if you want to contribute the maximum, you have to have an HDHP that has deductibles at least this large. A personal comment is that if you have a family plan that has a $10,000 deductible, it will be fairly inexpensive. But the insured won't necessarily have access to tax advantages and monies to cover the entire deductible because of these caps.

A sort of a sub-point about the size of the contribution is that the contribution limit is actually prorated for the number of months that the account holder is enrolled in an HDHP on the first of each month of that year. So if you're enrolled in an HDHP six months out of the 12, you can put in 50 percent of whatever this cap is, whether it's the cap itself or your HDHP. If you're in seven months you can put in 7/12. This doesn't mean that you can only put in $100 in the month that you have the coverage, but just for that calendar year that's the cap. You can still put the money into the HSA at any point during that calendar year while you have an HSA up to April 15th, which is your tax filing deadline for the next year.

There's also an additional catch-up contribution, which is available for account holders 55 and over and increases by $100 over a five- or six-year time period. It's currently $600 per HSA account holder. That's in addition to the individual and family cap. It's not dependent on the deductible, and it's also prorated based on your participation in the health plan for the year.

To talk about a couple more things on the HRAs versus HSAs, I want to actually go to the bottom two items first on Stahnke Slide 11. For rollover, which is the idea that you can keep the unused monies and use it in a future time period, for HRAs the employer determines what kind of rollover provision to include in their design. Regarding portability, again HRAs are portable at the discretion of the employer. So that portability does not have to exist. And again it's up to the employer for how

long they want to make that money available following termination of the employee for whatever reason.

On the HSA side again, the HSA is owned by the account holder, or the employee, so there's implicit rollover and there's implicit portability, because they get to keep that account forever, subject only to whatever maintenance fees are in place for the minimum balance requirements by the HSA custodian. So even if they do not continue to be enrolled in an HDHP, they can still maintain their HSA and use it for tax advantages purposes.

So going back to the top on the tax issues, both funds actually have great tax advantages. The HRA is deductible both to the employer and taxable to the employee. The same is true of the HSA. The HRA has tax advantage withdrawal, and so does the HSA if it's used for qualified medical expenses at certain premiums. If you use that money for something else there's a 10 percent penalty and you have to include the amount used from the HSA in your income tax and report that as income. If you're over 65, there's no penalty, but you do have to report it as income if you use it for a non-substantiated medical expense.

Finally the idea of tax advantage asset accumulation doesn't exist in the HRA. Well, actually it could exist if the employer wanted to define it. But there's no guarantee of that. And with the HSA they do allow you to take the money if your HSA custodian has the option of investing in whatever investments vehicle is available through your HSA custodian.

So in closing, the question that this prompts is: Would I rather use an HRA or an HSA? From an employer perspective, the question is: What are your goals? Do you really want to just do a cost shift? If so, go with an HSA because you're going to have a smaller premium and a higher deductible, and you don't have to contribute anything to the HSA. Of course, then it is truly just a cost shift and it may not accomplish the CDH goals that are desired.

Do I, as the employer, want to provide financial assistance during a cost shift? Either fund can work. Although, again, the limitation on the HRA is that you can't put any employee money there. That's a consideration. Do I want to provide advance funding of future medical expenses? Again, each can work as long as you include rollover in the HRA. Do I, as the employer, want to only pay for certain benefits? If I want to limit benefits to those that are covered by my medical plan, for instance, and not pay for more optional services that are allowed as qualified medical expenses, then the HRA is where I need to go. Ultimately though, the employer has to balance its health program goals with what it wants to do with controlling the funds. And that's going to help determine which mechanism is preferable.

MS. VICTORIA C. ARNDT: I will share some plan design features both for the HRA and the HSA, as well as some employer plan design recommendations on what we

can cover for those. So we're not just going to cover underlying plan designs, but also some consumerism features, rollover incentive, etc. Then I'll go through some numerical examples to see how some pricing might check out. Finally, I'll show some employer considerations in terms of key positioning and how you can make that look fancy and helpful to your employees, so that they enroll.

I'm going to cover underlying mechanics and features of the HSA and then the HRA fairly quickly. I'll take the HSA first. HSA is an HDHP, so from an underlying plan standpoint the order of operations is as can be seen in Arndt Slide 2. We'll go from the bottom to the top. A member has a $1,000 deductible, but they can also have a consumer fund, whether the employee himself contributes to it or just employer money. It can be both. If I'm a member and I go to the doctor and I have an HDHP, I'm not paying the co-pay off the bat, I'm not paying coinsurance off the bat; it's a deductible plan. So the full 100 percent of the cost of the visit may be discounted from a contracting standpoint. But the full $100 office cost is going to come out of my fund. That's what comes first. As the member depletes that fund, it actually counts for that $1,000 deductible. So once that fund is depleted, the member then has a small tier. This is what we call the gap between the deductible and the fund. That's a member liability. That's his responsibility. After he meets that full deductible then he goes into coinsurance up to his out-of-pocket max. Now I'll mention that co-pays are permitted here after the deductible. On a family coinsurance, though, co-pays may kind of mask the true cost of services. So coinsurance is my preferred method, but co-pays are certainly allowed here.

I want to talk about a couple of other notes on the underlying plans preventive care. We are also covering at 100 percent. I think one of the criticisms of consumer-driven health is that people may forego the necessary preventive care to prevent heart attacks, emergency room visits, etc. So a simple solution is to make it free. If people are incented to go the doctor to get their annual physicals, hazard screenings and well child visits, all that stuff would be some good well spent money up front.

The verbiage off to the right covers some of the deductible and out-of-pocket levels that Robert described, so I won't repeat them here. But I wanted to share with you the order of operations there. Moving to Arndt Slide 3, if that was the underlying plan this is the fund piece of it. The operations fund goes first, then deductible, then out-of-pocket. Again verbiage off to the right states the levels and uses of that fund amount. Internal revenue code 213(d) displays the covered expenses of what an FSA usually covers, for things like over-the-counter drugs, contact lenses, COBRA premiums, etc.

That was the HSA; Arndt Slide 4 is the HRA. The HRA can be a little more exciting in terms of features. As Robert mentioned, the employer has a bit more flexibility in terms of what he can do with an HRA design. For the order of operations, first are the operations, then deductible, then coinsurance up to the out-of-pocket. We can do a couple of cool things within HRA. I call this next generation, because of all the

neat features you can do. So some examples are multiple funds, incentive programs and HSA alongside it, different rollover, etc. I'll cover some more of those individually in a minute, but I wanted to point out that the employer has a lot more flexibility here. It's very important that you can define what is covered by the underlying plan. You can say these dollars can only be used for office visits, drugs, etc. You have a little bit more control over it versus on the HSA side. People can use their money for pizza and beer or whatever. It's their responsibility to self report it on their taxes. So from an employer standpoint, the HRA, at times, can look a little bit more attractive, because they have a little bit more control over what the dollars are used for.

I'm going to talk about some of the features one by one for the HRA. The first one is multiple funds. Here I show pharmacy, but another powerful separate fund might be a preventive care fund. That can kind of highlight those dollars, drop them off to the side and encourage people to use them. Here I show pharmacy, though. With a separate pharmacy fund you can either have a separate fund with a deductible or you can have it combined with the medical. I most often see it combined with the medical. I think from a member standpoint it's a little easier to track and understand because you have only one number you're accumulating to.

So why is separate pharmacy fund important? At a high level it kind of sets these dollars off to the side, as is pointed out in Arndt Slide 5. The member is a little bit more cognizant of what he's spending on a specific pharmacy expense. So he's probably more likely to move to generic drugs and use over-the-counter medicine when it's appropriate or find some alternatives. If a member has a $20 drug, for example, if he only has a $100 fund for pharmacy, that's a bigger hit to him. So it's kind of a budgeting mentality and he's going to say, "I only have $100, so I'll be a little bit more cost-conscientious and a better consumer as I'm spending those dollars."

Arndt Slide 6 highlights the up-front deductible. This is generally what I call cost sharing on the funds. An up-front deductible is just one example. Another example could be coinsurance on the fund. The high level idea here is to have members have a little skin in the game. The order of operations typically goes fund, deductible and then out of pocket. But instead of the fund being first, we're going to have a small up-front deductible, in this case $250.

First I'll give you a couple of examples. Let's say you're a 25-year-old male and you never go to the doctor. You have zero dollar claims. Now you have this HRA in front of you—a big $500 bucket of cash—what are you going to do? That's first dollar coverage, so you're going to go get your new knee checked out that's been bothering you, and you're going to get that alopecia, because you're 25 and you're embarrassed that you're losing your hair. You have cash now to spend on it. So you may actually utilize more services than you did before in the previous plan. So this up-front deductible might eliminate the concept of overcompensating the healthy.

My second point is that if somebody has a fund level here and the deductible up here this is your bridge. And your two and three are unused fund dollars rollover, your fund will grow, which means your bridge shrinks. If a bridge is a member's liability what's coming out of his pocket, that would suggest the cost would increase. So, as people's funds roll over, their bridges shrink. This up-front deductible would eliminate or kind of reduce any possibility that somebody is having a zero dollar bridge or maybe even a negative bridge. So if their fund exceeds their deductible, from a utilization standpoint that might be a bad thing. This up-front deductible always makes sure that employees have skin in the game and they're going to be better consumers outright.

The last specific feature that I want to outline here is incentive programs, as can be seen in Arndt Slide 7. I'm pretty high on these things. I think they are a good thing. The idea here is to reward people for good behavior. So for example, if they complete a health risk assessment, we're going to give them cash for that. It's a nice way of saying it's a bribe. I'm all for that. If that means they're more engaged then that's great. The idea here is that as they do those things the employer would feed extra dollars into the fund. So maybe instead of having a $500 fund here, you offer $450 and let people build back up those incentive dollars.

It's a good thing here. If somebody fills out a health risk assessment and they realize, for instance, that they are at risk of heart disease, it's going to be a long-term play with long-term savings. The same thing is true for using Web tools. If your doctor prescribes this drug and you go online and check it out and see that the generic is $40 cheaper, that's going to save us some money. So incentives are a great tool to help get people engaged. I'll also note that some recent HSA legislation interpretations suggest that incentive programs are now allowed on HSA as well. So that will allow a little bit more employer flexibility too. Incentive programs are good.

So on to pricing levers. What moves the price point? What can move the needle here? At a high level I'll group them into four different buckets: core fundamentals, plan design changes, consumerism and selection. One is core fundamentals. You can have all the bells and whistles in the world, but if you don't nail the basics, it's just not going to work. So I'll call it basic blocking and tackling, in terms of broad network key discounts, preventive care medicine and disease management, those are all good things. In terms of plan design changes we really need to move people to HDHPs. That's what a consumer-driven plan consists of. So that means deductible coinsurance; probably a big deductible of $1,000 or more. Again, I would avoid co-pays because it might kind of shield people from the actual services that they consume. The deductible and the coinsurance are good, but it's a matter of some cost sharing and some cost shifting. You kind of need that for HDHPs.

Consumerism is a big one. Thinking long-term, if we want people to eventually purchase health care as if they were buying a car, we want them to do research. We want them to use tools, find out information, become better buyers and do their

due diligence. We need to give them the know-how. So we need to incent them to use these tools to perform or to participate in disease management programs. We need to give them information. We need to have effective communication and messaging, so that they know how to navigate the system. My personal opinion is that consumers will move over time. It will take a little bit of a time for people to get used to these tools and to actually look at this stuff instead of handing $10 over to the doctor. It's a different mentality.

In terms of selection, I think that will absolutely increase in a choice environment, as members do what's best for them. Therefore, we can absolutely manage via a contribution strategy. I'll talk about that in a little bit.

Now I will move onto high level plan design recommendations. I will caveat all these statements by saying that these are intended to maximize cost savings and maximize consumer engagement. It all depends on what the employer wants. If the employer wants to offer a rich design and get high enrollments, he might not necessarily want to do some of these things. But these are what I like from a pricing standpoint, because it will drive your price down.

I'll start with the fund amount. You can start low and let employees build up the incentive. So let's say you have a $1,500 deductible and a $500 dollar fund, which is a nice size bridge. Instead of offering $500 now, maybe you make it $400 and let people earn dollars upward.

A 100 percent rollover is a good thing. Again, it promotes ownership of the fund. It avoids some of that move-it-or-lose-it mentality. If an employee knows that those dollars are going to be gone at the end of the year, then they can go blow it on expensive medicines or elective procedures.

In terms of the deductible, I like it to be three times or four times the fund amount, so that you can get a meaningful buy down. Again, it's kind of a necessary evil to move to the tied deductible health plans, so what you should compare is the group's current deductible to their deductible minus the fund. Again that's the bridge amount.

A side note, I recommend that the out-of-pocket match the increase of the deductible.

In terms of contribution strategy, the CDHT option is most often the lowest cost option. So if you get more people to enroll in the cheapest options, you're going to save a lot more money from a total employer cost standpoint. So driving enrollment into the CDHP option is definitely a good thing.

There are a couple of ways you could do this. One, you could position traditional plans as a buy-up vs. the CDHP. You could even meet the CDHP option free and make the other things a buy-up off that. Another option is to eliminate all this.

Offer CDHP on a full replacement basis. It's the only option for employees. I think a lot of employers are to adopt that methodology. A lot of people are trying to dip their toes in the water and get a little feel for it. They are a little bit afraid to take a big leap.

On to the numbers. Arndt Slide 10 attempts to show some illustrative cost saving. There are a few caveats here. Don't beat me up on the absolute numbers here. I want to use that as the focus on the relativities between options as we toggle different designs and features.

These numbers also are kind of HRA in a bubble, if you will. They don't reflect any risk election or employer contributions to premiums. So what I'm showing here is kind of a fund II scenario. The group currently has a $250 single-deductible plan, 90/70 coinsurance, and a blended per-employee-per-year (PEPY) with a cost on all tiers of $6,000 for simplicity. The group wants to implement an HRA, so let's focus on the top row. The group offers a $500 fund, $750 deductible for singles, and the coinsurance is the same at 90/70. From a bridge perspective, that deductible minus the fund is $250. It's the same as what the group currently has. So from a member utilization standpoint, it doesn't seem a lot different.

There are three kinds of cost outputs here: the plan cost, the fund cost and the fee. I'll take the plan cost first. That represents kind of the underlying plan from deductible to coinsurance, out of pocket, all that jazz. So the plan cost here is $5,595, which is minus 7 percent relative to the group starting point $6,000. The fund cost here is at $695, a couple of notes on this one. This is what we represent as a group expected fund liability. So of the $500 that they're providing to their single employees and the $1,000 to the family, you weight that out and say $695 is the percentage of that annual allotment the people will use. Note that that's on a cash basis. And we're saying policy year 2005 people will use on average $695. I think it's absolutely important to consult with the employer and the customer. From an accrual basis or a budgeting basis, they should account for fund dollars that roll over and that the employee can use next year.

The additional fees here are on top of the underlying plan's network access fee. Just from an administration standpoint, if you add those guys up you get $6,368, which is plus 6.1 percent.

Now note that all these figures are on a time-mutual basis. These are all 2005 figures. The group kept the same bridge amount, and it actually cost them more money. And again, I'll show a wide range of savings here. It really depends on what the employer wants to do. Maybe he wants to be paternalistic; maybe he wants to spend a little more money and keep his employees happy so that they stay with him.

The second alternative here is to have a bigger fund, bigger deductible. It's a nice sized bridge here what I'll call a two-times relationship. The adjustable is two times

the fund. You'll see here from an underlying plan standpoint, the plan costs us $4,285, which is a pretty significant decrement versus the group's current $6,000 plan. That's just the underlying plan. You do have to add in a fund cost. Here it's $1,390. That's a lot of cash, so that will absolutely whittle down your buy-down. Look at the first note that I show here on the bottom, which is that the $1,000 fund erodes the buy-down value.

With the same fees, the total cost saves you 4.1 percent. So there are better financial results. But again it might be a little tougher to swallow from an employee standpoint, because now he has a $1,000 bridge for his liabilities. Moving on to the third option, the fund amount here is $500. So you'll keep the $2,000 deductible and coinsurance at 90/70, but now you have a bigger bridge. That is a four-times relationship. You'll save on the plan cost as well as the fund cost here, so it's a good guy to both. Total cost gives you 17.5 percent. So you'll see that as you make your bridge bigger, its good for your underlying plans and good to your funds. Again to take it a step further, just a regular buy-down on your underlying plans saves you 20.3 percent.

The last option introduces an up-front deductible here. I am showing a 25 percent relationship, which means from an order of operations standpoint, if the deductible is $2,000 (carrying that deductible throughout all these last four scenarios), the member would first need a $500 deductible, then his $500 fund kicks in and he has a $1,000 bridge. Again, he has skin in the game, and you eliminate first dollar coverage. That again is a good guy to both your plan cost and your fund cost. It saves you 22.5 percent.

So my notes down here at the bottom state that a bigger bridge is good, and an up-front deductible is a good guy to both plan and fund.

FROM THE FLOOR: Does the fund cost increase over time with the rollover?

MS. ARNDT: Absolutely. Again, that's why it's important to speak to a customer or employer from a budgeting standpoint. Of the $695, if the annual allotment on a blended basis was $750, you'd have to say, next year that $55 next might count. So from a dollar basis, people generally use 60 percent of their funds in year one. Maybe in year two they would use 60 percent of an accumulated amount, which on an annual allotment basis might be something like 8 percent, or something like that. So on an absolute dollar basis people might use a little bit more, it's all just in presentation, percentages and how you share it.

Again the message here is that you can see a wide range of savings, but you have the flexibility, particularly with an HRA, to get to whatever the employer wants to achieve.

FROM THE FLOOR: Did the savings include any behavioral changes?

MS. ARNDT: The plan cost actually reflects what I called consumerism credit before. So the plan cost reflects the utilization component of the bridge that employees see, but the cost component of the high-deductible plan. It does also include some considerations that employees will behave better. It provides consumerism credit from them using decision support tools, rollover, up-front deductible, etc. It's kind of all in there.

If you're a benefit manager and somebody says to you you're going to save 20 percent, it might be a hard message to sell to the employees. Because to an employee, savings of 20 percent means my cost share is going to go up huge. So it might be a hard message to sell. I want to share some ideas on how an employer can spend his savings, and he can do that in a few fashions.

Employers should balance paternalism and budget when determining how to spend the savings. I will list three options. I recommend that the employer does a combination of them, but he can do only one if he wants to. The first one is to keep the money as profit and put it towards your bottom line. That's certainly budget-friendly, but from a PR perspective it's not a good thing. Your employees might not be happy with you, and they might leave you, etc. So I absolutely recommend that you combine this with one of the other two options I'm going to list.

The second option is to contribute to the fund. I will give you a quick example. If you have a $2,000 deductible and an 80/60 HSA with a $0 fund, that might be the 17.5 percent. (And when I say a $0 fund I really mean from an employer contribution perspective and employees can absolutely put their own money in here.) Let's say you have that same underlying plan, the same $2,000 deductible and 80/60 coinsurance, but with a $1,000 fund, you're going to save 4.1 percent. You're still saving money, but from an employee perspective you've already jump-started that funding. If the employer seeds the money into it, it shows employer commitment to this product and to the plan options, and employees are going to enroll in that. So again, if you get more people enrolled into the CDHP option, you're going to save more money over time.

The third option is to reduce premium. So if I'm an employee and I'm a member, my cost sharing is what's important to me, as well as what comes out of my paycheck each month or each two weeks. So an employer can set his contribution strategy to favor the CDHP option. A quick example here is an employee pay-all, which is kind of my term for employer puts $0 into the fund. A $2,000 deductible HSA might save you $1,872 versus the current plan. If you divide that $1,872 by 26 bi-weekly paychecks, you can save $72. So from a member standpoint, and employee standpoint, what's coming out of my gross pay each two weeks is a difference of $72. That can be pretty powerful in terms of getting people to enroll.

Again this is all dependent on what an employee wants to do. He may want to be paternalistic and have a rich plan, and he can contribute money to the fund. If he wants to be budget friendly and save money, he can just keep all his savings and

put it in his own pocket.

MS. KISMET TOKSU: I'd like to talk about HRAs, HSAs and the different issues from a plan marketing, sales and employer perspective. How do we sell these to employers? How do we market to consumers? What are the key operational issues?

I bring these up because, as you're pricing any of these and as you're putting together plans, you're really putting them together to be sold. At the end of the day you have to sell them. So you're a partner with your sales team in a lot of ways. Hopefully this will help you understand their perspective.

The end game here for the employer and the pitch for the health plan is to empower and partner with your employees to reduce trends and to support better health. It sounds simple. Here are the market drivers that everybody is talking about. Here are the key issues that are really keeping a lot of people up at night. First, premiums are increasing. They increased an average of 13.9 percent in 2003 and had a double-digit increase in 2004. Second, prescription cost increases are driving consumers toward alternatives, such as to Canada or towards generics, which can lower costs. Hopefully it's not going to drive them to the alternative of not taking their drugs. Another driver is that 58 percent of patients surveyed now use the Internet to become better educated about their treatment and their options.

Another one is that rising costs are really squeezing budgets and leaving us less money for salaries. This is very interesting for those of you who are pricing this out to union groups, particularly, because the cost of health care is being combined with a number of issues and it's not just health care issues. As a collective bargaining process that also involves the rest of their package, so you want to have that context.

Also, use of technology continues to increase. That impacts many things, such as the cost of health care, how people acquire information and how people use their health care.

Another driver comes from predictions that consumer choice health plans will account for 24 percent of membership by 2010. Even if that number is 20 percent or 30 percent, it's a huge number and it's very important to your clients. Next is that 76 percent of employers are likely to offer HSAs or HRA products in 2006. And health coverage is becoming a top leadership concern.

What I've noticed meeting with employers on behalf of health plans is that many times the exercise at hand is not to cut benefits; it's to figure out a way to provide comprehensive benefits within the confines of a budget. You really do need the prices to come down so that health care is affordable, but at the end of the day it's not about cutting the benefits in general.

So there's a business case for consumer choice and the business case has been developed and iterated over time. I've been working in consumer-directed health care since 2000, and I can tell you that the value proposition is still similar although it's gotten much easier to explain as people are familiar. The idea is to hold or minimize cost in year one.

In the beginning it was really about decreasing cost and it was interesting to go out and test market to employers and say, this consumer choice plan that looks so different and is a challenge to market is going to potentially increase your cost or it's going to be relative to your PPO. And there is significant push back. There were some takers.

But the promise now that's being made is that it's going to minimize or hold cost in year one, and then help them level out in subsequent years to minimize trends going forward. Consumer choice health plans largely continue to provide comprehensive high-quality medical benefits. In some cases, particularly with the individual market, there's a scaling back of some of the benefits. But in general, that's not what a lot of this business proposition is. Also, a business proposition here is to better utilize the system in health care. It's not to inhibit access, but rather to provide some better utilization, lower use of physician services, decrease use of infertility services and create a reduction of pharmacy claims. And at the end of the day, it's about changing behavior and driving to consumerism.

Consumers who are empowered make wise decisions. They really do. It can support recruitment and retention goals. Now that's not one that you, as actuaries, would be thinking of as you're pricing, but one of the big pushes, for example, with health systems was a high retention goal that was going to be tied to consumer choice plans. That impacts you in the pricing because if retention is improved, then more funds are held as they roll over. You should be aware that if there are retention goals associated, it may impact the length of time at which the funds are held for an HRA product. Also it provides incentives to become partners. You'll see that a lot in marketing and in how the health-care information is delivered. It's all about becoming partners and managing care and cost.

Toksu Slide 5 is an example of the Aetna health fund results. This basically shows two items: first of all, a population that moves for replacement from PPO to the Aetna health fund and how that showed a decrease in dollar. And it also shows the total Aetna health fund population moving 2001 to 2002. You see a small increase here. A sales and marketing person would use this to prove that by moving to a well constructed consumer choice plan you can decrease your cost over time and by retaining people in a consumer choice plan you can keep trend down to a more manageable level.

We talked a little bit ago about consumer adoption and utilization. One of the big items that impacts consumer adoption is, of course, the overall plan cost. It stands to reason that people are evaluating the cost benefit. There are many tools that can

be used in evaluating this. Also, the contribution strategy is key, and I would assume that that's part of your overall pricing assignment. You'll be asked to look at several different cost methodologies and contribution strategies. Management support and buy-in are also very important. And I would suggest that if you have a sales team that is saying, "We have a group here that is really supportive of this program," that would impact your numbers, because you could predict a greater number of people moving into your program.

Mandatory enrollment meetings are another example, and multi-channel decision support is another important item. Multi-channel decision support is reaching out to people where they are. Many years ago, before my consumer choice days, I worked for the president of a media company. One of the biggest lessons I can take away is that you meet people where they are. So if somebody is just trying to understand consumer choice, you show them how to use this program, how to choose it, how to evaluate it and how to make it work in their life when they need to. If people have more expertise and are very into the numbers, you provide tools with numbers and those kinds of things. Some people respond well to print; some people respond well to tools. Leave people where they are and use some multi-channel decision support to help people make wise decisions.

Now I want to discuss supporting sales to employers. First, understand the market drivers and the promise. The promise we talked about is reducing trend. It's also engaging employees as consumers. I'm seeing a really big drive toward consumerism across all plans. I think it's very interesting to see and I think you'll see this and may be able to factor that in it at some point to pricing for other products as well.

You should also take the advantage by analyzing the current plan and picking up trends from it. There are two reasons. First of all, it will really help in creating and recommending plan design because it's much easier to solve something that people understand from a consumer perspective than to necessarily come out with something very different. You also need to understand the patterns and utilization. You'll need to see the changes in things like preventive care. Health plans were really afraid from a strategic perspective of including preventive care until there was a lot of analysis on it and the numbers showed that something like less than $300 was typically spent on preventive care. So there was a number that could be plugged in for that feature of the program. If you understand your patterns of utilization of course, that helps in creating a solid product.

For present plan designs that match the current utilization and support the plan sponsor's goals, be prepared to discuss the winners and the losers. Your salespeople are going to want to know from you who wins from this and who loses from this. Pretend that you're in a consumer choice plan. Do you have any idea who the winners and losers are in your plans? There had been a lot of push back from employers who said, "We have a small sick population, but are those people going to be really feeling the brunt of this new plan?" And of course, the answer depends

on plan design. If you can look at your plan design and be able to discuss the winners and losers from a very personal perspective it's really helpful. Because at the end of the day, the sales and marketing people that you're supporting so that they can sell this, are talking to the employer who's putting themselves in this plan. People are going to ask them questions. Also be prepared to discuss HRA versus HSA and some of the factors that were talked about already. There are also more factors that you would want to delve into with respect to differences. Be prepared to talk about the impact, of course, of slice versus full replacement.

I'm going to briefly discuss the communication goals. There are really six key goals: communicating the true cost of health care; involving and educating employees around what they can do to manage costs and outcomes; providing a clear understanding of the plan options; supporting employees and their dependents so they may make informed decisions; incentivizing employees to take action; and reinforcing the employer-employee relationship.

When you're looking at a consumer choice plan, I think it's really important to have at least some understanding of the strength of the communications plan. I'll give you one case study example. One of the clients that I've been fortunate enough to work with is Keenan, based in California. Keenan works with Aetna, and has created a private label product and that product is called "Consumer Advance." The first employer that was sold on Consumer Advance was a union group. It is a challenge selling a union group. Of this group, 80 percent that made a change and 20 percent stayed in Kaiser. Of the 80 percent that made a change, 47 percent selected this plan. And that was because of a combination of contribution strategy and very strong communications.

There are also several key operational considerations, such as: the medical claims process like "shoeboxing" or integrated claims processing; funds release via debit card, check writing, automatic payment, etc.; funds management and investment options like simple savings, minimum balance investing and account holder transaction approval choices; customer service, such as strategy, coordination, roles and responsibilities; consumer education, decision support and access like strategy coordination and roles and responsibilities; IT, Web and HIPAA/privacy issues; partner selection and management; and care management.

I'd like to pull out just a couple of the key operational considerations, because they also impact pricing. Whether or not the medical claims process is simple makes a difference to when people access their money. Also whether it's HRA or HSA has an effect. Shoeboxing, for those of you who aren't familiar with the term, means that somebody is saving up all of their receipts and is going to submit them all at once. So if the process is easy and it's streamlined, then claims are paid and money is paid out of the HRA sooner than if somebody is shoe boxing.

The funds management strategy is key, and you'll want to get some understanding around how the funds are managed, what the investment options are and so forth.

That way you know what decisions the employee may be making.

In preparing for this, I was thinking about what other items actuaries would not be thinking of, the less technical analytical things that you would probably want to be turned onto. And I would suggest that there's one more and that is policy. There are so many policy issues out there that you're not going to want to know all of them, but you'll want to know some of the trends. I'm part of the HSA working group that meets on the Hill. I'm based in New York, but I live outside of Washington, D.C. There are a couple of key issues have just come up that will definitely impact pricing. For example, many of you may know about the FSA and the additional two and one-half months that are now allowed in order to use FSA funds. There is a big push to increase that length of time to perhaps a year. That's a really big impact.

Another big policy issue that you're going to want to be aware of is prescription drugs for preventive care. That is going to be a huge pricing consideration, not to mention an operational challenge. The third big issue that I'm sure is important for you to know is account setup. HSA account setup is a banking arrangement and you would say, "Well, how does that impact me?" It impacts you because the account may be unlike an insurance product where you can go through open enrollment and you can be enrolled 1/1/06. Until a signature card is returned, your HSA account is not opened and you may not use the funds retroactively. So if you don't get that signature card in by 1/1/06 and you get it in by 2/15, the amount of money that would have been allocated or funded does not exist. It cannot be used. It can be made up if the employer has a system set up. And there are several others including state issues.

What I would suggest, though, is if you have any kind of research team or research wire, you have to be copied on the major issues. I think that policy issues very much affect pricing. I would suggest that if you can keep an eye on the trends in terms of the adoption and the utilization, the program and policy, as I'm sure you do from a pricing perspective, it will really help you create another level of depth and support to the sales team. That will help you to create the plans that do what you promise they are going to do in terms of trend stating.

MR. STEVEN ZOLDOS: I have two questions, one for Robert and one for Victoria. For Robert, under HSAs who's responsible for policing that fund? These are contributed by the individual or the employer, and if they are using that money for health-care services or the pickup truck, like you said, is it the bank or trust responsible for policing that or is the individual on the honor system? And does the IRS get any kind of reporting?

MR. STAHNKE: In short, the account holders are responsible for providing the substantiation within their tax records. So, if they are audited, they can substantiate that their HSA withdrawal was used for qualified medical expenses or some of the premiums. But there is no obligation on the custodian, the employer or

the insurer to substantiate withdrawals from the HSA. The HSA custodian does have a fee to the IRS generally, which describes the amounts that were deposited. Their only check is generally based on the regulatory limits, not on a particular plan design limit. So, an example of something that can go poorly, if you use your HSA to pay for something and then get reimbursed by your health plan for the same thing, you have to put that money back into the HSA in order for it not to be taxed. You have to then report that that's a redeposit and not an additional contribution to your HSA custodian so that they don't include it on their IRS report.

MR. ZOLDOS: For Victoria, my question has to do with HSAs as well. In Florida they recently enacted a law that required all carriers, including HMOs, to provide a qualified health plan, such as an HDHP for individual health and for small group. HMO carriers that have traditionally negotiated with providers on a capitated basis either for durable medical (DM), diagnosis-related groups (DRGs) or physician capitation will now have to offer the high-deductible plan. It would seem that that type of reimbursement wouldn't work for an HMO. So does that mean that the average reimbursement to the provider is going to go up under a high-deductible plan because those capitations are going away?

MS. ARNDT: Yes, I was actually working with our Florida pricing team to work on the filings and getting those high-deductible plans out there for all of our products. And most of the carriers I've seen out there are offering HDHPs or more specifically HRAs and HSAs on PPO-type products, where capitation is not as prevalent. So I'm not sure it will work as well on an HMO scenario just because people are so much more tied to a co-pay environment. So it's definitely more prevalent in PPO today, but I haven't seen much of a move to put it on an HMO basis. I think the capitation in the general plan design make it more conducive to the PPO side. However, I haven't thought long-term about how those provider arrangements would work. But that's one consideration.

MR. GARY PETERSEN: I have two questions for the panel. I happen to live in a community that has a perfectly wonderful Mayo Clinic in it that has a fantastic executive physical program. Do our panelists have any recommendations in terms of what an adequate but cost effective limit would be on the 100 percent preventive services, so that people aren't spending $3,500 on their executive physicals?

MS. ARNDT: I'll start and then someone else can jump in. People can offer 100 percent preventive coverage absolutely with a cap of $300 or $500, whatever it is. It can be multiplied by a year tiering. Kismet cited the number of $300 as an average spend on preventive care. If I had to throw a cap on it, maybe I'd call it $500. But I think there's only so much someone can do in a year, in terms of preventive services. Obviously you can put caveats on it. For example, you can only get one annual physical. You can only go for cancer screenings every five years, or whatever the recommendation is. So I'm not sure that someone could possibly spend $3,500 each year if you spread that over five years. But from a pricing standpoint, obviously 100 percent and no cap will generate a higher price plan.

However, I think that's money well spent.

MS. TOKSU: Another perspective here is, operationally, you can tie that to specific services that are covered. Typically that's how it's done from an operational perspective. So you could say that of the 29 components of the Mayo program, eight fit into this preventive care bucket. And it just needs to be communicated what is covered in preventive care.

MR. STAHNKE: I think those were good answers. But the $300 to $500 is what we've seen typically. We also have plans that will cover those services after deductible and coinsurance, but we have fairly clearly defined exactly what is going to be considered as wellness or preventive in that case.

MR. PETERSEN: My second question is a pricing question. With respect to the utilization discount, are the people that are working on pricing recognizing a difference in utilization discount between whether it's an HRA or an HSA? And if so, can you give us any idea of what ranges you might be using of discounts under those two scenarios?

MS. ARNDT: I think HRA and HSA are a little bit different. Obviously they have the same underlying good guy credits for communication decision support tools. But, some of the consumers and features on HRA can be additional utilization letters, such as, for example, incentives, different rollover rules, cost sharing and things like that. But HSA also has a supportability side, which can be another utilization good guy. In terms of ranges, I've seen industry numbers anywhere from 0 percent in terms of consumers and credit up to 10 percent. So it really varies out there. And some people are putting a little more stock in it. Some people may kind of ramp up over a couple of years. They are a little bit different just because of the different features and flexibility you have between the two. But at a high level, they do have some common things.

MR. STAHNKE: My addition to that is that I'm concerned about deductible leveraging at some point and to what extent utilization and deductible leveraging are hiding each other right now. I'm also concerned as to what extent the utilization decreases are going to be overtaken by deductible leveraging at some point. That suggests to me higher trend on CDH plans. So the fact is that it has to be offset against the lower base, which is good. But again, it's not lower trend; it's higher trend.

MS. KRISTEN RUSSELL: I have a couple of questions for Kismet. The first one is the communications question. The program that you put up there has a lot of great points and all the points you want to be hitting if you have an enthusiastic audience, the support of an employer and a willing broker. What have you experienced and how have you handled either a reluctant broker, a reluctant employer or an unwilling audience? What strategies do you use? By a reluctant employer I mean he's willing to buy the plan because he wants the cost savings,

but he doesn't really want to let you in front of his members to communicate.

MS. TOKSU: That's a big issue. And if it's not a full replacement in that situation I think you just have to manage their expectations. If they're doing this as a way to just tip the toe in, it's very difficult to get good adoption on a consumer choice plan without access to members because they're not going to understand it. So health plans that typically have been very successful with consumer choice have had very strong step-by-step communication plans that even the employer could implement. So if it is an issue where the employer wants control, they could retain control of that. If it's a situation where the employer does not want that information communicated, then I would suggest the plan won't be successful. And it might not be worth the health plan's time.

MS. RUSSELL: And then reluctant members?

MS. TOKSU: In the case of reluctant members, you could be persuasive by providing information. It's not the right plan for everybody; it's the right plan for many. And you just want to help people decide which category they go in.

MS. RUSSELL: My second question is a policy question. One of the things that we're going to be running into come 1/1/06 is the end of the safe harbor for mandated benefits. So for those states in which they have small group mandates that are contradicting the HSA laws, have you heard of any progress? I just wanted to hear whether you heard because you're so close to Washington insiders and all the other folks in the political process.

MS. TOKSU: Actually yes. There are clarifications and changes up right now in eight states. And I'd have to check my research to tell you which of the eight. So there is a very big move by the states, because this is a program that has been very much supported by states. So I think that by 1/1/06 most of those issues will be resolved.

MR. HARRY SUTTON: My questions are for Victoria. In the very early slides that you showed, when you had your diagram, the consumer fund was at the bottom. In my opinion, the HSA was designed to try to save money for long-term care to finance your coverage after Medicare. But in your diagram you automatically processed the claim out of the fund. Now, do you manage the funds? It looked like you're administering to take the cost of the primary care claim or whatever it is out of the fund. In the medical savings account (MSA) business, a lot of employees just pay the minor cost out of their own pocket and let the fund build up. If you take the money out automatically, you're defeating them saving money for after retirement. I'm not sure exactly what the diagram in your discussion meant.

MS. ARNDT: I should have clarified that the order of operations of funds that pays first automatically is really an HRA thing. For HSA we can do automatic claim forwarding, as you mentioned. So if a claim comes into us the doctor says, "Give

me $125," we can go and check the member's fund. We do not administer that. We partner with a bank. We can take that $125 out of the fund and pay the provider automatically. It's an employee election whether they want to turn on that automatic claim forwarding or not. If they choose not to, they could just pay it out of their own pocket and reimburse themselves later via a check.

MR. SUTTON: Do you set up and manage the HSA funds yourself?

MS. ARNDT: They could. We partner with a bank, but because the employee owns the account, we're not forcing them to partner with our partner. They could go to any bank.

MR. SUTTON: I was very interested in your diagram, but my question is, did you have a very overcomplicated system that a lot of employees would not understand very well? How do you administer? It has to be much more complicated than a straight medical plan, right?

MS. ARNDT: The administration side is definitely difficult from a programming or mechanics standpoint. There are a lot of challenges. But I think a good strategy, because of all the flexibility that you have on HRA, is to start simple. You could just have a plain vanilla fund and deductible coinsurance, with medical and pharmacy combined. And then maybe in year two, as the employers are more enthused, you can add things like multi-funds, incentive programs and cost sharing on the fund. From a member standpoint that can be very confusing. So if you can start off with plain vanilla and make it more complicated as you go along. I think that's the beauty of the flexibility you have.

MR. PETER DAGGETT: I have kind of the same concern of the utilization based on the underlying HRA and HSA. From a regulatory standpoint, what is the stance or what is the interpretation on the ability? Because from the insurance company standpoint, all we're offering is that high-deductible plan, and the ability to underwrite or rate those high-deductible plans based on the HRA that's underlying at the HSA, the contribution strategy and varying the rates of our plan for that. What is the regulatory response to that?

MS. ARNDT: I'm not sure. I haven't heard a lot from the bureaus of insurance asking what your consumer features are and what your pricing is and text for those specifically? It absolutely affects the price point. What is the fund? How big is the bridge? What are the consumers and features? I'm actually a little bit surprised that the government has not been more forthcoming in requesting information on that.

MR. DAGGETT: Have you seen insurers doing that? Have you seen them burying it or not just having one flat price for this high-deductible plan and letting the employer choose what they put underneath it?

MS. ARNDT: I personally have seen variations in terms of features chosen and how

that moved the price point. I think the beauty of our competition, with all the carriers out there, is that they have different features and price accordingly for it. So it doesn't link specifically back to refilling. And you can look up on a grid what this plan looks like. There are so many moving pieces, such as the contribution strategy for selection and all that. So it's definitely something that I think warrants a little more consideration. We're working internally from a rate-filing perspective.