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Consumer-Driven Health Plans

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Summary: MSAs, HRAs HSAs—what are they? This session compares and contrasts consumer-driven health plans pre- and post-enactment of the new Medicare legislation. The issues involved in these plans are discussed from a managed-care company, employer and consumer perspective.

MS. JUDY STRACHAN: Paul has been at Aetna since 1988. David Tuomala has worked as a health actuary for over 13 years. He is currently director of actuarial services for Definity Health, a leading provider of consumer-driven health benefits, and has worked exclusively in the field of consumer-driven health benefits for the past four years. He was previously with Wellmark Blue Cross and Blue Shield of Iowa, where he provided actuarial support in many areas, including the large- and small-group insured individual Medicare supplement and managed care lines of business. He also has extensive experience in pricing, financing and regulation of health plans.

I'll let Steve speak first.

MR. STEPHEN J. KACZMAREK: If you looked at the program, one is supposed to have minimal or a little bit of experience for this topic. As I look around, I think there are a few people in here who have a bit more than just minimal experience, so we'll try and cover a wide range of experience levels throughout the presentation. We'll try and keep it free-flowing, and when you have any issues or questions, feel free to interject them.

This is the outline of what I intend to cover: where did consumer-driven health plans (CDHPs) come from; how are they different from other benefits; what types of CDHPs exist; what technical references exist; and how are actuaries developing cost projections, administration fees and reserves? Given that volume, we'll probably go fairly quickly.

I will mention at the onset that I have about 30 or 40 packets, and they're pretty thick. It's a couple of hundred pages of all the IRS notices and revenue rulings for health reimbursement arrangements (HRAs) and health savings accounts (HSAs). Believe it or not, it's not that bad of a read. Anyone who is so inclined can stop by afterward and I'll be glad to give you a packet. It will save you probably about an hour's worth of printing from the IRS Web site. It's a good reference if you work with these.

About five years ago, some of you may remember that there was a big push for defined contribution health care. Some of the appeal was that a defined contribution approach would have fixed costs for the plan sponsor; that they would ultimately be portable because whatever plan that person signed up for could be signed up for at his or her next employer; it would reduce the plan sponsor's liability (you may recall that at that time employees were suing their employers because their employers had selected the HMO that had done harm to them, which was guilt by association, I think); and it was an opportunity to give those employees broader choices. If you gave them $5,000 and told them to go out and get health-care coverage, they, in turn, would have the ability to choose from a broader array of choices, and then the choice would be theirs and not the plan sponsor's.

This died after about six or 12 months. One reason why it died is that the group mechanism fails. I'm speaking to the right group to illustrate that point. You're not going to be able to get those older workers or the more morbid workers coverage at an affordable price. Another reason it died is limited choices. Many of you in here price, or have priced, health benefits, and you would immediately be drawn to the leaner plans to attract the better risks, so the idea of broader choice wasn't accurate. No one would be offering those low cost-sharing benefits if anyone could sign up for any plan. Also, there were higher administrative costs. As you got down to the point where you had an individual who could sign up for any of the given plans, the administrative costs for enrollment and other associated functions would, in fact, be higher. The defined contribution approach quickly disappeared.

What emerged from that, though, were consumer-directed or consumer-driven health plans. These are a little different. They try and introduce consumerism to encourage prudent use of resources. They try to provide resources to allow the patient (the consumer) to make decisions on both courses of treatment as well as individual providers. I'm going to defer to Paul and Dave to speak about it a little more because they have some concrete examples of those. CDHPs also provide a financial incentive for healthy lifestyles, since the consumer (or the employee) is ultimately going to foot the bill for any ailments.

As we step back and look at CDHPs today, the two most common types are HRAs and HSAs. Some of you may have noticed a February 2004 press release that noted that we've hit the million-member mark for HRAs. That is a milestone, undoubtedly. It is worth noting that that's a million out of about 160 million Americans who receive their benefits through their employer, so it's still relatively small, but, nonetheless, it's a million.

There's also another variety of CDHPs with which some of you may be familiar. I'll give you one concrete example. Vivius has a "build your own health plan," where the consumer is able to choose from a variety of office visit co-pays, inpatient confinements and even the size of the network.
A third category is the industry that has sprung up to support CDHPs. These are the facilitators of CDHPs. These are companies that provide the software or the innovations that keep CDHPs moving to the next level.

The typical approach to an HRA or an HSA is to provide first-dollar coverage through those funds (either the HRA or the HSA), a gap in coverage and then at some point, a high-deductible health plan kicks in and affords coverage. You might have a $400 fund with a $1,000 deductible with that bridge, or that gap in the middle, which is $600.

Let's get specific. What are HRAs? First, what aren't they? They're not Archer medical savings accounts (MSAs), which were an under-50 product that had limited appeal and limited membership. They're not flexible spending accounts (FSAs), but HRAs and HSAs may be combined. We'll talk about that later. IRS Notice 2002-45 and Revenue Ruling 2002-41 are the two IRA documents that define HRAs, and it's worthwhile to point out that COBRA requirements apply.

The three items that define an HRA are: employer-funded; Section 213(d), the allowable expenses of where you start, but you can reduce them from that beginning list; and unused dollars, which are rolled forward. This is the first time we see the roll-forward feature of unused dollars because FSAs have the use-it-or-lose-it provision. To differentiate HRAs from HSAs, HRAs are not portable typically, and there are no plan design restrictions. You could offer an HRA with virtually any type of core medical plan or without a core medical plan.

Once again, I defer to Dave and Paul on these, but things like the health coach and online decision support tools are important elements to CDHPs and to HRAs in particular. The online decision support tools come in a number of varieties that have different purposes. There are online decision support tools that provide information about the treatment options and the cost of treatments. Other decision support tools that we're starting to see crop up that are worth mentioning are enrollment decision support tools. Starting January 1, many of the large carriers will be offering support to members who are trying to decide between an HRA and a traditional PPO or an HMO. That's important because many people attribute the very modest

enrollment in the CDHPs that we saw in the first year or two to few people understanding how their experience might work under an HRA versus their experience working under a traditional HMO plan. Those resources are an important development or innovation.

As a caution, there are quite a few variations in how HRAs can look when implemented. There's FSA and HRA integration. It's interesting to note that both Definity and Lumenos, two of the first companies to offer HRAs, typically handle this differently. One puts FSAs first, and one puts FSAs second. Certainly, that order is important if you think through the implications to the member. There's variation in the use of preventive care, the pharmacy benefit and the core plan design. Because there's no need for a high-deductible health plan, which we're going to talk about in a moment under the HSAs, we see a wide variety of core medical plans that go with HRAs.

When that fund ownership switches over to the employee is an important feature that's controlled by the plan sponsor in the summary plan description (SPD) or in the policy contract. That's important to note. The HRA can be structured so that it looks a little more like an HSA if you allow your employees to vest after a couple of years or if you have less-restrictive requirements for how they can use those funds in retirement.

Let's move on HSAs. Let's look at the three points that define an HSA. It was introduced by the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA). It adds Section 223 to the Internal Revenue Code. IRS Notice 2004-2 and Revenue Ruling 2004-45 define HSAs. Eligible individuals are those individuals who are not eligible for Medicare, who are not a dependent, and who have a high-deductible health plan (HDHP) but are not covered by other medical benefits (except preventive care or specific disease coverage).

Here are the three things that define an HSA. Unlike an HRA, which can receive funds only from an employer, an HSA can receive funds from either an employer or the employees who are covered by it. The funds are tax-exempt and can be invested. That employee who receives those funds is immediately vested in the HSA. Because the employee is vested in the funds, the employer cannot limit what is covered, and this is different from the HRAs where the employer can decide what an HRA covers. In this situation, we have an HSA where everything listed under Section 213(d) is an allowable expense.

The high-deductible plan that I was referring to a moment ago is a requirement. It's a fundamental difference between HRAs and HSAs. A high-deductible health plan must be offered with an HSA, and that person can't be receiving coverage from another benefit, except for preventive care and other minimal forms of insurance.

One other difference is the requirement for substantiation of claims. Under an HRA, substantiation is required, meaning that the employee who's covered has to be able

to submit a receipt to show, just like under an FSA, that he or she has incurred those costs. Under an HSA, the substantiation requirements are relaxed and, although the IRS may eventually ask that individual for proof that he or she incurred those costs, there's no need to substantiate claims for the HSA funds to be distributed. That's one other basic difference between these two funds.

I'd like to mention more technical stuff on HSAs regarding how they're contributed. A number of plan sponsors seem to be a little concerned that if they were to start up an HSA, they would be on the hook for the entire annual amount once the year began. As many of you know, that's the way an FSA will work. If an employee signs up for an FSA, allocates $5,000, gets LASIK eye surgery done on January 2 and then leaves the company on January 15, the company is on the hook for the $5,000. With HSAs, the contribution is done on one-twelfth of the annual amount, so there's not as much of a risk for the plan sponsor with an HSA as there is with an FSA. Of course, one way plan sponsors might control that risk with an FSA is to limit the amount of money that can be contributed into an FSA. That's why we typically see thresholds of around $5,000. The types of insurance coverage that can be paid for from an HSA include COBRA, health insurance when receiving unemployment, long-term care (LTC), employer-sponsored retiree medical and Medicare (but not Medigap).

In July 2004, we saw some more of the rules and regulations come out on HSAs. One thing that's worth noting is that the use of prescription drugs has a liberal interpretation. They've looked at certain drugs that can be used to prevent diseases from progressing or that could prevent diseases from occurring, and those pharmaceuticals can be covered under the core medical plan.

Also, HSA and FSA integration was a real sticking point for many of us as we tried to figure out how we would work with all these funds that we now have at our disposal. The regulations are pretty clear on this. The way they've allowed you to use these things side by side is interesting. You can put a limited-use FSA together with an HSA, meaning that this limited-use FSA might be for eyeglasses, dental or certain conditions that are not covered by an HSA. You can also have a suspended HSA, meaning that you could have someone who has contributed to an HSA over the course of time, but nothing is going to flow into it in a given year, so it has been suspended and put on hold. You can have an FSA that will kick in and be accessible after a deductible has been cleared. You could also have a retirement HSA. It's one where the funds won't be available until the employee retires. All those four specific examples of how these can be integrated are fairly well-documented.

Now that we've gone through the basics of what the HRAs and HSAs are, let's talk about the cost projections and pricing. First of all, we see there's a wide range of fees that are being charged for the use of HRAs or HSAs. We see everything from a couple of dollars per employee per month—we have to believe, based on how aggressive that is, that there's some sort of subsidization going on by the carriers

who offer that—all the way up to $10 or more per employee per month. We see a wide range for that administrative processing of HRAs and HSAs.

Most of us have started off by pricing that core medical plan, that high-deductible plan, just like any other stand-alone, high-deductible PPO product, which is where it starts. From that point, there's somewhat of a debate about which way you move with your utilization dampening. One line of thinking would say that because you have a fund available, and because people have access to first-dollar coverage, you would expect to see increased utilization. In that case, the typical utilization dampening of a company's high-deductible plan would be too much. There's a counter to that. Some people would say that the resources at their disposal were so good that they're going to encourage prudent use and reduce the overall cost. Most of us, being somewhat conservative by nature, would tend to go with the former, assuming that there's going to be a little more utilization because employees do have access to care with first-dollar coverage, using either the HRA or the HSA.

It's important to point out that some people are looking at this on a one-year projection, which I personally feel pretty strongly is the wrong way to look at this. Because that fund is going to roll over, you need to do a two- or three-year projection to estimate the cost impact of this product over several years. With the HSA, however, since the fund is portable, the pricing on that is trivial. If the employer is putting in $1,000, it's spent $1,000. Of course, it's one-twelfth of it a month but, nonetheless, it's unlike the HRA. We don't have to worry about the use pattern as much for the HSA portion of the benefit.

There are pricing considerations that pricing actuaries would ask themselves as they go through this product in trying to project costs. What's covered under the HRA? That's an important plan feature. If you stop and think about it, if you make an HRA available to employees and don't restrict it, you've provided an incremental benefit in a lot of areas that previously weren't covered. That employee could use those funds to pay for eyeglasses, so you've taken a subset of this group that has never had any claims, and they may have contacts, eyeglasses or other expenses that they never had. It's important to first understand what's covered. The ordering that we referred to earlier is important.

The plan language on how this works, especially the vesting piece, is essential. The actuaries that do the pricing on this need to understand that, as well as selection issues. If this product, either an HRA or an HSA, is offered along with other offerings, it's going to take a fair amount of work to estimate enrollment and the relative selection of the groups that select this product versus the other products being offered.

Finally, obviously those assumptions need to be communicated to the valuation actuary. There needs to be a close working relationship between pricing and reserving if they're separate areas in the company.

Let's talk about claim reserves. There are adjustments for high-deductible health plans. Recognize that what that pattern of paid claims looks like can be fundamentally different from other products. In the upcoming edition of the Health Section newsletter, I have an article that talks about some of the reserve considerations.

This gap between the HRA and the high-deductible health plan is important. How that gap changes over time is going to impact the reserve that needs to be held. This is assuming that the product is a combined fund and core medical. If you're just covering the core medical and not the fund, you don't have this issue. But if the product that you've sold is the HRA fund itself and that core medical coverage, the variation in that gap could be problematic for the actuary trying to project what the reserve should be over time because that can change year to year.

The issue of policy reserves is likely to be contentious. Consider the situation of a person who is on the eve of retirement and signs up for an HRA. If the policy language allows those funds to be used in retirement, and this employee retires and hasn't used that fund, there's going to be, at the end of the period, a balance that needs to be accounted for somehow. That specific situation is one that I'm throwing out as an example of where there might be the need for a policy reserve as early as year one with this product. When we get into the questions and start discussing this, I'd be curious about your reaction to that and whether or not you think that's valid or the situation that might preclude the need for considering a policy reserve for the product. If you do agree that a policy reserve is needed, of course we have the normal discounting for withdrawal and for interest to do the calculation to figure out what needs to be held.

Premium reserves is another issue that I think will be somewhat contentious. I'm specifically referring to the need to test for premium deficiency reserves. I want to point out the fundamental difference between having a policy reserve and a premium deficiency reserve. It's my understanding that a premium deficiency reserve would emerge whenever experience is developing differently than had been planned. You may start off with a product that you don't think needs a policy reserve but then note that your pricing (for whatever reason) may not have been sufficient. At that point, you may need to recognize the premium deficiency and consider holding a premium deficiency reserve. I will point out that if you're grouping it with your PPO product, that may be okay in the short term because it's immaterial, but over the course of time, the Statements of Standard Accounting Practice (SSAP) 54, which talks about the grouping of deficiency reserves, would be applicable here. There was a separate session on this yesterday, so you may have already covered this at length in that session.

MR. PAUL CONLIN: Good morning. I want to go over the lessons Aetna has learned. It's been three years since we first got serious about developing our first consumer-directed health product, which was an HRA at the time. This year, we've been developing our HSA product.

Before I get into the actuarial issues in the presentation, I want to go over a couple of the management lessons we've learned so far. In my 16 years at Aetna, Aetna has gone through various marketing incarnations. This goes back to the old PPO/HMO debate days. At various times we've said, "PPOs are better. HMOs don't control costs. They're just skimming off the best risks, and it's PPOs that control costs the best." Then we've did a 180° turn and said, "With HMOs you get a primary care physician (PCP)." We've doubled back on ourselves and had various opinions on that.

There has also been a third marketing stance we've taken, which is an agnostic one. That is, for some customers PPO is better and for some HMO is better. As an insurer, we wanted to be the best in both of those. Whenever we've taken either of the first two approaches, PPO is better or HMO is better, we've always lost market share and underperformed financially, whereas whenever we've taken the agnostic stance, we've always grown market share and had good financial results.

I think one of the lessons, as HRAs, HSAs and consumer-directed health plans yet to be even invented develop, is that we're going to try to be careful to not get religion on any one particular plan. We want to have the best HRA product out there, or we want to have the best HSA product. By the way, that doesn't mean that we don't have an opinion of which is better for us, because, for instance, we insure 31,000 employees, and every January 1 we have to make a decision of which plan or combinations of plans we're going to offer our own employees. Certainly, we're interested in the debate that will evolve, but we're trying to be careful. My lesson for other insurers is to be careful to not get tunnel vision and decide that one plan is the best for all. Let's try to keep an open mind, watch as things develop and try to observe that all the plans have something to offer certain employers.

Our second lesson that we've learned in three years is that for internal management reporting purposes and for systems purposes, we're not sure whether to look at these things as products or as delivery mechanisms. The analogy that we've observed internally on this is that PPOs and HMOs can be offered on either a fully insured basis or on an ASO basis. Fully insured and ASO aren't the product. The PPO plan or the HMO plan you're offering is the product. Similarly, on these consumer-directed health plans, the underlying plan can be an indemnity plan, a PPO plan, a point-of-service (POS) plan or an HMO plan. That's the product, goes the school of thought. These HRA and HSA wrappers are just a delivery mechanism.

In some ways, there are differences. By the way, these HRAs and HSAs can be offered on either a fully insured or ASO basis, for that matter, so the answer might be "neither." This might be a third dimension of these health plans. As you design your systems internally, try to keep your eyes on what's the product and what's the delivery mechanism when you group these. We don't have the answer on that, but a school of thought has developed that this consumer-directed health plan is just a

delivery mechanism for the underlying medical plan. Try to not lose focus on what the underlying medical plan is.

I'll talk about HRAs first. I'll talk about the insurer reporting issues and the customer reporting issues because as long as this is a hot topic, the consultants, the customers and the plan sponsors are going to be interested in seeing the results of how you're performing. On HSAs, I'll talk about the insurer reporting and the customer reporting.

HRAs are closer to traditional medical plans than they are to HSAs because they utilize some of the oldest ideas in insurance; an HRA is just a high-deductible medical plan with recent changes in tax legislation enabling the plan sponsor to chip in to assist the employee in paying those dollars, up until the employee reaches the deductible. Therefore, the balances under an HRA are notional. It's a bookkeeping entry. There are no real assets underlying the employee's balance. It's just what the plan sponsor is committing to assist the employee in paying. Therefore, from the insurer financial statement point of view, there are no asset or investment income reporting issues. It doesn't appear on the insurer financial statement.

If the fund part of the HRA is attached to an underlying medical plan, the HRA is invisible for reporting purposes. It flows through your income statements and balance sheets just like a regular PPO plan, a POS plan, an HMO or whatever the underlying plan is, and the combined plan is a high-deductible medical plan. You can sell the fund, the HRA, on a stand-alone basis, and some third-party insurer operates the insurance plan that's on its paper. In that situation, if you're the insurer running the fund part of the HRA, it's not even an insurance product, so you don't have to worry about the reporting issues.

The underlying medical plan of the HRA has an incurred but not reported (IBNR) reserve just as it would if there were no HRA attached to it. You have all the traditional IBNR reporting issues of all the difficulties associated with estimating the most recent periods. In addition to those usual IBNR reserving issues, the high member cost-sharing on the underlying plan complicates the reserve analysis by complicating the intra-year seasonality of incurred claims. For instance, if deductibles and out-of-pocket limits all reset on January 1, the insurer won't see many incurred claims coming in in January, February or March. Conversely, around November and December, you thought you were selling an 80/60 PPO plan, but you're now selling a 100 percent PPO plan because the members have met all their out-of-pocket limits.

It complicates, and it can also cause chaos internally because for internal management reporting purposes, the first six months of the year you're reporting PPO medical cost ratios (MCRs) in the low 70s; management gets all excited and reduces its forecast of MCRs for the year; all the claims come barreling through in October, November and December; and everyone is up in arms. What happened? Nothing happened. The seasonality is happening as it should. It's just that everyone

got overly enthusiastic about the good results that were coming in in January, February and March.

Because HRA balances are notional, no financial statement reserve is held for them. The employee generally surrenders unused balances upon termination of employment. What could change this is if HRA balances start to become more portable and can be used for things other than meeting the deductible or the out-of-pocket limit. As the insurer you want to be cautious about that, but as long as you can make the statement that the employee surrenders the balance, you have no liability on your financial statements.

Financial Accounting Standard (FAS) 60 says a liability occurs when an insured event occurs. No insured event occurs until the member incurs a claim. The statutory and the GAAP accounting standards are clear: as long as the employee needs to surrender the balance, there's no liability. Of course, the liability for incurred claims is already in the IBNR, so you don't need another liability for the unused balances.

Regarding premium deficiency reserves (PDRs), premium deficiencies are complicated even on vanilla products, but the usual statutory and GAAP PDR requirements apply to the underlying medical plan. If the entity buckets the underlying medical plan separately from its non-HRA block for pricing and management reporting purposes, arguably PDR testing should be separate, as well. I would call your attention to the new Standard of Practice (SOP) 42, which covers premium deficiency reserves among other things. It does have a clause in there that says under all circumstances, no matter how you bucket your business for PDR testing purposes, each individual bucket that you're testing should be material to the entity as a whole. Even if you bucket your HRAs separately for internal management reporting purposes and for pricing purposes, if they're not material to your company as a whole, Actuarial Standard of Practice (ASOP) 42 kicks in, and you don't have to do separate PDR testing for it. I would argue, of course.

Let's talk about HRA customer reporting. Customers switching to these, and customers who are considering switching to these, since these are so new, are going to want information: "If I switched, did I make the right decision? If I haven't switched yet, should I be switching?" It's going to put demands on the reporting system of your company to be able to demonstrate how the product is performing.

Aetna has put out the results of a study. Don't read too much into the conclusions in this because this was based on small amounts of data, and we all know the pitfalls of comparing a block of business over periods of time. Have you adjusted for demographics? There are all the things for which you have to adjust.

I'm going through this to show you the structure and the types of questions you have to be able to answer. You have to be able to provide data for these types of questions. They're different data than what are normally provided on PPO plans.

Aetna HealthFund, by the way, is just the marketing name of Aetna's HRA product. Aetna HealthFund members were first-year adopters. Medical results were from 19 customers, including one full replacement. There was a focused study on pharmacy results from one customer with integrated Rx. There were 13,500 members and 12 months of claim and utilization data. The comparison populations when we did this were a randomly selected population, not enrolled in Aetna HealthFund, and a continuously enrolled population from a PPO. Of course, these numbers will grow as the years go along and there are more members in here, but these were the data we had in June 2004, so this is what we used.

I'll skip through the conclusions and just show you Chart 1, the type of data you have to be able to present. You have to be able to present demographic data on your enrolled population. If a lot of the members have recently converted from traditional nonconsumer-directed health plans, you have to be able to show what type of plans they came from. Luckily, we had good representation of people coming from all sorts of combinations of products. As you roll out a consumer-directed health plan, keep in the back of your mind ahead of time that these are the data you're going to have to be able to report on because it's more difficult later to retrofit your management reporting systems to be able to report all this.

You're going to have to be able to report what the eligible charges were before all these members converted and what the eligible charges were after they converted.

Let me explain the way everyone thinks of the dollars that are being spent from the fund by the employee out of pocket and by the employer as medical charges come up during the year for the consumer-directed health plan. Dollars get spent from the bottom up on this. Dollars get paid out of the fund first. Next is the employee cost-sharing—the high deductible, the high out-of-pocket limit. The underlying medical plan, which in the case of Aetna HealthFund is a PPO plan, pays its share of the charges. Whatever is left over, if anything, is by definition the savings that occurred from switching to Aetna HealthFund. If there are no savings, all consumer-directed plans are doing is changing the allocation of employer money to employee money, which is fine, but the consumer-directed health plan in and of itself isn't accomplishing any savings to the health-care system as a whole.

The promise of consumer-directed health plans is that because members will be reluctant to spend or disincented to spend, they will shop around for specialists or shop around for hospitals to try to keep that spending as small as possible and the savings as large as possible.

I mentioned earlier the PPO and HMO debate. I'm not sure it ever got resolved of which saves money, PPOs or HMOs. Similarly, I suspect the debate will never be resolved as to whether consumer-directed really saves money or not. From our point of view as an insurer, we're being careful not to get tunnel vision and to make sure that we're the best at whichever we offer.

The other lesson is to make sure your management reporting systems can handle this type of information. This requires far more detail than a typical medical management reporting system has had to report to date. Have all the systems in place to be able to do this.

As far as the next steps, first there would be a more detailed understanding of utilization patterns. The study population has been in Aetna HealthFund for two years. As the years go by, you want to be able to look over this in multiple years. It will be interesting to look at people who accumulate fund balances. What do they do? Maybe they seek to protect those balances more, or maybe they say, "When the time comes, this is what I've been saving for. Now is the time I'm going to spend it." Maybe it's something in between. There will be even deeper data required of the fund balances that are being spent. Are they one year old? What's their duration? It will generate a demand for lots of management reporting data.

Look at behavior before and after the deductible is met. One thing about annual rate structures in here is that we all have the annual rate structures that have $1,000-deductible factors, $2,500-deductible factors and $5,000-deductible factors. Were they built with the intention of their ever being widely used? How good is that factor? A lot of us are going to learn by doing what the right factor is for the high deductible amounts and for the high out-of-pocket amounts.

There should be continued examination of maintenance of care. One thing, in case that hasn't come across yet, is that preventive services are generally covered 100 percent. This is one example of pulling the best of both PPO and HMO. One of the things consumer-directed health plans are inheriting from HMO is that annual physicals are generally covered 100 percent and other preventive services are generally covered 100 percent, regardless of what the fund balance is, what the deductible is, et cetera. What's the utilization on preventive services going to be, and does that utilization of preventive services save costs in the hospital and specialists?

HSAs are a more radical departure from traditional medical plans. First, the state of New York has confirmed that HSAs are not an insurance product as defined in Section 1101. That's a good thing from a statutory reporting point of view. It simplifies the reporting, as you're going to see that you have to put in your statutory blanks. It cannot be a funding arrangement where the HSA is not an employee benefit plan. In other words, the HSA still has to have a traditional plan sponsor and be offered as an employee benefit. It's accounted for in the statutory blank like funding agreements and other deposit funds. It's not an insurance product. There is not premium. There is not claims. This is the fund itself of the HSA. Of course, the underlying high-deductible medical plan *is* an insurance product.

The fund itself on the HSA uses fund accounting. Deposits, whether they come from the employee or the employer, are not revenue to the insurer. Withdrawals are not

claims and not expenses; they flow through the financial statements. They use fund accounting. The ending balance equals deposits minus withdrawals, plus credited interest, plus the starting fund balance. What's the source of earnings to the insurer if there's no revenue and no claims? The source of earnings to the insurer is the net investment income from the balances, less the interest credited to the balances, less administrative expenses from administering the accounts. It will be interesting if the fund balances don't generate enough critical mass. It's going to be difficult for high-cost insurers to administer these things profitably with all the fund transactions going in and out.

To be eligible for an HSA, you must be covered by a qualified high-deductible health plan. If you are covered by two high-deductible health plans, the contribution to the HSA is capped based on the lesser plan. You cannot be covered by a nonhigh deductible health plan that covers benefits already in the high-deductible health plan, so you have to be able to track what the underlying health plan is to the HSA. You cannot be covered by Medicare, and you cannot be a dependent on a tax return. The high-deductible health plan has two requirements. The annual deductible must at a minimum be $1,000 per individual and $2,000 per family. The sum of the deductible and the required out-of-pocket cannot exceed $5,000 per individual and $10,000 per family. The underlying high-deductible health plan can't be too rich, but it can't be too slimmed down, either. It has to be just right. It has to fit into this corridor.

There are also rules about HSA contributions that can be made by the employer, by the employee, by family members or by a combination. This means that as the insurer, you have to have the administrative capability to accept deposits from either employers or employees. It has a retail aspect to it. An employer can pay you by funds transfer, but a typical employee won't necessarily pay that way. The maximum contribution in any year is the lesser of the high-deductible health plan annual deductible, or $2,600 per individual, $5,150 per family. At 55 or older, as with many IRS-enabled pension plans, you can make make-up contributions. You can make larger contributions if you're 55 or older, and those will be growing every year.

There are also rules about rollover and transfer. The HSA participant can make one rollover per year. It must be deposited 60 days after receiving. That comes from 401(k) rules about rollovers and transfers. The account holder can request a transfer from one HSA administrator to another. Besides deposits coming from employees and employers, deposits are going to be coming from other HSA administrators. Similarly, you'll have to make disbursements to other HSA administrators as the balances grow. One of the potential pitfalls here is that transaction costs could be substantial. You have to be careful not to underestimate what those are going to be.

HSA withdrawals can be made at any time. They're not taxable if they're for qualified medical expenses or premiums. The HSA balance in the fund can never be

less than zero. This is one difference between HSAs and HRAs. Since HRAs are notional balances, you can have a negative balance, as long as for the full year the contributions and disbursements all even out. HSA is point in time. At no point in time can an HSA balance be less than zero. It's true fund accounting. Upon death, disability, age 65 or Medicare eligibility, funds can be withdrawn for nonmedical reasons without penalty, but the participant has to pay the federal income tax that is due. With every item that I mention, you see another source of transaction costs. You have to be able to track the age and the Medicare eligibility of all your HSA participants. There are definite recordkeeping issues to HSAs that HRAs don't have. HRAs more closely resemble, from an administrative point of view, a traditional medical plan. Administratively, an HSA more closely resembles a pension plan. That's the insurer reporting in HSAs.

There are also the usual customer-reporting issues. All the customers are going to want to know, "I'm in the HSA. Am I saving? What's my balance?" To pay for that, don't underestimate the administrative costs. You will typically want to charge a monthly or quarterly administration charge. You'll want to let the members know and send them balances of what they're being charged. You'll also want to plan for sending fund balance statements to members on a timely basis. There are a lot more recordkeeping issues with the HSA.

That's what we've learned in three years of developing these products and having them in force for a while. We're keeping our eyes open for the popularity of these in the marketplace. As legislation continues to evolve and change, and clarification continues to come, we're keeping up with that.

MR. DAVID TUOMALA: I'm with Definity Health. Unlike my colleague from Aetna, Definity Health is by no means agnostic about consumer-driven health care. In fact, we're precisely the opposite of that. However, from a valuation actuary perspective, I am able to be somewhat agnostic about valuation issues simply because we work only with employer plans. The decisions are the employers' decisions rather than my decisions. I'm here just to help them understand those decisions.

There are a few topics I wanted to cover today. Again, I will be strictly talking about the employer-sponsor side of the equation. First, I will talk about some of the employers that are offering consumer-driven health plans today through my company and about some of the common plan designs that they're seeing. I'll talk a little bit about our experience with HRA expenditures and rollovers. How much money do people spend when given one of these accounts? That will give you some sense of what assumptions you might need to make if you're working with one of these plans. I'll go over some specific employer valuation issues around consumer-directed health plans. Then I'll talk a little bit more about the differences between HRAs and HSAs, again, more from the employer perspective than from the plan perspective.

As far as the client base that we're working with today, our business is strictly self-funded employers, primarily large self-funded employers. Most of our client base is Fortune 100 to Fortune 1000 types of businesses. A lot of the early adopters of these products have been in the larger segment of the market.

We do have a fairly broad range of size distribution, from under 500 employees to over 50,000. I think our smallest client has been around 150 eligible employees up to several clients with 50,000 or more eligible. We had 14 total replacement clients in '03 and 18 total replacements clients in '04. To date, those have been primarily the smaller size—probably under 1,000. We have been seeing a lot of activity recently, in even the Fortune 500 clientele, that's starting to move toward full replacement with consumer-directed plans. Often, that's a combination of both PPO and the HRA model.

A comment was made earlier that we've seen relatively low penetration in these plans. To some extent that's true. On average we've run about 10 percent to 15 percent enrollment in a choice environment. About 30 percent of our client base in '04 had more than 20 percent enrolled in a choice environment. I think the characterization that there has generally been low enrollment is not necessarily true; I think that varies from company to company. Granted, there still are just one million people enrolled out of 160 million. The total penetration is still small but growing.

We have seen, and I'm not sure that this is true for all consumer-directed health plans, a lot of our clients offer more than one plan design option. Over half of our clients have two, three or four plan options in '04 rather than just a single one.

Another misconception or common characterization of consumer-driven plans is that they're usually a stripped-down benefit design and offer relatively lean benefits. Again, that's generally not true, at least of our business.
Personal care accounts (that's our term for it), or HRAs, are generally between $500 and $1,000. We had a majority with a $1,000 level in '03. We're seeing more business now placing with the $500 or $750 primarily.

The amount of member responsibility is the gap between the deductible and the HRA. Most of our clients are in the $500 to $750 range, so it's not a stripped-down benefit design. We started out with a lot of clients with 100 percent in-network coinsurance after that gap was met. We are seeing the market move away from that. Predominantly what we're seeing today is 90 percent in-network, maybe 70 percent out-of-network, or 80/60 or similar designs.

I'd like to talk a little bit about the experience with HRA rollovers. We looked at '03 calendar year and HRA rollovers, splitting them out into first-, second- and third-year experience, We've seen in the neighborhood of 28 percent to 34 percent of the available account balances (for second- and third-year plans that would include the amounts that carried over from the first year or from the second year). At the end

of the year, an average of 30 percent or so is still there. Fifty percent to 60 percent of employees would have a positive balance at the end of the plan year. On the low end, we've seen it go as low as 20 percent as far as the amount available and as high as 50 percent in certain clients.

Let's get into some of the valuation issues. The high-deductible plan is pretty straightforward. For us it's a self-funded plan, so you treat that like any other self-funded plan. As Paul mentioned, the incurred claims do exhibit a seasonal pattern. I wanted to give you a flavor for what we've seen on that. Our average deductible is around $1,500 or $1,600 for a single employee. If you're looking at a three-month period, the first quarter of the plan year, the expenses might be as much as 40 percent to 45 percent lower than the ultimate 12-month level. At six months they may be 10 percent to 12 percent lower, and at nine months they're around 4 percent to 5 percent lower. There is a fairly substantial seasonal pattern throughout the course of the plan year.

There are some general IBNR estimation issues. Obviously, 12-month periods are relatively straightforward. Your averaging for the noncredible (creditable??) months gets a little bit more problematic, due to the seasonality. You can try to do a direct seasonal adjustment, so you look at those patterns over time and adjust for them. You can also look at same months from prior periods and turn that forward. Neither works that well, so if anyone has any bright ideas about how to do that better, I would be happy to hear about them.

With our business we've seen a lot of change in enrollment. We have a lot of choice business and a lot of growth in enrollment, which further complicates trying to understand what that pattern is. There are limited historical data to develop your lag patterns. There are a lot of plan design differences, geographic differences and network differences. It's hard in the early going here to understand all of those issues.

Let's talk a little about employer accounting. Clearly, they are notional account balances on the HRA side, so they're unfunded. As has been mentioned previously, those balances are generally forfeited when employees terminate. Many employers do offer the balances to carry over into retirement for those people who participate. Generally, that's just like other retirement plans; they offer an HRA as another option. Carryover of unused amounts can create a potential future liability for employers. Some employers recognize that, and some employers don't recognize that; it's a mixed bag right now.

As far as options and practice for employers, many of them will treat it like any other self-funded benefit plan, so it's a contingent liability. Basically, they establish an IBNR for paid claims plus IBNR and have no provision for any accrued balances or unused balances.

Some employers, though, are creating a liability for those expected future HRA payments. There's some general support in the accounting literature for that, but obviously there's nothing specific. Some things that have been mentioned are FAS 43, FAS 106 or FAS 112. I think it's a tortured definition, but you can torture it to make HRA balances construed to "accrue" over time so that you get these balances each year. You can, I guess, deem them to accrue over time and can make an argument that you should accrue a liability for that over time. We have employers that are using both approaches today. I would guess for most large employers it's not really material how they do that. A lot of employers also use 100 percent of the HRA in determining what their funding amount is each year. Often they'll use 100 percent of that balance as their accrual, more or less.

Estimating HRA IBNR is, again, similar to a high-deductible plan. It has an inverse seasonality pattern, so we pay more on a per-employee-per-month basis in the early part of the plan year and less toward the end. For a three-month period, again, on average it's around 40 percent higher, for a six-month period it's about 30 percent higher, and it's 14 percent to 15 percent higher in the first nine months. There is a marked seasonal pattern on that one, as well, in a different direction.

There's a completely different completion pattern because there's a limited amount. You can't have incurred but not paid if you've exceeded that account balance. Again, there are limited historical data, outside of a few companies who have experience with these. There are differences by the amount of the account balance, so larger HRA and smaller HRA, and there are also differences in health status. A lot of the business that's enrolled in this is in a choice environment, so we have differences in health risk, et cetera.

Estimating unspent HRA liabilities eventually could become a fairly complicated projection if you want to do that. You can get into looking at retirement decrements, termination and things like that, as well as assumed claim differences by age, length of service and health status. Currently, no one is doing that, at least to our knowledge. They're basically using, at least on the employer side, simple estimates.

When we've done some long-term modeling with a huge number of assumptions going into it, it suggests that a fairly high percentage would be used if you look at a long period of time, such as a 20- or 30-year horizon, something on the order of 90 percent or more. This may get more specific as those balances grow, assuming that the business doesn't transfer to HSA immediately. If we do see groups that run out for a five- or 10-year period, the balances are obviously going to get bigger, and it may be more of an important issue than it is today. However, additional complexity may not be justified, given the relative size of this liability and the materiality for the rest of the employer's financial statement.

There are plan design differences between HRAs and HSAs. The high-deductible plan has been mentioned several times now. There are limited ranges for qualified

plans under HSAs. There are no limits on HRA design, so you have a lot more flexibility. In theory, at least, that reduces the amount of employer flexibility in designing an HSA plan. However, the plan designs that we're normally seeing on the HRA side are generally in that HSA allowable range anyway, so it's not as though (at least that aspect of it) the high-deductible plan has been a big constraint to employers or that it will be a big constraint.

A big constraint, though, is eligible benefits. For HRA models, in the early going, back in '01, we did see a lot of employers that offered a full spectrum Section 213(d) under the HRA—things like dental coverage, LASIK eye surgery, et cetera. Starting in '02, we saw most employers start offering just traditional health benefits. An employer likes to have that control over what's covered and not covered. Obviously, HSA benefits are broader. You're limited only by the 213(d), and the employer has no control at all over that. The eligible benefits include cash, so you can cash that money out, on a nontax-qualified basis, but you do have the option of taking that money out in cash. From an employer perspective, that may be an uncomfortable position, particularly for the employer contribution side.

On employer contributions, the HRA contributions are unfunded until they're used, so it's a noncash expense. It's not something that they have to fund, and they're forfeited on termination, generally speaking. HSA contributions are fully portable, so you have a cash expense when they're contributed.

Those examples lead to differences in cash flow. The HRA contribution is available at all times. From an employee perspective, this is a plus. At the beginning of the plan year you have access to that full amount of your HRA contribution from the employer; this is not necessarily so for HSA. However, the cash flow for the HRA is dependent on the claim payments. HSA is available only as a cash account, so it's available only when the money is in there. If your employer is contributing one-twelfth of that amount per month, it's likely that employees will run short and not have a benefit from that HSA. Again, the account balance could lag claims.

There is one possible exception—this is buried in the rules that came out in June—with the cafeteria plan. An employer apparently can prefund employee contributions through a cafeteria plan, but there are some other considerations that may make that less attractive, such as discrimination testing.

HRA is clearly an employer-administered plan. The employer chooses everything about that plan. It chooses one vendor. It's easy to integrate claim payments with the HRA and the HDHP. However, HSA is an individual account. Employees can choose whichever vendor they want, in theory. It makes benefit integration more problematic and more difficult.

Regarding modeling assumptions, we haven't done a lot of this yet. I think this is a transition issue between HRAs and HSAs; employers, at least, will be interested in, "What does that mean to me as a plan sponsor?" Some assumptions that we'll need

to be looking at are seasonality, as I mentioned; the claim payment pattern of the HRA, which is important in determining the equivalent value; employee turnover and timing because HSA money is a cash expense and HRA money is an incurred expense; interest credit; contribution strategy, which is whether you do that monthly (you could theoretically do that at the beginning of the year, but I don't believe that employers are going to be willing to do that), or do some combination of some small amount at the beginning of the year and some amount monthly; and equivalence determination. There are a couple of ways you might want to determine that equivalence. I don't know that anyone is doing much with this today. You can look at first-year present value of cash flow, or you could look at long-term present value of cash flow. There are probably other options, too. Those are the first couple that we've thought of.

MR. STEVEN L. WITULSKI: In an HRA account, what options do employers have regarding termination of that kind of a plan or contribution structure? Do they have options of what happens to account balances, et cetera?

MR. TUOMALA: It's like a self-funded plan in all aspects. They're free to change the plan or terminate the plan at any point, as they would with any other self-funded plan.

MR. JACK F. SULGER: I have a couple of questions. The first one is what is the definition of an incurred claim? Is it date of service, date of admission, date of disability? I'm thinking of extension of benefits. Does that come into play again? My other question is about coordination of benefits and carryover deductibles. Is that part of the plan design?

MR. CONLIN: I'll answer the question about the incurred claims. The answer is yes, it's all three and even more, depending on your reimbursement strategy. For instance, if your hospital reimbursement is diagnosis-related group- (DRG-) related, you've incurred the entire reimbursement as soon as the admission happens. If it's a per diem—it's incurred and you reimburse day-by-day—the incurred claim happens day-by-day. It's no different from an underlying medical plan defining the incurred claim.

Keep in mind that the IBNR is two pieces: what you already know about but haven't paid yet, and what you don't know about. The piece you don't know about is an estimate anyway. You use the usual estimation techniques, wait 90 days and see how good your guess was. From that point of view, it's no different from a traditional medical plan.

MR. TUOMALA: Let me add to that. From an incurred claim perspective, it may differ, although not necessarily from an IBNR estimation standpoint. When we administer the HRA component for plan sponsors, normally we treat that on a paid basis. If a claim comes in, and there's money available in the account, regardless of incurral date, with the exception being as long as they were covered by the plan

when the service date occurred, we would treat that as an eligible expense for the HRA component of it. For the high-deductible health plan component of it, we usually, with Paul's caveats there, would use the service date or the traditional incurred date rule for that.

MR. KACZMAREK: I'll take a shot at the other two. For the deductible carryover, the same rules for the high-deductible plan would apply. If you have a three-month provision, whenever the core insurance, the high-deductible health plan, kicks in. coverage would be dependent upon whether or not there was a carryover from the preceding year. That would be common to the core medical program.

For the coordination of benefits (COB), in the case of the HSA it's a little easier because of the limitation on duplicate coverage. With an HRA, I think you still have the coordination between the core medical programs.

MR. CONLIN: Let me follow up with that. For coordination purposes on the HRA model, we coordinate like any other benefit. If you have dollars available in your account, that would pay according to the coordination rules. If there was money, you're secondary, you would pay out of the account first and then apply benefit rules otherwise.

We don't normally apply deductible carryover credit in our standard benefit design. It is available in an HRA model. It's just not something in which most employers have been interested.

MS. KAREN BENDER: In the high-deductible health plans, if you have a carryover, how does that integrate with the minimum deductible that enables you to be qualified, that gets indexed every year? Right now the minimum high-deductible health plan, I believe, is $1,000. If you have a carryover from '04 to '05, you don't have a $1,000 deductible for '05, and obviously that gets indexed. How does that coordinate?

MR. CONLIN: Yes, absolutely. If the underlying high-deductible health plan has a $1,000 deductible, and you have a $10,000 fund balance, if you choose, you don't have to pay anything out-of-pocket that year. Keep in mind that you don't *have* to spend the fund on the deductible.

MS. STRACHAN: The question as I understand it was about the deductible carryover. If you have a $1,000 deductible and at the end of the year can carry $200 over, you don't have a $1,000 deductible in the next year. Will that violate the federal HSA rules?

MR. KACZMAREK: I think you could have a carryover provision that still was below those threshold levels, but obviously it would be safer to adhere to the lesser of those two. If you had a $200 carryover, and your core plan was $1,200, it would meet the HDHP minimum as specified by the IRS. That would be the safe thing. But

I think that today's point is that that's probably one reason why most companies may be suspending that provision in the core medical coverage.

Chart 1