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Benefit Insights

Health Savings Accounts: The Latest Chapter in Consumer-Directed Health Care

Though the debate surrounding the Medicare Prescription Drug and Modernization Act focused on the federal medical program for seniors, the law also created a new type of tax-favored account that may have profound implications for employer-sponsored health care.

These accounts, called Health Savings Accounts (HSAs), offered to individuals who are covered by a high-deductible health plan a tax-favored way to save and pay for medical expenses. Both employers and individuals can contribute to a HSA; individual contributions are deductible; and accrued amounts can be carried over year-to-year and are nonforfeitable. These advantages, coupled with the desire on the part of many employers to move toward a more consumer-directed model for the health plans they offer to employees, make HSAs an attractive arrangement to consider.

In order to participate in a HSA, an individual must be covered by a high-deductible health plan, defined as a plan with a minimum deductible of $1,000 for an individual or $2,000 for a family, and an out-of-pocket expense limit that is no more than $5000 for individuals or $10,000 for families. Generally, HSA eligibility also hinges on the individual not being covered by any other plan, though coverage under plans such as accident, disability, dental, long-term care, and specific illnesses is permitted.

An employer that offers a high-deductible health plan can establish HSAs for employees who are covered by that plan, or individuals covered by a high-deductible plan can establish a HSA on their own. HSAs must be funded, with amounts held in a trust or custodial-type of account and a bank, insurance company, or other approved administrator acting as trustee. HSA earnings are tax-free.

The employer, the accountholder, or both, may make contributions to a HSA. The annual contribution amount is the lesser of the health plan deductible or $2,600 for individuals with individual coverage and $5,150 for individuals with family coverage (these amounts are estimated for 2004 and are adjusted annually). Individuals age 55 and older can make larger contributions. Employer contributions are excluded from gross income and individual contributions are deductible in computing the individual's adjusted gross income. (An employer can choose to offer a HSA through a cafeteria plan, in which case participating employees would make contributions on a pre-tax basis.). An individual cannot make contributions after becoming eligible for Medicare, although withdrawals continue to be permitted.

Amounts paid from a HSA for "qualified medical expenses" are distributed tax-free. The term "qualified medical expenses" includes most items defined as medical expenses under Section 213 of the tax code, but specifically excludes health plan premiums. However, certain types of health plan premiums can be paid for tax-free from a HSA: COBRA premiums; long-term care insurance premiums; health plan premiums paid by Medicare-eligible individuals (other than those for Medigap policies); and health plan premiums paid by individuals who are collecting unemployment compensation.

Amounts paid from a HSA for anything other than a qualified medical expense are included in the accountholder's gross income and generally are subject to an additional 10% tax (the law provides that distributions made after an accountholder's death, disability, or attaining Medicare eligibility are not subject to the additional 10% tax).

As noted above, an individual has a nonforfeitable right to

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Consumer-Driven Health Plans Earn Important Role in Insurance Industry

Very few of us actually understand the consequences of our health care decisions. For a $20 co-payment, we can get a cholesterol-lowering drug that costs $100 per month rather than change our diet or increase the amount we exercise. But, if we had to pay full price for our prescriptions and other medical care, most of us would consider these expenses more carefully before dipping into our own pockets.

This is the behavior some employers are hoping to spark by offering “consumer-driven” health plans (CDHPs).

Under a consumer-driven health plan, an employer still contracts with insurers to purchase group insurance and retains some measure of control over health insurance purchasing decisions. CDHPs often give employees more choice in terms of benefit options, allowing them to choose their own deductible levels based on individual needs. In turn, these options also increase their share of the costs and risks associated with health care.

For example, let’s say that benefits under a CDHP cover the first $500 to $1,500 of an employee’s medical care costs per year. After this level is reached, employees are responsible for all additional expenses until a pre-selected deductible has been met, usually somewhere between $1,000 to $3,000. Once this annual deductible is reached, the insurance plan kicks in and covers say 60 to 70 percent of medical costs for an out-of-network provider or say 80 to 100 percent for a provider within an established network.

Now, if the initial $500 to $1,500 given to the employee is not spent, an employer can setup their plan to have any remaining amount rolled over to use the following year by that employee. But, because the employer retains ownership of this account, any funds left over if the employee leaves the company are forfeited.

Plans such as these are so new that there is no way to judge their overall impact on health insurance costs or how widely accepted they will be by employers and employees. What is for sure is that these plans seem to be picking up steam within the industry.

It goes without saying that the growth of CDHPs will adversely affect Pharmacy Benefit Managers (PBMs), and despite the unprecedented growth and popularity witnessed by these plans over the last few years, consumer-driven health plans may leave them struggling to remain prominent and profitable. In fact, PBMs are closely monitoring new consumer directed plans that offer pharmacy-only benefits.

Designed to function much like consumer-driven health plans, members of these plans use their pharmacy savings account to cover prescription drug costs. Any unused funds can be rolled over to the next year.

Other similarities between the new pharmacy-only consumer directed plan and consumer-driven health plans are the concerns for decreased utilization, and the perception that both plans punish people with chronic conditions such as asthma, diabetes, heart disease, high blood pressure, or mood disorder.

According to the Yale School of Medicine, asthma, diabetes, heart disease, high blood pressure and mood disorders cost Americans more than $62 billion a year in treatment and prescription drug costs. Critics of both the consumer-driven health plans and the new pharmacy-only consumer plans are concerned that “consumerism” will force employees to skip needed care or medical treatment, and forego on filling important, needed prescription drugs. Only time will tell.

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amounts that have accrued in a HSA. Unused amounts roll over year-to-year, even if the HSA is offered through a cafeteria plan. Upon death, the amount in a HSA can be transferred to a spouse tax-free, but transfers to others are taxable. HSA interests also can transfer tax-free upon divorce.

HSAs may be established beginning January 1, 2004.

Because the law creating HSAs is new, certain operational specifics have yet to be addressed, such as who will be responsible for determining that distributions are used for qualified medical expenses. However, it is clear that HSAs hold promise for employers that want to better define their contribution for health care and shift to employees more control over how health plan dollars are spent. If your interest has been piqued by what you’ve read about consumer-directed health plans, HSAs are worth investigating.

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A Look Behind the Curtain – Inside the Drug Formulary

Your company, like most employers, probably has a prescription drug program that includes a drug formulary. You know how the formulary works with your co-pay design, incentivizing members to make cost-effective medication choices. Now, peek behind the curtain and see how the formulary works from the insurer's side.

Purpose

Insurers (and employers) use the formulary to manage costs and to improve care. When a drug company introduces a new drug that is similar to other drugs already available to treat the same disorder, they are considered to be "therapeutically equivalent" or, work in the same way to treat the disorder. Given an equal choice, the insurer might offer only the less expensive drug in its formulary, i.e., "equal quality at a better price" or require higher co-pay for the more expensive drug. In the case of Lipitor versus Pravachol, both drugs belong in a therapeutic class called "statins." They lower cholesterol by slowing down the body's ability to make cholesterol. Drugs in this class include atorvastatin (brand name Lipitor), fluvastatin (Lescol), lovastatin (Mevacor), pravastatin (Pravachol) and simvastatin (Zocor). Consequently, the insurer may choose to cover only one or two of these drugs, based on their ability to negotiate favorable pricing.

Drug Selection

Insurers use a pharmacy & therapeutics (P&T) committee to select formulary drugs. The committee, made up of doctors and pharmacists, review the medical research on drugs within therapeutic categories. Within each category, they select the drugs that are "best in class" for inclusion on the formulary. The insurer then works to negotiate the best prices for the selected drugs.

The committee also tracks trends in side effects and outcomes of various drugs and may determine that a drug be eliminated if their ongoing research suggests that the benefits are not as real as the drug maker originally claimed.

In this way, the formulary protects plan members from drugs that are not performing as planned.

Cost

Insurers or, more frequently, sub-contracted pharmacy benefit managers (PBMs) negotiate the purchase price of drugs based on three factors: volume, "class of trade" and "ability to move market."

Volume

Insurers negotiate better pricing based on the volume of drugs they expect to purchase – the greater the volume, the lower the price. To the extent that a formulary delivers greater volume of one drug over another, the formulary creates a volume advantage that is useful in negotiation.

Class of Trade

Drug manufacturers must follow a "class of trade" system that provides:

- Lowest pricing to the federal government;
- Next lowest pricing to hospitals;
- Next lowest pricing to HMOs and other captive settings;
- Next lowest (or highest) pricing to purchasers for retail trade.

Insurers that qualify as HMOs or represent other captive populations will usually achieve a pricing advantage due to special status pricing.

Ability to Move Market

The formulary is vitally important in delivering market to manufacturers. When an insurer or PBM can tell Pfizer, manufacturer of Lipitor, that all ("all" is always qualified) prescriptions for cholesterol-lowering drugs will be written for Lipitor (versus Zocor or Prevachol), they are "delivering market" and creating a competitive advantage for Lipitor that Pfizer is willing to pay for through lowered pricing.

Outcome

Formularies can improve care through the careful, ongoing review of drug effectiveness results by the formulary decision makers, leading to best choices based on the latest research and, and, use market forces to deliver lower pricing.

How Your Small Group Health Insurance Renewal Is Determined

Have you ever wondered how insurers determine small group (2-50 employees) renewal rates? Be assured that it's not an arbitrary process. Yes, there is a method to this madness! Although there are various formulas used, generally insurers use the following factors to calculate your renewal rates:

General Health Care "Trend"

This is a baseline factor applied to all group health insurance renewals. Basically "trend" refers to the cost of health care products and services, and how consumers utilize these products and services. New facilities, technologies, and procedures encourage more people to receive advanced services. The costs of these goods and services are expensive and increasing rapidly.

This component also includes "prescription drug trend". More drugs are being introduced into the market and are being aggressively marketed. The costs of advertising and research/development of these drugs are significant. These rising costs, in combination with increasing utilization, all contribute to this baseline factor.

Keep in mind this "trend" also has much to do with your group's geographic location. Just as home prices differ upon location, so do health care costs. Premiums in certain areas may reflect the higher cost of more people using state-of-the-art, yet expensive treatments and services.

Group-Specific Medical/Health Factor

When permitted by state regulations, a carrier may adjust renewal rates based on the overall health of the people covered under your health plan. Your premiums may be adjusted to cover expected future claims costs. Depending on your state, certain rate caps might exist which limit the amount an insurer can raise premiums based on your group's health status alone.

Most carriers use a "prospective" system, meaning that they look at medical conditions and diagnoses, which may affect the group's claims experience in the coming year. Claims from the past year, which are resolved or if the risk is no longer present, are not taken into account using a prospective rating system.

Your renewal adjustment can also be positively impacted by good claims experience.

Group-Specific Characteristic/Demographic Profile

This component includes:

1. Age bracket changes (An employee or spouse turns 40, for example, moving them from the 35-39 bracket to the 40-44 bracket.)
2. Gender and coverage composition changes (The percentage of females and males changes or the mix of single and family contracts changes.)
3. Changes in the group's location (Claims costs are geographically-based, so the rates may change if the company moves to a new locale.)

Group-Specific Administrative Expenses

This factor includes the fixed costs needed to administer the plan. The larger the group, the lower the expense load. For example, a two-person group would have a larger expense load, as a percentage of premiums, than a 25-person group.

So, what can you do to influence the costs? Ideas include adjusting your plan design and/or premium contribution to support more efficient utilization, encouraging employees to be smart health care consumers through communication efforts, and promoting prevention and wellness programs. It's a start at least …

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