



**August 4, 2006**

**We hope the following information from our Center for Benefits Management is useful.**

### **Why Are We Doing This?**

Over the last 20 years benefits managers have introduced many healthcare changes to their employees. Almost none of these changes were requested by employees. In fact, implementing these changes has often required benefits managers to put forth huge efforts in education, explanation and persuasion. Top management wanted to understand financial impact. HR wanted to know how the change would affect employees. And the employees wanted to know why the company couldn't just leave things alone. If there has been any bedrock for the benefits manager, it has been the conviction that he/she knew the answer to the question, "Why are we doing this?" Almost always, the justification has been to save the medical plan money.

Currently, one of the big changes being introduced by benefits managers is consumer directed healthcare plans (CDHP). These plans are no longer just for the early-adopters. Indeed, according to the 2005 Kaiser Employer Health Benefits Survey, over 20% of all employers, large or small, have added CDHPs to their array of plan options. These high deductible health plans (HDHPs), along with Health Reimbursement or Health Savings Accounts (HRAs, HSAs), now cover over 3 million Americans, according to the trade group, America's Health Insurance Plans.

So why are we doing this? In late July, Buck Consultants published survey results of 130 companies that have installed CDHPs. Notably, 85% of respondents said that cost reduction was the main reason they offered these plans. The hoped-for cost reduction is supposed to result from better consumer decision making fostered by greater employee cost sharing. The greater cost sharing comes from the higher deductibles in the CDHPs compared to the deductible levels in the traditional plan options. In fact, Mercer Health & Benefits has estimated that employee cost sharing increases by 18% when comparing average deductibles in CDHPs to the average PPO plan deductibles. This is enough to make one think that desire and outcome have finally intersected.

But maybe it's a bit early to pop open the champagne bottles. Just three weeks ago the journal *Health Affairs* published a study sponsored by the Commonwealth Fund that "puts a cork in it", so to speak. As reported by *CFO.com*, the study says that since many health plans already have substantial cost sharing (one of those onerous changes we mentioned above), the big reduction in medical spending executives expect from adopting high deductible CDHPs probably will not materialize. In other words, if you've been assertive in your health care management in the past, you may need a reason other than immediate cost savings to sell your new CDHP. This especially may be true if the new plan includes the cost of HRAs or HSAs funded with employer money.

Consider the study's logic:

- The high cost users, responsible for the bulk of plan expenses, will have their personal cost limited by plan maximums. Their expenses are so great that even after paying the greater CDHP deductibles, the largest portion of their high costs will still be paid by the plan. Not much savings here.
- Secondly, almost by definition, the low cost people incur such small medical expenses that higher deductibles are of almost no cost shifting impact.
- This leaves the mid-range plan users, those whose costs are between \$700 and \$6,100 annually. According to the study, they are the only group likely to experience increased cost sharing (the source of any savings). But, this group simply doesn't represent enough dollars to generate material overall plan savings.
- Add to this scenario the employer cost of HRA or HSA funding plus greater administration and employee education fees, and some employers may just have the recipe for a near term cost increase!

The Chelko Consulting Group assists a number of clients that have actively managed the cost drivers of their healthcare plans. For this kind of client, we have seen the unsettling corroboration of the Commonwealth Fund's study. So where does one turn?

Certainly, it is way too early to turn away from CDHPs. But for those historically aggressive benefits managers that want to instill a consumerist mentality within their employee populations, expected big-time cost savings may be losing its top spot on the list of "talking points" with management, HR and employees. And perhaps that's not a bad thing because our focus might be redirected to where it belongs.

Making the transition from passive patient to knowledgeable, confident and judicious *healthcare consumer* is about much more than whether CDHP's high deductibles will immediately reduce plan cost. It's about people acquiring skills like knowing how to choose the right provider, knowing how to manage an office visit and knowing when the heavily promoted drug is or is not the one they need. Leading this transformation demands that benefits managers articulate the elements of a paradigm shift, not just a new form of cost shift. In the end, "Why are we doing this?" is not mainly about changing the plan design. It must be about engaging and training people to change their behavior.

## **HSA Today**

Continuing our series of Questions and Answers about HSAs that are practical but less publicized.

**Question:** An employer has collectively bargained employees and negotiates an equal cents-per-hour employer contribution to the HSAs of all eligible bargained employees irrespective of their coverage categories. Does this action violate the comparability rules?

**Answer:** No. Under the Final Comparable Contributions Regulations, the comparability rules do not apply to employees that are covered under a collective bargaining agreement where health benefits were bargained in good faith. This new rule applies to employer HSA contributions made on and after January 1, 2007.

The Chelko Consulting Group LLC is not offering legal advice. Our comments should be accepted subject to legal review and confirmation by your legal counsel.