

***An Employer's Guide to
Patient-Directed Healthcare Benefits***



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Acknowledgements

This project was conceived at the June, 2000 meeting of the Wye River Group on Healthcare, as we struggled to outline a road map for greater employer/consumer/patient involvement in healthcare purchasing. In this report, we have used the term employee, consumer, and patient to represent the same individual but acting in various roles while dealing with the healthcare system. We strongly believe that consumers should have greater choice and better information on which to base healthcare decisions. This paper was designed to describe and clarify various evolving methods of healthcare financing, the current regulatory and tax environment, and the political appetite for change.

Utility was the hallmark of this publication. We identified two principal audiences: the employer community and those individuals and organizations engaged in public policy. Writing to appeal to both of these constituencies proved difficult but not insurmountable. We assembled a cross-section of healthcare stakeholders and, drawing on the broad healthcare expertise of PricewaterhouseCoopers, worked with them to develop and articulate the ideas in this document. We did not want a research paper that would sit on a shelf, rather, we envisioned a living document that would be updatable and serve as a tool for employers and policymakers alike.

This product is the result of a great deal of teamwork. Mr. Ken Berkowitz and Mr. Bill Rosenberg of PricewaterhouseCoopers were the principal content architects and should be recognized additionally for their patience and perseverance, as we all “wordsmithed” the document to ensure it best met the articulated needs. Several committee members spent considerable time on the project and made important contributions, including Ms. Karen Williams, Dr. Marcia Comstock, Mr. Phil Hutchinson, Ms. Ann Killian and Mr. Jon Comola. We also want to recognize

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To access the Employers’ Guide to Patient-Directed Healthcare Benefits on the web, please select the links at any of the following organizations:

- <http://www.wyerivergroup.com>
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For more information, to arrange a presentation on our work, or if you are interested in receiving updates about this document, please contact Mr. Jon Comola at Wye River Group 512.472.2005 (email jcomola@texas.net) or Mr. Ronald E. Bachman at 678.419.1388 (email ronald.e.bachman@us.pwcglobal.com).

We believe you will find this document an important asset in understanding and navigating emerging finance models for healthcare purchasing.



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Employer's Guide To Patient-Directed Healthcare Benefits Executive Summary

Background

While our current employment-sponsored healthcare system has met the health insurance coverage needs of millions of Americans, well known challenges exist within the system. These challenges affect a large cross-section of society including the American business community, consumers, healthcare insurers and providers, and those in the public policy arena. Two groups, in particular, that have been especially disenfranchised in the current system include the uninsured and retirees. Payors generally, and employers especially, have been vigilant in their pursuit of strategies to conquer the often elusive objectives of cost control, access and quality and have had some notable successes. However, the convergence of a number of important factors is fueling renewed interest in uncovering new solutions to these well-known challenges. Chief among these factors are escalating medical costs, changing consumer expectations, the backlash against managed care, the increasing burden of healthcare benefits administration and the threat of liability on employers.

The term "defined contribution" is being used widely today to describe one type of potential solution and is attracting increasing attention. These approaches - at their most basic level - entail an employer's establishing a core contribution amount for healthcare benefits but go a great deal further than that. Perhaps more properly called *patient-directed* healthcare approaches, these represent an array of designs that include both commonly understood variations and emerging approaches that involve promising new elements and applications. Several of these approaches are possible under today's legal and regulatory framework.

This *Employer's Guide to Patient-Directed Healthcare Benefits* identifies a range of approaches intended to appeal to the broadest possible audience and range of objectives. The *Guide* endeavors to describe the many facets and relative

merits of patient-directed healthcare approaches. It also offers employers who wish to implement these programs some practical "how to" advice and suggests to policymakers possible modifications to current laws and regulations that would encourage innovation and expansion in this area. It should be noted that there are a number of changes which are vital to the success of a transition to patient-directed approaches (i.e., evolution of decision-support tools, benefit administration processes, public confidence in quality information) that are not in the scope of this *Guide*.

Concept Definition

The label "defined contribution", and simple definitions associated with it, have significant limitations in conveying the full range of possibilities associated with the concepts discussed in this Guide. As suggested previously, "patient-directed healthcare benefits" (PDHB) **is an approach for providing healthcare benefits that combines a core contribution of funding by employers with increased choice and responsibility for employees and increased accountability for health plans and providers.** Typically, an employer makes its core contribution toward either a "plan" (e.g., a health insurance plan, an HMO, etc.) or an "account" (e.g., a personal health account) or both, and then gives employees choices as to how the money will be spent.

Two breakthroughs in the recent evolution of PDHB warrant attention because they are keys for potential new models:

- Greater flexibility than previously thought is permitted regarding how an employer's core contribution can be used to overcome some of the significant limitations of healthcare flexible spending accounts (FSAs). Specifically, it is believed that *employer-only* dollars set aside for

medical expenses can be accumulated from year to year (i.e., do not have a “use it or lose it” requirement). Moreover, it is believed these accounts can be used to purchase health insurance, and at the employer’s discretion, can be portable after employment ends (though there is not currently a cash option).

- The emergence of web-enabled decision support tools and administrative services that make it easier for employers to provide more choices to employees, while possibly reducing their administrative burden, and for employees to make informed decisions about healthcare coverage issues more independently.

PDHB constitutes an important shift to a more individually empowered system. Giving consumers more control over their healthcare choices can provide an impetus for positive health system change – and can be politically palatable. With proper execution, these approaches also help address some of the most significant healthcare challenges a broad group of stakeholders face today. PDHB approaches open up a range of new possibilities for different types of employers to meet both their and their employees’ healthcare objectives as well as help correct undesirable aspects of the system at-large (e.g., the insulation of the consumer from the actual cost of healthcare). Because these approaches do so without discarding what is working in the current system - including the present method of employment-sponsored financing - they constitute an incremental reform that appears to coincide well with our nation’s values and consumer expectations of employer-sponsored healthcare.

Principal PDHB Examples

Patient-Directed Healthcare Benefits is not a single point but a broad *continuum* of approaches with fungible components. The principal examples described herein fall along this continuum that moves from more employer-directed to increasingly patient-directed approaches (see Exhibit B on p. 19). The two ends of the continuum - a single plan offered by an employer to its employees and an employer’s providing only wages - are commonly cited today but are of little relevance to this discussion. The examples that are of

greatest relevance all employ a plan, an account or both within an employer-sponsored healthcare benefit program.

These examples also vary widely along the continuum based on the following components:

- breadth of employee coverage choices
- consumer’s stake in spending decisions
- flexibility of funding/financing options
- employer administrative stewardship
- continuity of coverage and care (see pp. 14-16 for a detailed explanation of these dimensions).

The degree to which an employer steps back from designing plans or “earmarking” funds can vary widely in these examples, as can the degree to which an employee can configure his or her personal healthcare approach. Most importantly, the ability to combine and “modulate” these features in different ways illustrates the wide-ranging opportunities to expand consumer choice and discretion over the resources available to them for healthcare.

Outlined below are four principal PDHB examples - moving from least to most patient-directed - including:

- Multi-Plan Option
- Multi-Plan Option including “Supermarket” concept plus Health Account (Personal Health Account (PHA) and/or Flexible Spending Account (FSA))
- High Deductible Plan plus Health Account (PHA and/or FSA)
- PHA plus FSA

These as well as several additional examples are described in considerably more detail in Section III of the *Guide*.

Multi-Plan Option

The Multi-Option example, a strategy that is used currently by many large employers, offers employees a choice of health insurers, or a choice of plan designs (i.e., HMO, PPO, POS) offered by a single insurer, or both, with a fixed contribution toward the cost of the plan chosen. In other words, an employee can “buy up” if he or she desires a more expensive plan. In this example, the employer selects the health plans

to be offered and sets the company contribution. The employee decides which plan best suits his or her needs and pays any difference in cost. Employers offering such plans set their contributions on any one of a number of uniform bases, such as a core dollar amount, a percentage of either average or lowest plan cost, or on some other basis. The employee's cost varies depending on the plan chosen. Many employers use approaches like this one today, including the Federal Employees Health Benefit Program (FEHBP). There are no legal or regulatory barriers to implementing this form of PDHB today.

Supermarket plus Personal Health Account (PHA) plus Flexible Spending Account (FSA)

The Supermarket plus PHA plus FSA example possesses two incremental changes from the previous example. First, a third party healthcare "supermarket" provides a more comprehensive menu of health insurance and plan design choices as well as key administrative services and possibly better prices as a result of requiring health plans to compete. Second, a versatile "account" or accounts are added to the offering. Key benefits of the account mechanism are the potentially desirable consequences resulting from making the consumer a direct participant in making cost/benefit choices on a service-by-service basis, as well as providing a vehicle for individuals to achieve the continuity of care and security generated by the ability to save for their future health care needs. Retirees, in particular, stand to benefit greatly from this aspect

One account component, the Section 125 Flexible Spending Account (FSA) is a common arrangement whereby employees (typically not employers, although possible) set aside pre-tax money to pay for anticipated healthcare expenses not covered by their primary plan. The second account component, the Personal Health Account (PHA), stems from a fresh interpretation of the Internal Revenue Code that appears to overcome some of the significant limitations of FSAs. These limitations of FSAs are well known and include the "use-it-or-lose-it" provision (i.e., the inability for funds to accumulate from year to year), the inability to use the money to purchase insurance, and the inability for the accounts to be portable. Only employer funds can be used in this PHA type of account. While two conceptually separate accounts are required based on today's legal regulatory framework to make the construct work, it

would clearly be more practical and intuitive if a single account mechanism could possess all the proper attributes.

High Deductible Plan plus PHA plus FSA

The High Deductible Plan plus PHA plus FSA model is identical to the previous example with the exception that the menu of health plan choices is limited to a fairly small number of high-deductible plan designs (although an employer, as opposed to a supermarket, conceivably still can establish the menu). This example emphasizes employee responsibility by separating the *insurance* aspects of the healthcare coverage from the *tax-advantaged pre-payment* components, thereby putting cost/benefit decisions around the latter directly in the control of employees. The high-deductible plan protects employees from the costs of expensive, catastrophic occurrences. Many such designs also cover the cost of "good medicine" (e.g., immunizations, screenings, routine physicals) to encourage their use. The analogue to this example in use today is the Medical Savings Account (MSA) enabled by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) minus some of the MSA's limitations.

PHA plus FSA

The PHA plus FSA example is the most patient-directed approach presented here. This example removes the requirement that an employee purchase insurance with the employer's core contribution, although an employee can choose to do so. This example is not in place at this particular time, but has some unique potential applications. The primary advantage of this example is to lessen the burden for employers who do not currently offer a plan to employees because they cannot afford the cost of the least costly plan available. A future enhancement to this approach - possible only with regulatory clarification or change - could be to remove the non-intuitive "firewall" that regulatory language has erected between FSA (usually employee) and PHA (employer) dollars.

As suggested, a few of the examples discussed above capitalize on interpretations of the current tax and regulatory framework that may currently "push the envelope". While a growing swell of companies and their clients are moving forward with PDHB approaches, removing obstacles and clarifying existing policies would very likely add to the momentum that is building.

Potential Tax and Regulatory Modifications

There are a number of specific areas in today's tax and regulatory framework that act as barriers to a healthcare system seeking to evolve beyond traditional models. The following is a discussion of some of these obstacles that could be removed or clarified to overcome these barriers and to encourage innovation. More information on this topic can be found in the *Appendix*.

Taxability and Deductibility Changes

Repeal "Use-It-Or-Lose It" Rules

Employers today may establish flexible spending accounts for their employees under Section 125 of the Internal Revenue Code. FSAs are accounts typically funded on a pre-tax basis through employee salary reductions. Under current law, any amounts in the account unused as of the end of the year must be forfeited. This forfeiture requirement, frequently referred to as the "use it or lose it" rule, keeps FSA amounts from being carried over to subsequent years and provides strong incentives to individuals to consume healthcare by the end of the year (PHAs do not have this disadvantage when designed within certain specific guidelines). Repeal or modification of the "use it or lose it" rule could encourage individuals to save for subsequent years and remove the incentive for individuals to spend money in their accounts simply to avoid the loss. Allowing "build up" and "roll over" would furthermore enable election of high-deductible, lower-premium plans.

Permit Purchase of Insurance Through FSAs

Under Section 125, consumers are restricted to using FSA funds for only certain types of expenses, such as medical expenses incurred by the employee. Tax rules prohibit individuals from using FSA funds to purchase health insurance. Modifying those rules could facilitate greater choice for consumers with respect to insurance and medical services and open up new avenues for employers who can't afford the entry cost of a health insurance policy to contribute nonetheless to an employee's medical or insurance expenses.

Clarify Rollover Treatment

FSA regulations have generally been read by many to inhibit the ability to roll over employer-only healthcare accounts from year to year. Notwithstanding unofficial statements by the IRS, official IRS guidance is needed to clarify whether "employer-only" healthcare accounts can be rolled over from year to year. Tax rules should be clarified to remove the "firewall" between both employee and employer monies and allow both types to be rolled over for future periods. Such clarification would be of special value to low-wage workers.

Clarify Flexibility of Fund Uses For PHAs

Currently a no-ruling area by the IRS, the scope of an individual's flexibility in, and tax-treatment of, using funds accumulated in a healthcare account need clarification. For example, under current MSA rules, an individual may take a distribution of accumulated amounts as cash instead of as healthcare benefits. Clarification would likely encourage individual savings for healthcare.

Allow for Tax-Efficient Portability of PHAs

Today, there is no tax-efficient mechanism for an employee to take a Personal Health Account with him or her upon termination of employment. This presents an obstacle to designing an account under which unused amounts are available for healthcare reimbursements regardless of employment with a specific employer. Such a mechanism would, for example, allow for funding of COBRA benefits or other bridge policies for the newly uninsured or early retirees.

Regulatory Changes

Relax Certain Requirements around AHPs/HealthMarts While Ensuring Necessary Consumer Protections

Group purchasing arrangements - especially those classified as Multiple-Employer Welfare Arrangements (MEWAs) - raise federal ERISA and state insurance regulatory issues under current law. Federal reforms could address many of these issues, such as by allowing trade, industry, professional associations and emerging benefit "supermarkets" to offer coverage exempt from state-mandated benefits or small employers to seek coverage through nonprofit organizations, such as HealthMarts. Such group purchasing entities could

be structured to allow greater flexibility and choice while ensuring a federal or state floor of protection, such as insurance reserve requirements and related protections, without stifling positive innovations.

Key Implementation Considerations for Employers

The form of PDHB that will appeal to employers will vary almost as widely as employers do. On one end of the spectrum, are employers considering offering healthcare benefits for the very first time. On the other end are large, innovative employers already offering an array of varied healthcare benefit options and health plans to a geographically diverse employee and retiree population.

Employers of all types may want to thoroughly examine Section V in this *Guide*, which includes specific implementation steps, several examples of implementation and other important considerations. While many of the key themes here mirror those involved with implementing any new healthcare program (e.g., setting objectives and strategy; analyzing cost, access, quality, and administration; vendor selection; etc.), there are several areas under PDHB that warrant additional attention. These special issues include establishing a thoughtful core contribution strategy, being especially mindful of the impact of adverse selection, and considering the very important communication, employee education, and transition issues surrounding the introduction of a program of this type.

Employers will want to seek counsel from their business advisors, including their consultants, brokers and attorneys about the approaches most appropriate for their particular circumstances, and for implementation assistance. Local and national Chambers of Commerce can also point employers in the right direction.

Conclusion

The evolution of compelling patient-directed healthcare approaches is an important development that promises to help address some of our country's most vexing health insurance challenges. There are an array of different forms that patient-directed healthcare models can take, each with different attributes and relative merits. Employers seeking innovative solutions to today's healthcare challenges should consider the role patient-directed approaches could play in their employee healthcare offering. Policymakers interested in opening up new avenues for reducing the ranks of the un- and under-insured, as well as addressing other well-known system shortcomings, might also explore the possibilities afforded by these concepts. Considering at once the rising cost of healthcare, the current sentiments of employers and consumers, the swelling ranks of those disenfranchised by the system, and the availability of enabling technologies that expand our notion of what is possible, the timing may be exceptionally ripe for patient-directed approaches to be further cultivated.

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Preface

Purpose of this Report

Borrowed from the realm of retirement plans, the moniker “defined contribution” has been used widely in healthcare circles to describe a group of both old and new healthcare benefits delivery approaches. However, since this designation falls far short of characterizing these approaches in entirety, Patient-Directed Healthcare Benefits has been suggested for the purposes of this paper. Patient-Directed Healthcare Benefit (PDHB) programs available today expand the range of healthcare benefit options for employers and their employees. Given the evolutionary nature of the concept and perceptions created by the use of the term defined contribution, there is some confusion about what PDHB approaches actually entail and how employers and their employees can take advantage of what they offer.

Generally, PDHB models entail an employer’s establishing a core contribution to healthcare benefits with employees selecting one from a variety of healthcare options based on perceived value. In addition to the core contribution, the concept implies greater choice, flexibility and responsibility for employees and increased provider and insurer accountability to the individual. Many important features of such programs actually pertain to expanded opportunities for employees to determine how to use employer contributions and for employers to meet important objectives. The purpose of this paper is to describe PDHB’s many facets in practical terms for employers and those interested in its health policy implications.

This paper provides employers with information about a variety of PDHB approaches, their pro’s and con’s for employers and employees and some practical “how to” advice for those wishing to implement PDHB programs. This report also covers possible modifications to current laws and regulations that would lessen obstacles to the growth of PDHB.

Potential policy initiatives warrant attention for two reasons. First, health policy must address the concerns of employers and employees because no other segment of our society is as affected by health policy. Six out of ten Americans receive their healthcare coverage through the workplace.¹ Second, one of the most pressing problems in our healthcare system today, the uninsured, is essentially connected to employment. More than 8 out of 10 uninsured Americans are workers or dependents of workers². In other words, PDHB potentially offers significant benefits to the broadest possible segment of our society: consumers – whether employed, insured, or not.

Overview of this Report

This report discusses PDHB in three stages of development:

- 1) mature examples that are in use today
- 2) emerging, innovative examples
- 3) a next-generation of PDHB

The first two stages – mature and emerging - are of practical importance to employers and employees because they include a variety of PDHB approaches that can be implemented today. The principle difference between the two stages is that the former includes examples with substantial track records and the latter, by definition, does not. The next generation stage suggests means of enhancing the value of PDHB approaches if specific, enabling policy changes are made.

Section II of this report, defines PDHB and provides an overview of some major healthcare challenges PDHB approaches can address. The balance of this report offers descriptions of specific PDHB examples (Section III), an overview of legal and regulatory issues surrounding PDHB (Section IV), guidance for employers on how to implement PDHB (Section V), and conclusions (VI).

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Overview of the Patient-Directed Healthcare Benefits Approach

PDHB is an approach to the design and delivery of healthcare benefits that has evolved over time and is now garnering increased attention. One reason for this attention is the potential that PDHB holds for addressing several major healthcare challenges faced by employers, consumers and policymakers. After outlining these challenges, this section provides a definition of PDHB, how PDHB approaches can help address these challenges and prospects for their widespread use.

Healthcare Challenges that PDHB Can Address

While some believe the healthcare system in the United States is well ahead of most other countries, there is clearly room for improvement. Patient-directed healthcare approaches for designing and delivering healthcare benefits hold great promise for addressing several of the more pressing challenges that employers, employees and policymakers face today.

Employer Challenges

Employers have devoted much energy over the years identifying healthcare strategies, like managed care, that promised both affordability and generous benefits for employees. The perception that managed care may have reached its full potential has fueled employer concern about making significant financial commitments to programs that require much management time and attention, yet can be a source of dissatisfaction for employees. Rather, employers have begun to think about how, by playing a different role in the healthcare benefits process, they can help resolve some of the challenges faced by all participants.

The three top healthcare challenges *employers* face today pertain to the cost of healthcare benefits, the related administrative burden and the need to offer employees more choice³. These challenges present employers with conflicting objectives. Facing a tight labor market, employers are limited in the extent

to which they can shift costs to employees. Rather, to attract and retain employees, employers increasingly seek to offer more benefit choices and innovative benefit designs.

Offering employees additional and more innovative benefit choices increases the likelihood that an individual employee will find a benefit option that meets his or her needs, but may also increase an employer's administrative burden. Today's employer typically wants to spend more time focusing on its core business. Patient-directed approaches to offering employee healthcare benefits can help resolve this conundrum.

In addition to the difficulty of dealing with the conflicting objectives of cost control, employee choice, and administrative ease, each of these and other challenges is vexing in its own right.

Employers today bear the burden of:

- ***escalating medical costs,***
- ***complex healthcare benefits administration***
- ***increasing liability exposure; and***
- ***changing employment relationships.***

Escalating Medical Costs

Employers have faced two consecutive years of healthcare cost increases, and some corporations report that health benefit costs are again their fastest rising expense. Among other drivers, rising medical costs caused by technology advances and increasing consumer demand have constrained the ability of employers to control their healthcare expenditures over time. Smaller employers are particularly impacted by this problem because they have fewer options at their disposal to manage costs. Between 1992 and 1999, the per employee (active only) cost of healthcare has increased 27% to over \$4,430 per employee in 1999 vs. \$3,502 in 1992.⁴ In addition, healthcare costs are expected to increase by over 13% on average in 2001.⁵ This is the highest year-over-year percentage increase in over a decade.

Complex Healthcare Benefits Administration

While employers' direct investments in healthcare premiums or medical expenses get plenty of attention, administrative costs and the behind-the-scenes effort required to support their healthcare benefit programs are often unappreciated. Corporate benefits staff are increasingly consumed by managing health plan procurement, enrollment, premium payment and eligibility lists, as well as troubleshooting routine coverage and claims payment issues.

Employers are also finding it more difficult to manage healthcare vendor relationships. Even very large employers are experiencing a loss of influence once held with their contracted health plans. Employers are interested in solutions that can create increased accountability of the healthcare industry and that ease their administrative burden.

Many employers are concerned about the

- *quality of service the healthcare system provides*
- *the fallout from consolidations or market withdrawals; and*
- *their ability to protect their employees from the cost of medical care.*

Increased Liability Exposure

Recently, Congress has stepped up its debate about medical liability. By sponsoring a health plan or participating in coverage or medical necessity decisions, employers may incur increased exposure to lawsuits under federal or state law for administrative errors or for treatment decisions made by medical or health plan professionals. When employees experience an undesired outcome in their medical treatment or with their insurance coverage, they often look to the employer to help correct the situation. With medical and pharmaceutical technology advancing as rapidly as it is, the complexity and risk of the employer's role is exacerbated.

Many employers seriously question whether they can effectively serve as arbiters of coverage and medical necessity. Employers are also gravely concerned about the implications of new interpretations of employer liability and about controlling their legal exposure in this area. Patient-directed

health plans, which transfer various levels of responsibility back to consumers and healthcare providers, may serve to lessen some of these liability risks.

Changing Employment Relationships

Traditional employment relationships are changing as younger generations enter the workforce, and, as a result, traditional approaches to employee benefits are becoming less relevant in the new economy. Some predict that in the economy of the future, workers will be more like free agents. As their work experiences become more transitory and short term project-oriented, workers will be more interested in benefit portability, flexibility, and work-life balance than in job security. Some observers note that a Patient-directed approach to healthcare is very consistent with these evolving needs, values, and expectations.

Many employers seriously question whether they can effectively serve as arbiters of coverage and medical necessity in an era of rapidly evolving medical and pharmaceutical technology.

Employee Challenges

The employees to whom employers wish to offer more choice, even in the best of circumstances, often do not have choices that match their needs well. For example, a young, single employee has different healthcare needs than a head of a household with young children, and they have needs that differ from older employees with chronic conditions. PDHB approaches can greatly expand the health plan choices employees have. As discussed in Section IV, the importance of providing appropriate choices to employees must be balanced with the adverse selection risks that could undermine other objectives if not managed properly.

35% of employees with healthcare coverage have only one plan offered to them by their employer⁶.

Even when employers do offer a choice of plans, employees often find that their ability to exercise consumer choice is constrained

in other ways. When employers change health insurance companies or plan designs or employees change jobs, for example, employees can experience serious disruptions in their coverage and healthcare. If an employee's primary care physician (PCP) does not participate in a new insurer's plan, the employee must change doctors or pay more out-of-pocket costs. If an employee takes a preferred prescription drug for a chronic condition, a new plan design that prefers a different drug for the same condition will present a similar challenge. Most consumers would prefer to have more influence in these circumstances.

Compared to consumers' ability to purchase other goods and services, employees have limited ability to select:

- their health insurance
- the scope and level of benefits in their plans; and
- doctors and hospitals.

PDHB can provide employees with the same choices consumers generally enjoy and, not incidentally, can perhaps also help employers achieve their cost containment goals.

One way employers can give employees the same flexibility in healthcare choices as they generally have in other purchasing behavior is to provide more cash for healthcare spending. Many policymakers have noted that the increase of insurance coverage has increased healthcare prices and spending⁷. Yet the vast majority of funding for employee healthcare is directed toward insurance. Were employees given not only more choices among different types of insurance, but also choices between insurance and other means of funding their healthcare expenses, they could become a powerful force for more accountability in the U.S. healthcare system. PDHB approaches can enable consumers of healthcare to vote with their feet – to move their business from one insurer to another, from one plan design to another, from one doctor to another, from one drug to another – based on their perceptions of cost and quality.

Public Policy Challenges

Those interested in healthcare policy should find PDHB appealing because of its potential to address the challenges employers and employees/consumers face. But it is also appealing because of PDHB's potential to address one of the country's greatest challenges — the uninsured, whether employed or retired but not yet eligible for Medicare. To the extent that PDHB addresses employers' concerns, more will offer some level of healthcare benefits. Similarly, greater accountability in the healthcare system will presumably have the effect of making healthcare more affordable.

The employment-based healthcare system works reasonably well for the 172 million Americans it covers, but there is room for improvement.⁸ The Patient-directed healthcare approaches outlined below are not the only solution for our healthcare system's challenges, but they do offer promising and innovative solutions that build on a successful base.

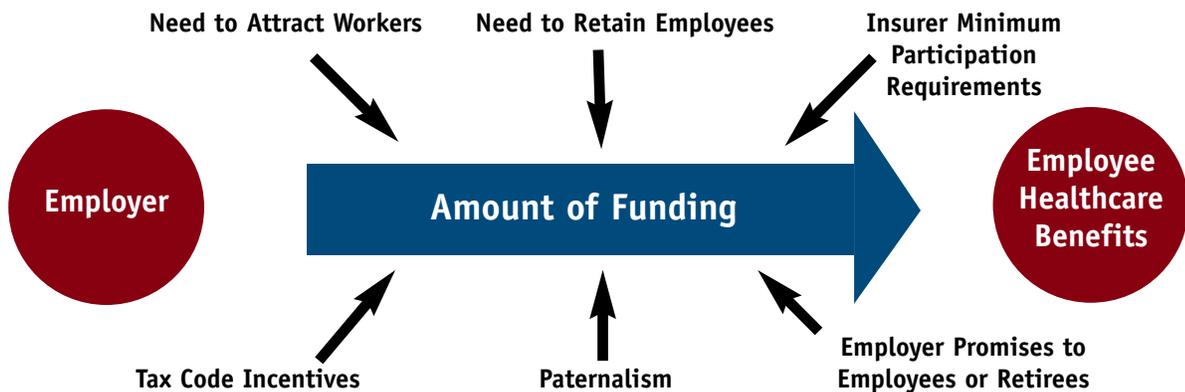
Definition of Patient-Directed Healthcare Benefits

PDHB is an approach for providing healthcare benefits to employees that combines a core contribution of funding by employers with increased choice and responsibility for employees and increased accountability for health plans and providers.

Under PDHB an employer makes its core contribution toward either a plan (e.g., a health insurance plan, an HMO, etc.) or an account (e.g., a flexible spending account), or both, and then gives the employees choices as to how the money may be spent.

The degree to which an employer steps back from designing plans or earmarking funds can vary among PDHB models, as can the degree to which an employee can design his or her personal healthcare approach.

Exhibit A
Voluntary Employer Funding of Healthcare Benefits is Influenced by many Factors



What PDHB is Not

The term “Defined Contribution Healthcare Benefits” is widely used to describe benefits approaches similar to those we discuss in this report. The term “Patient-Directed” is preferred to “Defined Contribution” because the emphasis is more properly stated. The principle emphasis of PDHB is on increasing the flexibility employees have in using employer-provided funds and their own funds, to design and enjoy their benefits.

While PDHB provides a new framework for employers and employees to manage healthcare costs, relinquishing control over benefits design and delivery does not necessarily translate into employers spending less. This is because an employer’s ability to control the level of funding for employee benefits is affected by many factors illustrated in Exhibit A. Most importantly, employers today can increase, decrease or terminate their contribution at will, because funding is voluntary. In practice, this ability is constrained by:

- the need to attract and retain employees, as well the desire to keep morale high
- insurer requirements that a minimum percentage of employees participate in a plan
- the strong incentive to provide employees with compensation in the form of non-taxable healthcare benefits
- paternalism toward employees
- employer promises to employees or retirees

While PDHB does not inherently mean that employers will cut back on their current contributions towards healthcare benefits, for employers who choose to explore this aspect, it can make future contribution levels much more predictable.

July 2000 research conducted by Harris Interactive dramatically illustrated that employers that had implemented what they considered “defined contribution” healthcare benefits plans were unable to increase employee contributions significantly more than those who did not implement such plans.⁹ In sum, PDHB can help employers control costs, but it is neither a “silver bullet” nor the essence of the concept.

Dimensions of PDHB

As previously noted, PDHB approaches vary along a continuum depending on the role employers and employees take in design and delivery of healthcare benefits. These roles also vary along the following dimensions:

- breadth of coverage choices for employees
- consumer’s stake in spending decisions
- flexibility of funding options for employees
- continuity of coverage and care afforded to employees
- employer administrative stewardship

These factors determine the extent to which a healthcare benefits program is “employer-directed” or “patient directed.” A review of these dimensions reveals additional facets of PDHB and how PDHB approaches can help address today’s health-care challenges.

Breadth of Coverage Choices

Employees will find that many PDHB strategies can offer much greater opportunity for them to tailor healthcare benefits to their individual needs – employees of smaller employers, who currently enjoy the least amount of choice, especially. More patient-directed approaches can enable employees to:

- select a plan from a large menu of health plan choices annually
- virtually “build” his or her own benefit plan by selecting a level of managed care, a provider network and benefit design features
- choose a plan with relatively higher or lower employee contributions toward premium costs.

Consumer’s Stake in Spending Decisions

Under patient-directed healthcare benefits, an employer makes a core contribution regardless of the choices made by each employee. Employees, as consumers, can trade up and pay the difference between the employer contribution and the healthcare benefits approach they prefer. When employees have a greater role in determining how they spend their own money as well as the funding their employer provides, employees will have a much greater stake in ensuring that they receive value for money spent. This incentive can be particularly forceful when a consumer pays the full price of a doctor’s visit or prescription drug instead of a \$10 copay or if she knows the actual, full cost of the insurance plan she selects. And when the plan or doctor or drug selected does not meet a consumer’s expectations, he or she can select an alternative.

Flexibility of Funding Options

To date, employers have had two options to provide employees with healthcare coverage, insurance plans and healthcare accounts. The former range from indemnity coverage to managed care to high-deductible plan designs. The latter may include flexible spending accounts, authorized by Sec. 125 of the Internal Revenue Code or, to some degree, medical spending accounts (MSAs) authorized on a pilot basis

by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and recently extended.

These two coverage building blocks – plans and accounts – can support a fairly broad array of choices for employers and employees, but they also have had some important limitations to date. Perhaps the greatest limitation from an employee’s perspective is that the employer usually decides how much of its core contribution will be used to purchase insurance. In addition, with current healthcare benefit approaches,

- the minimum cost to offer a meaningful healthcare benefit may be too high for many small employers
- when employers are willing to provide funding toward a healthcare plan, they typically do so for a one-year term and only for full-time, active employees
- employees with working spouses may not be able to combine the amounts of funding their respective employers provide

New PDHB models seek to leverage current and new or proposed funding mechanisms to overcome these limitations. Some next generation PDHB funding models, for example, contemplate the possibility of pooling employer and employee contributions to plans or accounts when family members work for different employers. As the multi-wage-earner family is already more of the rule than the exception, the ability to pool funding across employers would mean that employers who cannot afford to fund a significant portion of cost of a plan could fund at least *some* portion of the cost for active employees or retirees.¹⁰

Providing the ability to accumulate funds in health plan accounts over time, including post-employment, may also lower the amount of funding employers must give to provide a minimum benefit of tangible value. Under some PDHB models, employees can fund their own healthcare protection by saving unused money in their health accounts and by taking the accounts with them when they terminate employment. In such situations, employees can save funds for future healthcare needs, such as a period when they lose coverage, or for other healthcare insurance like long-term care.

Continuity of Coverage and Care

The connection of healthcare coverage to employment causes well-known discontinuities in coverage and care. These can arise when employers change plan designs, vendors, or, more likely, when an employee changes jobs. COBRA offers one way of smoothing the transition from one job to another by permitting individuals to continue coverage at group rates, generally for up to 18 months after termination of employment.

Almost 20% of American employees, on average, separate from employment each year, whether voluntarily or otherwise.¹¹

While COBRA addresses the important issue of whether or not an employee has access to coverage, there are other important challenges COBRA was never intended to address. COBRA does not provide employees with:

- a vehicle to fund the cost of coverage when they terminate employment;
- a mechanism to continue in the same plan design after COBRA ends
- an ability to stay with the same healthcare provider after COBRA ends
- a method for retirees to bridge between retirement and Medicare eligibility without a gap in coverage

Some of the more flexible emerging and next generation PDHB funding arrangements can provide a vehicle for employees to save for future healthcare needs, and can help maintain the continuity of plan design, health plan and provider relationships – a need that can be particularly important where managed care plan designs and networks are prominent.

Employer Administrative Stewardship

PDHB can allow employers to reduce their role in the design and delivery of employees' healthcare plans, where appropriate and desired, to varying degrees. For a PDHB approach to be more patient-directed, however, current roles may have to be changed substantially. The PDHB examples discussed in the next section of this report can significantly change the role of employers, and consequently employees, in:

- determining the scope and level of health insurance benefits (which healthcare goods and services are covered and how much)
- selecting health insurance companies, HMOs or other healthcare plans, and providers
- determining how much money is spent on insurance versus how much is set aside as cash for other healthcare expenses
- plan administration (especially with new, internet-based PDHB approaches)

Employers can design PDHB approaches that encompass all or just some of these changes, and they can phase in changes over time depending on their philosophy and how well prepared their employees are to "pick up the ball." The degree to which these changes are made greatly affects the degree to which employees and the system at-large can benefit from PDHB.

What are the Prospects for the Growth of PDHB?

Surveys regarding defined contribution healthcare benefits have indicated varying, but generally high degrees of interest in what we call PDHB among healthcare leaders, employers and consumers. One survey found that approximately 60% of healthcare thought leaders in the United States were of the opinion that "employers will move to a defined contribution healthcare benefits system" and that "most employers will offer medical savings accounts as an option."¹² A survey of employers found that more than two-thirds had "not yet considered a defined, contribution healthcare benefits structure for healthcare benefits, but may consider it in the future."¹³

Perhaps of greatest note is a survey of employees that emphasized the value they would receive from PDHB. That survey sought attitudes about being able to "select from any health plan being offered in your area, at the cost you choose, using both your employer contributions and the personal contributions you make."¹⁴ This survey found that 43% were either extremely or very interested.

Although there is a high degree of interest in patient-directed healthcare benefits, there are a number of changes that would make PDHB even more compelling:

- a loosening of the labor market could make employers less concerned about changing their healthcare plans
- increased clarity and/or selected changes in tax and insurance regulations could make PDHB more attractive to employers and employees
- after leading employers successfully implement innovative PDHB models, many other employers might follow
- if employers' liability exposure increases significantly, PDHB could become much more attractive as a solution

PDHB models hold promise for addressing some of our nation's greatest healthcare challenges. It would appear that it is only a matter of time before we learn just how effective they can be.

- III -

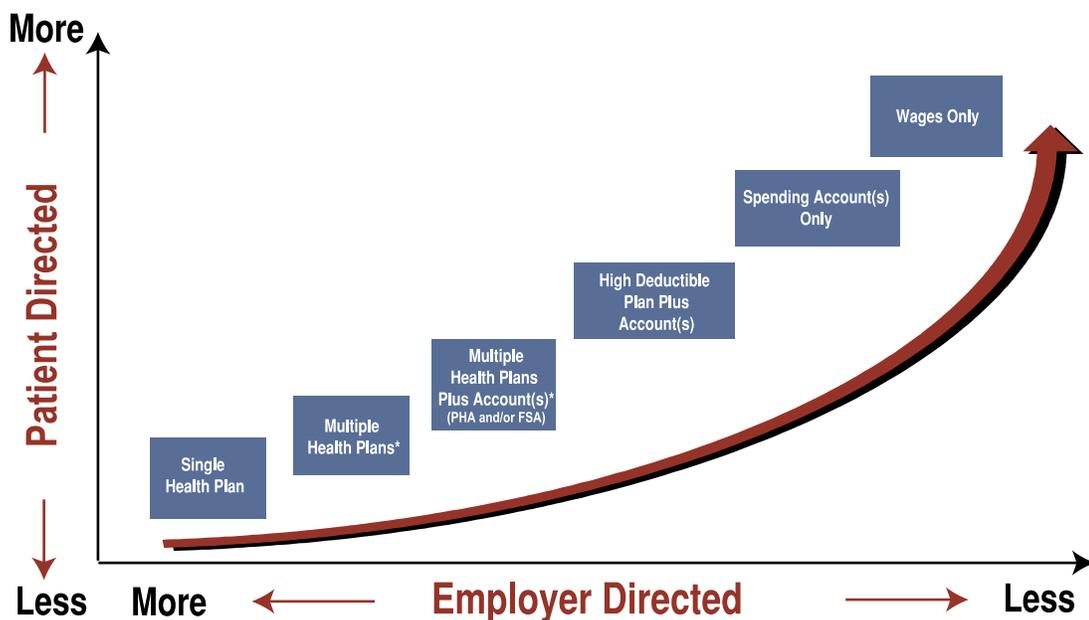
Patient-Directed Healthcare Benefits Examples

Introduction and Overview

Generally, examples of PDHB fall along a continuum, as shown in Exhibit B. The two ends of the continuum are commonly used today, and are provided as reference points. At one end of the continuum, the employer chooses a single plan and offers it to employees. This may be an HMO, PPO, POS, High Deductible, Indemnity or any other plan arrangement. The distinguishing feature is that only one benefit program is offered and the only employee choice is to participate or not. At the other end of the continuum is another common arrangement, the employer offers no health benefit plan. Employees that choose to spend their wages on health insurance are free to select from all market offerings.¹⁵ The decision to participate in a health program and the specific product selection are out of the domain of the employer.

The examples discussed below fall in between these two extremes and can take myriad forms. They all employ one or two key building blocks of employee healthcare benefit programs, **healthcare plans** and **healthcare accounts**, but can vary with respect to the number and type of plans and accounts employed. They are arrayed in Exhibit B in order to show how various combinations of plans and accounts are more or less patient-directed. The examples shown toward the lower left-hand corner are relatively more employer-directed, while those toward the upper right-hand corner are more patient-directed. The differences among the examples in Exhibit B are further explained by five factors discussed below.

Exhibit B - Continuum of PDHB Approaches



**Includes one insurer multiple plan designs, multiple insurers with same or multiple plan designs, and "supermarket" concept.*

Key Dimensions of PDHB

- **Breadth of Coverage Choices:** *Number and variety of plan type and design, carrier and provider choices for the consumer.*
- **Continuity of Coverage and Care:** *Ability of the consumer to continue plan design, carrier and/or provider choices during and post employment.*
- **Consumer’s Stake in Spending Decisions:** *The extent to which a consumer perceives money to be spent as his or her own money (i.e., which otherwise could be used for other purposes) when making healthcare cost and value judgments. Examples include: premium contribution vs. level of out-of-pocket payments in plan design, one treatment option vs. another, in- vs. out-of-network provider, preferred vs. non-preferred drug.*
- **Flexibility of Funding Options for the Consumer:** *The flexibility a consumer has in directing the use of employer-provided and personal healthcare funds. Examples include: deciding how much insurance to purchase vs. how much money to save for future healthcare expenses or insurance; having the ability to pool the funds with funds accumulated by other family members (i.e., including other employers’ contributions).*
- **Employer Administrative Stewardship:** *The extent to which the employer determines: which plan design, carrier and provider choices are available and whether employee obtains insurance and/or accounts. The amount of time an employer must devote to plan administration and vendor management.*

The first four PDHB dimensions – Breadth of Coverage Choices, and Continuity of Coverage and Care, Consumer’s Stake in Spending Decisions, and Flexibility of Funding Options – include aspects of PDHB design that enhance the consumer’s role. The more coverage and care choices, the greater their stake in spending decisions, and the more flexibility of funding, the more the consumer can direct his or her own benefits and care. The last dimension, Employer Administrative Stewardship, works in the opposite direction – more employer direction diminishes the consumer’s role in benefit design and delivery of care.

Plans and Accounts – the Building Blocks of PDHB

As noted above, all examples of PDHB comprise one or two basic building blocks: a **plan** and/or an **account**. These are the basic vehicles by which employees can use an employer’s **core contribution** for their healthcare. One difference between a plan and an account is the extent to which the employer determines the way healthcare funds are spent. If the employer is contributing to a health insurance plan, the employer essentially determines the form of coverage. Employee contributions, if any, must be spent on the form of coverage selected by the employer. Today, it is most common for employers to require that their core contribution be applied to a healthcare plan, and for employers to determine the scope and level of coverage, i.e., what the plan will pay for and how much. The simplest and most common form

Exhibit 1b - Baseline Model

Description	Key Dimensions	Comments
Employer provides core contribution and offers one health plan choice, i.e., there is no “menu” of choices. Employee’s choice is to participate in the employer’s plan or not.	Choice of Coverage Low  High	<i>Consumer has no choice of plan design, carrier or provider networks – only one choice for each is offered</i>
	Continuity of Coverage and Care Low  High	<i>Employer’s change of plan design, carrier or provider network or termination of employment will disrupt consumer’s coverage and care</i>
	Consumer’s Stake in Spending Decisions Low  High	<i>Consumer has no choice of levels of coverage vs. contribution to premium and no pre-tax savings account; Typical benefit plan design tends to insulate employee from the cost of healthcare goods and services</i>
	Flexibility of Funding Options for Consumer Low  High	<i>No consumer choice of coverage vs. account; only one choice of how much insurance to purchase; no ability to save for future needs or to pool employer contribution with core contributions from other employers</i>
	Employer Administrative Stewardship Low  High	<i>Employer controls all aspects of benefit plan design and delivery.</i>

Exhibit 2a - Multi-Plan Option

For Health Insurance Only →



Employer provides a core contribution and a menu of plan options to an employee. The actual amount of funding is typically not disclosed.

Employer selects plan, making cost/value judgements based only on employee cost and plan design or type.

<i>XYZ Co. Health Plan Choices</i>	
Plan	Employee Cost
A (PPO)	\$ 50
B (HMO)	\$ 10
C (Indemnity)	\$100
D (High Deductible)	\$ 0

Until recently small employers may not have been able to handle the administrative complexity of Multi-Plan Options. Recently several insurers have made Multi-Plan Options available to the smallest groups.

of healthcare plan employers offer and a view of how the five key dimensions of PDHB apply to it are explored in Exhibit 1b.

Example 2 - Multi-Plan Option

Example 1 - Baseline Healthcare Benefit Plan

The baseline example summarized in Exhibit 1b is the most employer-directed form of healthcare benefits. With but one plan available, and no account, employees have no choice of plan design, carrier or provider network – their only real choice is whether or not to participate. When they do chose to participate, employees perceive the cost of insurance to be only their own contribution, and the cost of healthcare goods and services to be the co-pays, deductibles and coinsurance they pay – not the actual costs.¹⁶ They have no tax-advantaged way to save for even those out-of-pocket costs.

The example shown in Exhibit 2a, the Multi-Plan Option adds one feature to the baseline example, a choice of plans for employees, generally with different levels of premium sharing associated with each choice. Employers offering such plans set their contributions on any one of a number of uniform bases, such as a core dollar amount, a percentage of either average or lowest plan cost, or on some other basis. Employers also typically establish different contributions depending on whether the employee selects coverage for the employee only, or covers additional family members.¹⁷

Perhaps the greatest limitation of the baseline example for employees is evident when the employer decides to change plan designs or carriers and provider networks, or when the employee changes jobs. When these events occur, the employee typically will find that he or she must change plan designs, insurers and, sometimes, the providers they see or the preferred maintenance drugs they use.

The employee’s required contribution amount becomes the de facto price of the plan. In other words, the employee makes cost-value decisions based only on the employee contribution amount since the actual amount of the employer funding typically is not disclosed. The Federal Employees Health Benefit Plan (FEHBP) is a prominent example of a basic Multi-Plan Option approach.

Exhibit 2b - Multi-Plan Option

Description (Incremental Features in Bold)	Key Dimensions	Change from Prior Example
Employer provides core contribution and offers multiple health plan choices. Employer sets the “menu”. Employee choice is to participate or not and plan type (e.g., HMO, PPO, high deductible, etc.). Employee’s cost (premium contribution) will vary depending on which plan is chosen.	Choice of Coverage Low ← → High	<i>More choices of plan type, plan design, carrier and providers</i>
	Continuity of Coverage and Care Low ← → High	<i>Employee choices and care preference may be disrupted if the employer changes the menu or if employment ends</i>
	Consumer’s Stake in Spending Decisions Low ← → High	<i>Consumer chooses plan based on preferences and cost (premium contribution). May be able to choose plan design that increases stake (e.g., high deductible)</i>
	Flexibility of Funding Options for Consumer Low ← → High	<i>Consumer may choose “richer” plan design to reduce out-of-pocket costs later</i>
	Employer Administrative Stewardship Low ← → High	<i>Offering choice of plans and premium contributions adds administrative requirements</i>

As shown in Exhibit 2b, the addition of plan choices to the Baseline example has three positive impacts on the consumer:

- 1) With more plans from which to choose, the employee is more likely to find one that meets his or her needs
- 2) The employee has more flexibility in deciding how much to contribute toward the premium of his or her healthcare plan
- 3) If the employee chooses a high-deductible plan, the employee will have additional discretion when contemplating spending on routine medical care needs.

While these advantages of the Multi-Plan Option approach over the Baseline example are significant, the approach still has limitations. The employee is still subject to disruption of coverage or care if the employer changes the options on the menu or if employment ends. In addition, employees that do not select a high deductible plan, or those to which one is not offered, will still be insulated from the costs of medical care.

Building Toward Patient Directed Healthcare Benefits – Adding Healthcare Spending Accounts.

A healthcare spending account is money that is set aside to reimburse employees for non-covered healthcare expenses not covered by insurance. Generally, all types of healthcare spending accounts include the following features:

- Employers provide an account in the employee’s name to which the employer and/or the employee may contribute on a pre-tax basis
- An employee may use the money in the account to pay for additional qualified healthcare goods and services
- If the account is set up as a debit account, the employee may use debit card transactions to pay for healthcare goods and services

A healthcare spending account is not a health plan as discussed above because it does not constitute insurance coverage. Such accounts – the most common of which are Flexible Spending Accounts (FSA) – are popular because the money that goes into them is not taxable as income to the employee.

Exhibit 3a - Multi-Plan Option + FSA



Employer provides \$110 "Flex Credits" and a menu of healthcare and other benefits plan options to an employee. The actual amount of funding is typically not disclosed.



Employer selects plan, making cost/value judgements based only on employee cost and plan type.

*XYZ Co. Benefit Choices
(Example showing selection of PPO)*

Plan	Price Tag	Employee Cost
A. PPO	\$150	\$150
B. HMO	\$110	
C. Indemnity	\$200	
D. High Deduct.	\$100	
Total		\$150
Less Flex Credits		\$110
Net Cost to Employee		\$ 40

(Above) Employee selects plan(s), making cost/value judgements based on total cost to him/her and plan type



Employee* makes voluntary pre-tax contribution to account

**Technically, an employer may also contribute to the account, but this is uncommon today.*

Personal Health Account (Sec. 125 FSA)



(Above) Employee can spend dollars in Personal Health Account on IRS-approved health care goods and services, excluding health insurance premiums.

Employee pre-tax contributions can be used today to help pay for healthcare expenses. That is, an employer's plan could, as many do today, allow an employee to reduce his or her salary and have such amount saved "on account" used to pay for healthcare expenses. These arrangements, i.e., FSAs, provide that amounts unused at year-end must be forfeited.

Example 3 – Multi-Plan Option + FSA

The type of Healthcare Spending Account that is by far most widely used today is the Section 125 healthcare flexible spending account (FSA).¹⁹ The addition of this type of account to the Multi- Plan Option Example is illustrated in Exhibit 3a. Employees, and occasionally employers, contribute funds to these accounts on a pre-tax basis, typically up to a maximum of \$5,000 per year, although there is currently no legal limit to the amount. The money in these accounts may be used to pay for healthcare expenses incurred by the employee or family members that are not reimbursed by a healthcare plan, e.g., deductibles and coinsurance, expenses for non-covered goods and services.

A key feature of FSAs as currently structured is that unused amounts are lost if not used by the end of a plan year and cannot be taken, except in a limited way under COBRA, by the employee if he or she changes jobs, i.e., FSAs are not portable. In addition, it is important to note that FSA money can only be used to reimburse an employee for IRS-approved medical expenses, excluding health insurance premiums.

Theoretically, Section 125 FSAs expand employee choice and introduce a measure of increased individual responsibility for how money is spent without requiring much employer administrative involvement. In practice, the use-it-or-lose-it provision can negate these possibilities. For example, this provision creates an incentive for employees to spend money on services that may not really be needed in order to avoid loss of funds. Furthermore, some employers may decline to offer the accounts, despite the tax savings to employees, because of negative employee reactions when they lose their unspent money. In addition, the prohibition against using FSA funds for insurance premiums obviously places a limit on a significant possible use of the money. The impact of adding the FSA to the prior example is summarized in Example 3b.

Exhibit 3b - Multi-Plan Option Plus FSA

Description <i>(Incremental Features in Bold)</i>	Key Dimensions	Change from Prior Example
Employer provides core contribution and offers multiple health plan choices. Employer sets the “menu”. Employee choice is to participate or not and plan type (e.g., HMO, PPO, high deductible, etc.) and how much pre-tax money to set aside in FSA account. Employee’s cost (premium contribution) will vary depending on which plan is chosen.	Choice of Coverage Low  High	<i>Availability of FSA may modestly increase consumer’s choice by providing vehicle to save for out-of-pocket costs</i>
	Continuity of Coverage and Care Low  High	<i>Employee choices and care preference may be disrupted if the employer changes the menu or if employment ends. FSAs do not help during job loss or retirement because FSAs do not accumulate and are not portable</i>
	Consumer’s Stake in Spending Decisions Low  High	<i>Money in FSA is the consumer’s own, but “use-it-or-lose-it” requirement distorts incentives</i>
	Flexibility of Funding Options for Consumer Low  High	<i>Consumer may decide to place money in FSA that otherwise might have been used for premium contribution.</i>
	Employer Administrative Stewardship Low  High	<i>Modest additional administrative requirements</i>

FSAs do not now help employees when they become unemployed or retire because the accounts cannot accumulate from year to year and cannot be taken with the employee when employment ends.

Example 4 – Healthcare Supermarket + FSA

In this example, illustrated in Exhibit 4a the menu of health plan choices is determined not by the employer but by a third party, a health supermarket. Since the health supermarket is in the business of offering health plan choices, the number of choices offered is theoretically greater than the number an employer may wish to offer on its own. The premiums offered by the third party may be risk adjusted for each employer or may have one community rated premium schedule for all employers using the supermarket. Self-insurance may or may not be allowed, but is typically less practical in this model.

Healthcare Supermarkets, particularly with Internet-based administration, can help small employers offer their employees many plan choices without an excessive administrative burden . In addition, the Internet can be a powerful tool for providing employees with the tools they will need to make their plan choices.

A number of Internet start-ups and some major health plans are offering Health Care Supermarket plans, sometimes with spending

accounts. Employers of all sizes are considering them and some have moved to this model. As shown in Exhibit 4b, this approach typically affords employees, particularly employees of small employers, many more choices of benefit plan designs, carriers and provider networks. In addition, to the extent that many employers in a given market move toward the same such plans, their presence may hold some promise for improving the continuity of coverage and care for employees and their ability to pool contributions from multiple employers.

Along with these incremental advantages for employees comes one important advantage for employers – a large reduction in their administrative burden. Because the supermarket offers the plans, negotiates with carriers and communicates and offers choices to employees, there is much less work for employers to do. Employers seeking to refocus on their core businesses are likely to find healthcare supermarkets to be attractive complements to other outsourcing activities. A key critical success factor for Healthcare Supermarkets is the ability to attract insurers to participate.

As shown in Exhibit 4b, the Supermarket + FSA tips the scale much more toward patient-directed benefits and care than previous examples. When a Personal Health Account (PHA), an evolution in healthcare spending account, without the limitations of an FSA is added, we move even further up the continuum.

The growth of Healthcare Supermarkets may allow more employees to maintain the continuity of their insurance coverage and care in progress. Eventually multiple wage earner families could “pool” their employers’ contributions and thereby enhance their purchasing power by making coverage more affordable.

Exhibit 4a - Healthcare Supermarket + FSA



Employer provides \$100 and access to a menu of healthcare plan options to an employee. The amount of funding may be disclosed.



Plan	Price Tag	Employee Contribution	Employee Cost
A. (PPO)	\$150	\$100	\$ 50
B. (HMO)	\$110	\$100	\$ 10
C. (Indemnity)	\$200	\$100	\$100
D. (high Ded.)	\$100	\$100	\$ 0

(Above) Employee selects plan, making cost/value judgements based on total cost, net cost to him/her and plan type.



Personal Health Account (Sec. 125 FSA)

Employee makes voluntary pre contribution to Healthcare FSA account.



(Above) Employee can spend dollars in Personal Health accounts on IRS-approved health care goods and services. Dollars are forfeited if not used by year-end.

*Technically employer may also contribute to FSA account but this is uncommon today.

Opportunities to pool core contributions from multiple employers may require a change in ERISA rules to allow multiple employer plans to avoid the application of a patchwork of state laws. Depending on plan design and the amount of employer involvement, a healthcare supermarket might be considered a multiple employer welfare arrangement (MEWA) subject to state regulation and possibly ERISA requirements.

Exhibit 4b - Healthcare Supermarket + Flexible Spending Account

Description (Incremental Features in Bold)	Key Dimensions	Change from Prior Example
Employer provides core contribution and access to healthcare “supermarket” .	Choice of Coverage Low ←————→ High	Many more plan choices made available by healthcare supermarket
Supermarket offers multiple health plan choices, sets the menu and provides comprehensive administration.	Continuity of Coverage and Care Low ←————→ High	Modest increase in potential to continue coverage and care preferences after employment ends (e.g., if next employer or spouse’s employer uses supermarket)
Employee choice is to participate or not and the plan type (e.g., HMO, PPO, high-deductible, etc.) and how much pre-tax money to set aside in FSA account.	Consumer’s Stake in Spending Decisions Low ←————→ High	Consumer’s stake may increase if supermarket offers wide range of premiums, cost sharing options and FSAs
Employee’s cost (premium contribution) will vary depending on which plan is chosen.	Flexibility of Funding Options for Consumer Low ←————→ High	May have the future ability to pool employer contributions toward the supermarket if spouse’s employer also contributes toward same supermarket
	Employer Administrative Stewardship Low ←————→ High	Employer chooses supermarket, but supermarket selects plan designs, carriers and provider networks to offer. Employer administrative requirements reduced

Emerging Personal Healthcare Account (PHA) – Eliminating the “Use-it-or-Lose-it”

As the next series of PDHB examples illustrates, a PHA, as described below, with no use-it-or-lose-it requirements greatly expands the potential for employees to obtain a better sense of the true cost of healthcare and greater control over healthcare spending decisions. A key theme of the PHA is that the consumer is a direct participant in making cost/benefit choices on a service-by-service basis. Consumers will become aware of the price of services leading to their assessment of the cost and benefit of spending money on a specific service. This, in turn, is expected to result in more plan and provider accountability and competition. Finally, if a benefit program is paid for on a premium basis, employees will be directly involved in the cost/benefit decisions associated with selecting the programs presented. A PHA that encompasses these incentives is now emerging.

The emerging model of the Personal Health Account (PHA) allows unused employer contributions in the PHA to be rolled over and accumulated from year to year. These amounts could also be used for healthcare expenses after termination of employment (including retirement), if an employer wishes to so design its plan. Some employers may choose to have unused amounts forfeited upon termination of employment, and this is also permitted. These employer-only amounts can be used to pay for healthcare expenses or insurance. Monies are required to be used for eligible medical expenses only. There is no cash option. Since employers can only take a deduction when monies are disbursed, for-profit companies would not likely explicitly fund these employer-only accounts although a liability would be recognized. Tax deductibility considerations for not-for-profit, or state and local government employers are, of course, less relevant.

This emerging type of PHA stems from a fresh interpretation of Section 105 of the Internal Revenue Code (IRC). Employees may continue to fund FSAs on a pre-tax basis, but, in addition, employers may establish separate accounts that are limited to only employer contributions for individual

employees. Funds in both accounts are pre-tax and can be used to pay for healthcare expenses that are not covered by a healthcare plan (as in the current model FSA). The key difference between the PHA and the FSA is that unused employer contributions in the PHA can by the employer's design be rolled over and accumulate from year to year, and can be used to purchase insurance. The ability to roll over unused monies from year to year greatly increases the employee's stake in spending decisions and, if access to the PHA continues post-employment, to save money for periods of unemployment or retirement.

Risk Selection and Management Issues

There are both potential adverse-selection and risk-adjustment issues that employers ought to consider in the Multi-plan Option examples discussed above. The following is a brief overview of these issues as they are discussed in more detail in Section IV later in the document.

With all multi-plan models, employees are likely to select programs that coincide well with their particular healthcare needs, potentially causing additional claims costs related to their “selection.” In other words, employees who expect to use their benefit will select plans more likely to reimburse them well. Young or very healthy employees, not expecting to use their benefits, more likely will select the plan that has the lowest cost to them. To balance the positive aspects of choice with the potential negative aspects of selection, the employer may want to carefully consider the scope and level of choice offered.

As to risk adjustment, the employer will need to decide how to equitably allocate the total dollars that it plans to spend among employees and what criteria it will use to do so. Under conventional plans, employers typically provide subsidies to employees with families, and sometimes recognize other cost differences, like geography. However, there are a number of other variables that can be used to differentiate risks, as long as doing so does not violate HIPAA's prohibitions on discriminating in premiums or contributions based on health status. It should be noted that new risk adjustment methods are likely to result in more complex administration and additional data needs, which, in turn, may create data privacy issues for the employer. It should also be noted that, since subsidies are likely to be more

apparent to employees under this model, employers should be prepared to make some tough decisions as well as communicate to employees about this sensitive issue.

Finally, if a plan is self-insured, it may be less practical to prospectively “budget” the employer contribution because, in practice, actual claims expenses often exceed projections. Also, to date, consumers have not widely used the Internet to purchase insurance, and especially have not used it to purchase health insurance. Employers seeking to implement this approach may have to better understand this challenge to navigate it effectively.

Example 5 – Healthcare Supermarket +FSA + PHA

This example is the same as Example 4, the Healthcare Supermarket + FSA except the emerging employer-provided PHA is added, as shown in Exhibit 5a. A number of startup and established healthcare companies offer such plans with the following components:

Core Contribution Component

In this example, the employer provides a Core Contribution on behalf of the employee that can be used to select from a menu of plan choices offered by the “supermarket” and/or to establish a segregated account. If the employee selects an option that costs more than the amount of the employer contribution, the employee is required to make up the difference.

Exhibit 5a - Supermarket + FSA + PHA



Employer provides \$100 and access to a menu of healthcare plan options to an employee. The actual amount of funding may be disclosed.

Supermarket Menu			
Plan	Price Tag	Employee Contribution	Employee Cost
A. (PPO)	\$150	\$100	\$ 50
B. (HMO)	\$110	\$100	\$ 10
C. (Indemnity)	\$200	\$100	\$100
D. (high Ded.)	\$100	\$100	\$ 0

(Left) Employee selects plan, making cost/value judgments based on total cost, net cost to him/her and plan type.



(Below) Employee can spend dollars in Personal Health Accounts on IRS-approved health care goods and services. Sec. 105 dollars can be accumulated year to year at employer discretion and spent on insurance premiums. Sec. 125 dollars are forfeited if not used by year-end and cannot be spent on insurance.



Personal Health Account (Sec. 105)

Employer makes voluntary "pre-tax" contribution to segregated notational account.



Personal Health Account (Sec. 125 FSA)

Employee* makes voluntary pre-tax contribution to Sec. 125 Healthcare FSA account



*Technically, an employer may also contribute to the account, but this is uncommon today.

PHA Component

The employee deposits money into his or her FSA and the employer establishes an employer-only PHA in the employee's name.²⁰ These accounts function as described above. They can be used to pay for IRS-approved healthcare goods and services. Unused contributions from the employer-only account can accumulate from year to year, but employee contributions to FSA must be used by the end of the year or are lost and cannot be used to purchase insurance.

As summarized in Exhibit 5b, this approach provides the following incremental advantages due to the addition of the employer-provided PHA:

- Increases the potential for continuity of coverage and care by affording employees the opportunity to accumulate PHA dollars over time, for example, to pay long term care premiums or fund post-retirement expenses and generally increase individual financial security for healthcare.

- Increases the flexibility of funding by giving the employee a more tangible complement to insurance
- Without application of use-it-or-lose-it requirements, the employer-only PHA can effectively increase employees' stake in healthcare economic decisions

The latter point, in particular, is illustrated in the next example, where only High Deductible Plans are offered.

The financial and administrative issues associated with the Supermarket + FSA + PHA example include those noted above in connection with the examples' "plan" and "account" components. Furthermore, the interaction of the two model components raises a few additional issues about the relative use of each. For example, how far should an employer go toward encouraging the use of "accounts" (e.g., PHAs) at the expense of funding a "plan"? Will high deductible health insurance plans cause employees to increasingly defer seeking care and will this result in greater expense in the long run?

Exhibit 5b - Healthcare Supermarket + Flexible Spending Account + Personal Health Account

Description (Incremental Features in Bold)	Key Dimensions	Change from Prior Example
Employer provides core contribution and access to healthcare "supermarket". Supermarket offers multiple health plan choices, sets the menu and provides comprehensive administration. Employer also provides segregated Personal Health Account (PHA) (Sec. 105) that may be used by the employee to pay for non-covered expenses or saved to pay for future healthcare coverage or goods and services when the employee is unemployed or retires. Employee choice is to participate or not and the plan type (e.g., HMO, PPO, high-deductible plan, etc.), how much pre-tax money to set aside in FSA account, and whether or not to spend or save money in the PHA. Employee's cost (premium contribution) will vary depending on which plan is chosen.	Choice of Coverage Low ←————→ High	Employee can choose how to combine plans and accounts (i.e., lower premiums by funding cost-sharing and vision care from accounts)
	Continuity of Coverage and Care Low ←————→ High	Ability of consumer to accumulate money in PHA from year to year and to take it with him or her post employment, may enable continuity of coverage choices
	Consumer's Stake in Spending Decisions Low ←————→ High	Employer-provided PHA without "use-it-or-lose-it" requirements increases consumer's stake in spending decisions. Coordinating plans and accounts increases stake
	Flexibility of Funding Options for Consumer Low ←————→ High	Increased ability to decide between spending and saving PHA money; may spend PHA money on healthcare goods & services or insurance
	Employer Administrative Stewardship Low ←————→ High	Employer may have some administration associated with spending accounts and must consider risk selection and subsidy issues

Exhibit 6a - High Deductible Plan + FSA + PHA



Employer provides \$90 and access to a menu of catastrophic healthcare plan options to an employee. The actual amount of funding may be disclosed.

<i>Employer - or Exchange-based Menu</i>			
Catastrophic Plan	Plan Cost	Employee Contribution	Employee Cost
A. \$2000 deduct. 90/10 coins.	\$100	\$90	\$10
B. \$1000 deduct. 80/20 coins.	\$120	\$90	\$30
C. \$5000 deduct. 100/0 coins.	\$ 90	\$90	\$ 0

(Left) Employee selects plan, making cost/value judgments based on total cost, net cost to him/her and plan type.



(Below) Employee can spend dollars in Personal Health Accounts on IRS-approved health care goods and services. Sec. 105 dollars can be accumulated year to year at employers discretion and spent on insurance premiums. Sec. 125 dollars are forfeited if not used by year-end.



Personal Health Account (Sec. 105)

Employer makes voluntary "pre-tax" contribution to segregated account.



Personal Health Account (Sec. 125 FSA)

Employee* makes voluntary pre-tax contribution to Sec. 125 Healthcare FSA account

*Technically, an employer may also contribute to the account, but this is uncommon today.



A PHA that permits employees to save employer contributions has potentially significant ramifications for small employers, the uninsured and retirees. Small employers that cannot afford to fund fully even low-cost insurance can provide their employees with pre-tax dollars that can be combined with employee funds and used to pay for premiums, current healthcare needs, or saved for future use. When these funds are saved, employees, can pool their PHA accounts with their spouses' PHAs (if available) to buy insurance or pay for care, or they can continue to save for retirement needs, such as Medigap with prescription coverage or even long term care insurance.

Example 6– High Deductible Plan + FSA + PHA

This example is identical to Example 5 with one exception: the menu of plan choices is limited to one or a fairly small number of high-deductible or catastrophic health insurance plan designs (see Exhibit 6a). While this approach clearly limits employee choice of plan design, it does provide an appealing option for employers who wish to emphasize personal responsibility for employees in their healthcare benefit program.

By limiting the plan choices to high-deductible plans, perhaps with minor variations in co-insurance, employers can protect employees from the costs of catastrophic illness or injury. By funding a flexible PHA, employers can also give employees greater responsibility, choice and flexibility in funding routine care, and/or non-traditional healthcare services. To name a few, young professionals or employed, uninsured individuals in need of a low cost plan might find this option particularly attractive.

Such plans combined with accounts might also appeal to higher wage workers who can afford to be at-risk for high deductibles and prefer to save for future needs.

In a sense, this approach separates the insurance aspects of healthcare benefits from the tax-advantaged-pre-payment benefits that have grown over the years. By traditional definition, insurance should apply only to relatively infrequent, random, events each of which carries with it the risk of a large loss. As important as many routine medical visits, tests and procedures are, they are not truly insurable events since they are predictable as to timing and cost. In this model, the employer removes such healthcare goods and services from the realm of a plan and transfers the responsibility to budget for, and wisely use, predictable services to the employee. The intent is to mobilize consumers in the battle against rising healthcare costs. In some variants, such plans may pay 100% for certain preventive services to make sure that financial incentives do not cause consumers to defer such

Exhibit 6b - High Deductible Plan + FSA + PHA

Description (Incremental Features in Bold)	Key Dimensions	Change from Prior Example
Employer provides core contribution and access to multiple high deductible plan choices. Employer also provides segregated Personal Health Account (PHA) (Sec. 105) that may be used by the employee to pay for non-covered expenses or saved to pay for future healthcare coverage or goods and services when the employee is unemployed or retires. Employee choice is to participate or not and the type of high-deductible plan (e.g., different deductible, coinsurance levels) , how much pre-tax money to set aside in FSA account, and whether or not to spend or save money in the PHA. Employee's cost (premium contribution) will vary depending on which plan is chosen.	Choice of Coverage Low High	<i>A menu of relatively high deductible plans reduces consumer's plan choices (although may use PHA to purchase supplemental insurance, if available)</i>
	Continuity of Coverage and Care Low High	
	Consumer's Stake in Spending Decisions Low High	<i>Choice of a range of relatively high deductible plans increases consumer's consideration of cost and value when purchasing healthcare goods and services</i>
	Flexibility of Funding Options for Consumer Low High	
	Employer Administrative Stewardship Low High	<i>Employer may control menu of plan designs offered by selecting the "high deductible + account" approach</i>

tests and visits. Prime examples of the High Deductible approach are MSA plans, plans offered by a number of startup and established healthcare companies and the South African healthcare system. Such plans may not be best for the chronically ill who have predictably high costs and care needs unless specifically designed with these special needs in mind. The incremental advantages of this example are summarized in Exhibit 6b.

Example 7 – PHA + FSA

While clearly a more advanced form, one way to increase the extent to which the consumer directs his or her own coverage and care is to eliminate the requirement that he or she must purchase insurance. This example (Exhibit 7a) illustrates this approach and Exhibit 7b summarizes its incremental advantages over the High Deductible + FSA + PHA example. This is the most patient-directed example that is feasible today, and has the advantage of lowering the “ante” for small employers who cannot afford to offer even the least costly insurance plan to their employees. One downside of this approach that may concern

some employers is that employees able to protect themselves against catastrophic losses by using accumulated PHA funds plus their own money may choose not to do so.

Since there are many more choices for employees, and, in particular, choices that were not previously available (e.g., preventive healthcare), there are potential selection issues under “account only” examples such as the PHA + FSA approach. Employees will self-select services that coincide very well with their known healthcare needs, creating additional claims. To counteract this effect and potentially reduce claims, employers may decide to subsidize the contributions of employees who choose healthy lifestyles, such as by allocating more dollars to those employees that utilize exercise and diet programs consistent with HIPAA’s nondiscrimination provisions. Moreover, it is possible that the judicious use of preventive or alternative care may actually result in lower claims costs. To that end, effective employee education and communications initiatives will be very important.

Determining an approach to administering Personal Health Accounts and establishing supporting policies are additional issues for employers to consider. Some larger employers may consider in-house administrative solutions. Alternatively, there are numerous organizations today that have this capability, from health plans to third-party administrators, to benefits administration

outsourcing firms. Additionally, employers will need to make many administrative policy decisions, such as management of an employee’s account balance when he or she terminates employment, or whether the employer will “guarantee” unfunded employer-only dollar account balances.

Exhibit 7a - PHA + FSA



Employee makes voluntary pre-tax contributions to Sec. 125 Healthcare FSA account.



Can be spent on IRS-approved health care goods and services, but employee must either use-it-or-lose-it at year end (Sec. 125)



Employer credits pre-tax contribution to segregated account.



Can be spent on IRS-approved healthcare goods and services, and health insurance, and employee can accumulate unused dollars from one year to the next* (Employer-only)

**Use of account post-employment is at employer's discretion.*

Exhibit 7b - Personal Health Account + Flexible Spending Account

Description (Incremental Features in Bold)	Key Dimensions	Change from Prior Example
<p>Employer provides ONLY a core pre-tax contribution to a Personal Health Account. The employee may use the money in the account to pay for insurance or health care goods and services. If the employer’s design permits, employee may save the money for future (e.g., next year’s) healthcare needs, or for needs that arise after employment (e.g., unemployment, retirement). Family members with PHAs from different employers may seek reimbursement for collective expenses from both PHAs. Employee may also contribute pre-tax money to an FSA.</p>	<p>Choice of Coverage Low  High</p>	<p>Maximum ability for employee to select plan design, carrier and provider network, assuming availability of supermarket or mature individual insurance market</p>
	<p>Continuity of Coverage and Care Low  High</p>	<p>May use accumulated employer-provided funds to continue coverage post-employment</p>
	<p>Consumer’s Stake in Spending Decisions Low  High</p>	<p>Employer-provided funds likely to be perceived by consumer as if they were consumer’s own funds and treated accordingly</p>
	<p>Flexibility of Funding Options for Consumer Low  High</p>	<p>Maximum ability for employee to chose between coverage vs. accounts and to pool employer-provided funds with other funds</p>
	<p>Employer Administrative Stewardship Low  High</p>	<p>Least employer control over use of core contribution; minimal administrative requirements</p>

Example 8 – Next Generation PHA

Exhibit 8a illustrates a future vision for PDHB that could be implemented were several changes made in current regulations. The ability of employees to accumulate funds from year to year makes the emerging employer-only PHA an attractive option for expanding flexible, continuous coverage. The next generation of these accounts would go two steps further by simplifying the funding requirements for employers, and eliminating the firewall between employee funded and employer-only monies. As shown in Exhibit 8a, such an approach would enable multiple wage earner families to pool their employee and employer-funded money for healthcare expenditures through the use of “Joint” PHAs. They would also be able to use the money not only to pay for healthcare expenses, but also for health or long term care insurance policies. The availability of such a funding vehicle would create PHAs that:

- Provide the greatest opportunity to pool funds from all possible sources

- Accumulate over time to fund a family’s health care needs during or after employment
- Afford consumers expanded choice as to how they take care of their healthcare needs
- Greatly increase consumers’ stake in their healthcare economic decisions, and thereby introduce a new force to contain healthcare costs
- Provide an avenue for employers to provide any level of funding they can afford with minimal administrative burden

The incremental advantages of this next generation example are shown in Exhibit 8b.

The next generation PHA would require modification of the tax rules in order to rollover employee pre tax contributions in an FSA, as well as to use them for the purchase of insurance. Further, rule modifications would be necessary to allow for portability, pooling and tax-efficient employee and spousal contributions for healthcare needs.

Exhibit 8a - Next Generation PHA



Employee #1 makes voluntary contribution to account.



Employer #1 makes voluntary contribution to account.



Employee #2 (spouse of employee #1) makes voluntary contribution to account.



Employer #2 makes voluntary contribution to account.



“Joint” Personal Health Account (pools dollars from all four sources)



Can be spent on health insurance or long term care insurance policy.



Can be spent on IRS-approved healthcare goods and services and other healthcare goods and services not typically covered by today’s plans.



All dollars in the account are portable, and can be used even if individual loses her job.



Can be accumulated and used for retirement.



Exhibit 8b - Next Generation Personal Health Account

Description (Incremental Features in Bold)	Key Dimensions	Change from Prior Example
Employer provides a core pre-tax contribution to a Personal Health Account. The employee may add his or her own pre-tax dollars to the account and use the money in the account to pay for insurance or health care goods and services. If the employer's design permits, employee may save the money for future (e.g., next year's) healthcare needs, or for needs that arise after employment (e.g., unemployment, retirement). Family members with PHAs from different employers may seek reimbursement for collective expenses from both PHAs.	Choice of Coverage Low High	<i>This would depend somewhat on access to, and quality of the individual insurance market for those who do not self-insure</i>
	Continuity of Coverage and Care Low High	<i>Depends somewhat on continued or guaranteed access to the individual insurance market</i>
	Consumer's Stake in Spending Decisions Low High	<i>Increased ability of employee to decide how to use his or her own money (in addition to employer-provided funds)</i>
	Flexibility of Funding Options for Consumer Low High	<i>Maximum ability for consumer to choose combination of insurance and savings to cover their health care needs</i>
	Employer Administrative Stewardship Low High	<i>Minor possible administrative requirement to administer employee contributions to account</i>

- IV -

Legal, Regulatory, Financial and Actuarial Issues

Creating An Hospitable Tax and Regulatory Environment

While a more progressive attitude seems to be taking hold in Congress - and the Internal Revenue Code appears increasingly flexible - there clearly are elements in today's tax and regulatory framework that act as "fences" to a healthcare system that is straining to evolve beyond traditional models. Many of these items, as they relate to particular patient-directed approaches, have been introduced briefly in Section III. The following discussion - which can be viewed as "action steps" for policy-makers - highlights some of the fences that could be moved to shape a more flexible perimeter that encourages innovative financing of healthcare. While we do not go into detail here on the vast array of federal and state laws and regulations that impact employer-provided health benefits, those seeking such a discussion can find it in the *Appendix*.

It is worth noting that ideas around tax credits are evolving and many proposals under development in Congress contemplate a range or continuum of tax-related incentives. Most of these proposals are aimed at encouraging low wage workers to obtain health insurance by providing incentives that foster its purchase. It is our view that there is nothing inherent in the concept of tax credits that undermines employer-sponsored health insurance or that is incompatible with the patient-directed approaches described in this document.

Individual tax credits for the purchase of health insurance and patient-directed models are complementary approaches that stitch together the current and an evolving system.

Taxability and Deductibility Changes

Repeal "Use-It-or-Lose-It" Rules: Current tax rules act as primary constraints with regard to the Personal Health Account (PHA) model as a stand-alone approach or combined with "plans". The emerging and next generation

PHA both depend on the flexibility of employees being able to rollover unused amounts in employer and/or employee healthcare accounts to subsequent years. It is this flexibility that positions the employee as a prudent healthcare consumer. The use-or-lose-it requirement associated with FSAs today encourage the opposite behavior. It forces employees to consume healthcare regardless of need by year-end and discourages employees from assuming reasonable risk over time. To align tax policy with healthcare policy, the FSA use-or-lose-it rule needs to be repealed.

Permit Purchase of Insurance Through FSAs: Next generation PHAs would also require a modification to current FSA rules in order to allow the purchase of insurance with FSA amounts as current regulations prohibit the purchase of insurance using FSA amounts.

Clarify Rollover Treatment: Official IRS guidance is unclear as to whether employer-only healthcare accounts can be rolled over for future use. Today, notwithstanding recent unofficial statements by the IRS, the FSA regulations have been read by some to question the ability to roll over such amounts. Moreover, the taxability of such amounts is currently treated by the IRS as a no ruling area, which means that the IRS will not respond to a formal request for clarification. Clarity of the tax rules to allow both employee and employer amounts to be rolled over to future periods could also help lift the air of doubt surrounding the tax efficient use of dual-purpose profit sharing plans, though this not discussed here.

Flexibility in Choice: Assuming tax clarification could be achieved regarding roll over abilities, additional clarification would be important for flexibility in using accumulated healthcare contributions for other purposes. Under current MSA rules, an individual may take a distribution of accumulated amounts as cash instead of as healthcare benefits. Such cash distribution loses its tax-free status and may be included in the individual's income when distributed and subject to an additional 15% tax if before age 65.

Whether or not using age 65 is the most appropriate threshold, it still encourages individual savings for healthcare, even if ultimately the full amount is unnecessary. This may be the case because of future changes in healthcare laws or if the spouse has comprehensive healthcare coverage.

Portability: Another next generation challenge for PHAs deals with the portability of healthcare accounts. Today, there is no tax efficient way for an employee to take a PHA with him or her on termination of employment. In the employer-only account, an employer, as a matter of plan design, could choose to have unused amounts forfeited on termination of employment or could make amounts available for healthcare reimbursements of former employees and dependents. However, there is no tax efficient mechanism today that would allow the terminating employee to take the account with him. That is, there is no Individual Retirement Account (IRA) equivalent for healthcare. A “next generation” Personal Health Account (PHA) could have certain IRA-like properties such as tax-free earnings.

The “next generation” PHA could also be used as a vehicle for individuals to save for future healthcare needs or purchase long-term care insurance and for employers to make contributions for healthcare, similar to today’s IRAs. This PHA might be one way to help address another situation in today’s economy where a husband and wife may each be working more than one job but none of the employers provides healthcare benefits. Such an approach might be a way to encourage such employers to make some type of contribution to the PHA, which together with other employer contributions may be sufficient for the individual to purchase healthcare coverage. The husband and wife could use amounts from their own PHA in combination to purchase family coverage.

To the extent that health coverage purchased with PHA funds is attributable to employer contributions, the coverage and benefits would presumably be tax-free as an employer-provided benefit. To the extent such coverage would be purchased with PHA amounts attributable to employee contributions, the benefits received would be tax free under IRS Section 104, but the employee would only be able to deduct amounts that, together with other healthcare expenditures, exceeded 7.5 percent of adjusted gross income. To encourage employer and employee

contributions to a PHA, the tax laws could be modified to provide a tax credit for employee contributions.

Regulatory Changes

Group purchasing arrangements raise federal and state regulatory issues. Federal legislation to create federally-recognized association health plans (AHPs) or HealthMarts could avoid some of the state insurance regulations, although most of the legislative proposals offered in the 105th and 106th Congresses would have made such entities subject to federal requirements and certain state reserve requirements or premium taxes.

AHPs: Under most legislative proposals, AHPs could be sponsored by trade, industry, or professional associations that have been in existence for at least three years if they agree to offer all benefit plans to all member firms. An AHP could choose to offer self-insured or insured plans, as long as it offered at least one fully insured plan. AHPs also would have to meet other federal requirements, such as financial solvency standards.

Although coverage offered through an AHP would be exempt from state benefit mandates, it would be subject to state premium taxes. AHPs would have to meet the premium setting regulations of each state in which enrollees reside. For example, New York requires that small-group policies be community rated; Florida and Minnesota require modified community rating; and California, Illinois, Minnesota, and Texas limit the degree to which premiums for a particular policy can vary among firms. However, premiums offered through AHPs would be based on the expected costs of enrollees of the association’s firm members and not on the costs of the broader small group market that the state small market regulations contemplate.

HealthMarts: Under most of the legislative proposals, HealthMarts would be nonprofit organizations that offer health insurance products to all small firms within their geographic service area, which would have to cover at least one county or an area of equivalent size. All of the benefit plans that a HealthMart offered would have to be offered to any small employer within its service area, and employers who chose to participate would have to agree to purchase coverage only through the HealthMart. Benefit plans offered through a HealthMart would be exempt from most state benefit mandates

but would be subject to state premium taxes. HealthMarts also would be subject to state premium regulations that applied within their service area, such as the community rating and premium related laws described above. HealthMarts could only offer fully insured plans from insurance carriers licensed in the state.

Congressional proposals have also included the motion of an Individual Membership Association (IMA). These entities would allow individuals to purchase insurance unburdened by the embedded cost of compliance with certain federal or state regulations, like benefit mandates.

Whether offered in the traditional small group market, through an AHP or by a HealthMart, a health insurance policy would be subject to state premium taxes. Premium taxes and related assessments are estimated to increase costs to insured health plans by 2 percent. The degree to which an AHP or a HealthMart would decrease small employers' healthcare costs by avoiding benefit mandates would vary by state. Small employers could decrease cost by not purchasing benefits its employees did not value in those states that mandate the inclusion of more expensive benefits, such as mental health or substance abuse treatment. Some small employers would choose to offer such benefits regardless of the presence or absence of a state mandate.

Financial and Actuarial Issues

In addition to the tax and regulatory issues discussed, there are a number of practical challenges that employers as well as payors will face under PDHB. These issues were raised briefly in Section III in the discussion of PDHB examples. While many of these issues are not new, some of the technical applications are. Further, PDHB increases the focus on these considerations, as outlined below.

Selection Issues

A centerpiece of PDHB is providing employees more choices and the ability to self-direct their healthcare spending. While many employers' healthcare programs offer a relatively limited number of options, virtually all PDHB models allow employees to select coverage options that better meet their specific healthcare needs. Emerging models, for instance, allow employees to choose on a service-by-service basis or build their own provider

networks. While more choice is a desirable tenet of PDHB, it must be managed because this enhanced ability to choose brings with it the increased opportunity for adverse-selection. Insurance principles dictate that large unpredictable losses are spread among participants who have equal expectations of loss. Insureds that do not incur a loss pay for the costs of those who do. Adverse selection occurs when an individual has advance knowledge of a loss and seeks a means for paying for it.

Health insurance benefit programs today cover a number of predictable healthcare services that are known to the employee at the time of benefit election. Predictable cost include:

- immunizations,
- maternity care,
- annual physical examinations

Technically, these benefits are not insurable, rather the costs are prepaid. Most employers have managed adverse selection by limiting benefit choices and by carefully devising employee contributions for each plan option.

If not managed, adverse selection may result in increased utilization and cost. It may not impact employers financially if they have developed a PDHB program with a preset core contribution, i.e., irrespective of the plan's actual experience. But, for employers who self-insure and retain financial risk, selection clearly has an impact. Under either scenario, adverse selection can create undesirable consequences to the financial health of the plan and employees who participate in it.

Managing Adverse Selection

Employers should be mindful of the potential impact of selection, particularly when designing and communicating PDHB programs. Employers may decide to limit certain types of choices, or to eliminate some entirely, to mitigate potential selection issues.

A method that some PDHB models employ to manage adverse selection is to aggregate large groups of individuals into a risk pool. For example, pooling could be based on a group of employers with similar characteristics, e.g., geographic, demographic. This, as well as other possible methods, may be utilized to minimize any selection issues.

Another element of selection is wide swings in experience in the initial years of the plan resulting from employees adjusting to the new program. Employers that base financial elements of their programs, e.g., contribution levels solely or partially on actual claims, may need to determine the credibility of such experience. Underwriting techniques may be required, including blending with general experience or averaging experience over a few years.

Designing a PDHB program that applies the Personal Health Account to known preplanned expenses and an insurance plan for insurable losses, may mitigate some adverse selection experience in the current models. Financial modeling and program design are critical to successful implementation of this strategy.

Risk Adjustment Techniques

In addition to considering the plan design issues discussed above, the employer may want to vary the financial contributions provided to employees using risk adjustment techniques. Currently, most employers vary the amount they contribute to employees using a limited number of variables, such as family status. Almost all employers give proportionally more contribution to families than to singles, for instance.

Keeping in mind regulatory or legal issues that may limit such variation, there are other variables by which to define contributions such as:

- geography
- actual utilization
- behavior patterns

While it is possible for these adjustments to result in contribution amounts that are more equitable to employees, communicating the employer's definition of equity to employees may be challenging.

Additionally, some employers may base contributions on variables that encourage wellness, such as participation in weight loss, blood pressure or exercise programs, or annual physicals. The idea is to reward such behavior and thereby lower costs. The program may also be established to produce its own financial reward. Employees that carefully use their

Personal Health Account to manage their own care and reduce future costs may thereby, on average, roll over greater balances in the account from year to year. The reward is a greater PHA accumulation over time.

A downside of these programs is that they can be more potentially complex to administer. As such, employers ought to consider this factor when designing the financial aspects of their PDHB approach.

Self-insurance versus Fully-insured

For employers who will consider self- or fully-insured funding vehicles, many of the relative advantages and disadvantages still hold. However, there is an additional consideration for PDHB models, namely the compatibility between controlling the contribution level and the difficulty of doing so under a self-funded arrangement. Employers who want to preset their core contribution will find that it is usually more straightforward with a fully-insured arrangement because insurance premiums are typically prospective. Because claims experience is not fully known until the end of the plan year, it is more difficult to prospectively set contributions under a self-insured model. Self-insurance does not preclude an employer from presetting its contributions, it simply presents an additional challenge. The risk of claim fluctuation can usually be mitigated with reinsurance or adjustments to future employee contributions for past events.

Individual Insurance – Risk Pooling

Today's employer-based healthcare programs are inherently group purchasing models where the employer's eligible population is the "group". In general, large employer groups receive lower health insurance rates than small employer groups for many reasons, including bulk purchasing dynamics and the ability of larger groups to be experience-rated. While small employers increasingly have collaborated to gain such leverage, they - as well as individuals - are generally not afforded the same advantages as large employers. An additional challenge relates to employees with preexisting medical conditions and their ability to obtain health insurance.

While the individual health insurance market is not the fulcrum upon which PDHB approaches hinge, the PDHB

examples discussed in this paper tend to blur traditionally held perceptions about what constitutes group and individual insurance. This is a significant issue for insurers and employers that is spawning new, creative ways of looking at traditional pooling approaches.

Individual health insurance policies are usually expensive under today's definition for several reasons including the risk characteristics of policyholders, higher marketing costs, and greater volatility of claims experience. Most employers would not adopt a PDHB model if their employees' only choice were to buy one of these relatively expensive individual policies. However, if PDHB models prompted enough consumers to purchase individual policies, the overall costs of these policies probably would decrease somewhat. Nonetheless, it would require a significant number of consumers to purchase individual policies before they would be price-competitive with group policies. Also, pursuant to common interpretations of the IRC discussed in the **Appendix**, the relative tax disadvantages of individual policies are considered a hindrance. Accordingly, employers and employees will likely only embrace PDHB approaches that permit employees who purchase insurance to obtain them not only at fair and equitable rates, but also without regard to any prior medical conditions. For these reasons, pooling of risks by groups of employees or by coalitions of employers should be considered to mitigate such concerns.

Next Steps for Employers

The purpose of this section is to present practical suggestions to employers on how to develop a strategy and implement a viable PDHB approach, such as some of those outlined in Section III. Since employers clearly are not a homogeneous body, it is particularly challenging to address the full range of issues facing such a diverse group. On one end of the spectrum there are large, national employers employing tens of thousands of employees. These employers typically maintain a sophisticated in-house benefits department and offer comprehensive, multi-option healthcare programs to employees. On the other end of the spectrum, there are the small employers. Having more limited resources, these employers currently may not offer healthcare benefits at all. If they do, they very likely do not employ an in-house benefits professional, and may spend only a very small amount of time each year thinking about healthcare. Of course, there are many different types of employers in between these two examples and, just as many appropriate PDHB strategies. Below we discuss six employer characteristics and their implications for PDHB strategy and implementation.

Key Implementation Considerations Based On Employer Profile

Which PDHB approach will appeal to an employer - as well as a strategy for implementation - will depend on a host of factors, including:

- size (number of employees)
- type of employee population
- philosophy and human resource and overall business objectives
- whether the employer currently offers healthcare benefits

- available internal resources to manage the healthcare benefit function
- availability of options in the geographic area
- current position on the “patient-directed” continuum

These factors and the key issues associated with them are discussed in greater detail below.

Size

The number of people employed has significant bearing on which PDHB approach and implementation strategy will be appropriate for an organization. This is true for several reasons including the way federal and state insurance regulations work, and, in turn, the way insurance products typically are offered. Large employers also can avail themselves more readily of healthcare benefits financing approaches, like self-funding (as opposed to fully insured) and experience rating (as opposed to community rating). Smaller employers are not afforded the advantages of economies of scale that arise from bulk purchasing as easily, one possible exception being the increasing prevalence of purchasing coalitions in certain states, i.e., HIPCs, AHPs, HealthMarts²¹.

A key implication of all these factors is that large employers may have considerably more latitude to design a PDHB program that meets their needs, while smaller employers may be constrained by what is commercially-available. The good news for the smaller employer is that many new commercially-available products promise more flexibility and functionality than small employers have today. The bad news is that, as is often the case today, these products may be more expensive than similar products available to larger employers.

Type of Employee Population

While PDHB addresses several major employer and employee concerns, it will have some practical constraints for employers with certain types of workforces. Employers with collective bargaining units or with many retirees who have been promised benefits in the future, may not see PDHB as a workable strategy in the short term, if ever. Moreover, because of the greater information needs employees have under PDHB, not every employee population group will be well suited to the responsibilities that accompany a PDHB approach; employees without ready access to the Internet, for instance.

Philosophy, Human Resource, and Overall Business Objectives

Many PDHB approaches rest on the belief that promoting more individual employee responsibility and personalization is an appropriate and efficient way of delivering healthcare benefits. How far an employer takes this will depend on its philosophy and human resource and overall business objectives.

At one extreme, an employer could be relatively paternalistic. They could provide very generous core contributions, maintain intensive oversight over the plan, give employees some additional choice and responsibility, and provide much of the administrative support typical of plan sponsors today. At the other extreme, an employer could decide to maintain a financial commitment to healthcare, but outsource virtually all of the significant administrative, maintenance and decision-making responsibilities to a third party or their employees. Of course, there are many permutations between these two. In addition, these permutations in between also represent transitional steps employers could take over time.

Whether You Currently Offer Healthcare Benefits

While virtually all large employers currently offer healthcare benefits, many smaller employers cannot afford to do so. A significant factor for smaller employers in the decision whether to offer healthcare benefits or not, is their and their employees' ability to pay for them. Another important factor in many markets is the availability of viable choices.

When considering PDHB plans, small employers, in particular, should consider:

- ***tools to help employees make new choices***
- ***employee readiness for new decision-making responsibilities***
- ***the time commitment available for administration***
- ***options available locally***
- ***the merits of joining a purchasing coalition***

Smaller employers that currently do not offer healthcare benefits at all may have more options under PDHB than they have had in the past.

Under certain PDHB models, small employers do not have to sponsor a plan e.g., coverage to provide a benefit. Rather, they can establish a Personal Health Account at virtually any dollar level that employees can use to purchase insurance or directly purchase healthcare services as needed.

PDHB is a way to offer employee healthcare benefits for the first time and to do so within a predictable and controllable financial framework.

Available Resources to Manage Healthcare Benefits

Another factor in deciding which PDHB approach is best for a particular employer is the resources available to manage healthcare benefits. Employers large and small know that sponsoring a healthcare program and managing it well can be time consuming. In the past, smaller employers have been at somewhat of a disadvantage in managing their employee benefits. Now some emerging PDHB approaches offer turnkey healthcare programs that package health plan information, evaluation, purchasing, enrollment, and administrative support services.

PDHB also brings with it new challenges. Chief among these is the need for employees to be educated so that they can make new healthcare choices. Employers of all sizes will need to pay particular attention to the area of employee education and communication under PDHB. Smaller employers imple

menting PDHB may have to rely even more heavily than they do today on their agent, broker or insurance carrier for assistance in these areas.

Available Options in Your Geographic Area

While purchasing a commercially available PDHB product will not appeal to employers of all types and sizes, those who are interested in such a product may find that they are not yet available in the markets where their employees are located. Many companies are piloting their products only in specific U.S. markets where the capacity exists. Employers considering implementation of a PDHB approach should consult with their advisors, search the internet and/or confer with their local or national Chamber of Commerce to find out what their respective market(s) offer.

Small employers not used to designing healthcare benefit programs should talk to their business advisors -- brokers or consultants -- about PDHB options. Your Chamber of Commerce can also point you in the right direction.

How an Employer Could Offer a Patient-Directed Healthcare Benefits Approach

Once you determine a basic strategy, you will need to decide on more specific elements of your PDHB approach, particularly, objectives for:

- the financial budget for healthcare
- level of employee choice, and
- level of administrative involvement

Implementation Steps for PDHB

PDHB is generally new for most employers and, as such, introduces certain issues that some employers have not previously examined. However, the strategy development process closely corresponds to that of a typical benefit program. Outlined below is one possible process for a PDHB approach that consists of six steps, and a series of action items.

Six Steps to Implement PDHB

- 1) Conduct a diagnostic review***
- 2) Design program strategy and explore solutions***
- 3) Perform financial modeling***
- 4) Evaluate results and select a specific approach***
- 5) Implement and communicate***
- 6) Monitor performance***

Many of these steps require new approaches, such as modeling techniques, unique to PDHB. And each of the following steps will, in one way or another, be impacted by the size, culture and other criteria for the specific employer. This section is written for an average employer. However, Exhibit 9 shows several examples of specific approaches for employers of different sizes and varying objectives.

Conduct a Diagnostic Review

The first step in evaluating any new approach is determining whether it is an appropriate strategy for your organization. Typically, this will include:

- evaluating current plans
- assessing current and expected future costs
- possibly surveying employees and retirees
- interviewing senior management to confirm an understanding and agreement on the company's culture and near-term and long-term goals

It is possible that certain company goals and objectives may be more feasible under PDHB than under previous benefit strategies.

Additionally, employers should consider the following steps and questions:

- Examine the overall business strategy, as well as short-term and long-term financial, human resources and administrative objectives. Are any of the PDHB current models consistent with short-term strategy? Is it such that a transition over time to emerging or next-generation models will be consistent with the company's long-term strategy?

Exhibit 9 - Examples of PDHB Implementation

Employer Characteristics	Example	Illustrative PDHB Approach	
		Phase I	Phase II
Doesn't currently offer healthcare benefits because the current minimum entry cost is too high	<ul style="list-style-type: none"> • Smaller Employer • Employer With Seasonal Workforce 	<ul style="list-style-type: none"> • Offer employees a Personal Health Account (employer-only) funded with \$100 per month to offset some of the costs associated with employees' routine healthcare needs (e.g., doctor's visits, prescriptions) or to help them purchase insurance. Allow employee to make contributions to a Sec. 125 account (See Example 7 in Section 3) 	<ul style="list-style-type: none"> • Offer employees other additional health plan choices through a healthcare supermarket (See Examples 4 and 5) • Add a contributory catastrophic plan
Currently offers a single health plan with a single vendor. Wants to manage cost and offer more choice but is concerned about administrative burden	<ul style="list-style-type: none"> • Smaller Employer • Medium Employer 	<ul style="list-style-type: none"> • Offer employees an insurer-sponsored or "private label" PDHB Multi-Plan Option. Add an FSA. Alternatively, consider joining a local purchasing cooperative offering a similar menu of health plan choices. (See Examples 2 and 3) 	<ul style="list-style-type: none"> • Offer internet-enabled Multi-Plan Option + PHA program with expanded plan and benefit level choices and, by using a healthcare supermarket, reduced employer administrative burden (See Example 5)
Currently offers a comprehensive, multi-option healthcare program with varying contributions and an FSA. Wants to promote employee empowerment while managing the company's cost and administrative burden	<ul style="list-style-type: none"> • Large Employer 	<ul style="list-style-type: none"> • Offer employees expanded plan and benefit level options through a third-party healthcare "supermarket" offering full administrative outsourcing coupled with a web-enabled health plan selection interface. Maintain FSA (See Example 4) 	<ul style="list-style-type: none"> • Establish a PHA (employer-only) with a portion or all of future increases to employer's core contribution. Allow employees to retain account post-employment. Add catastrophic or other innovative plan option. (See Examples 5 and 6)

- If one of the PDHB models, or a transition along the spectrum, makes sense, what would be the various target dates for such implementation, and what are realistic financial goals for each period?
- Is an optional or full replacement approach more consistent with the organizational culture?

Design Program Strategy and Explore Alternative Solutions

In this step, employers will want to understand the basic tenets of PDHB models and the specific components of each. Employers will also need to understand the various financial, administrative, human resources, regulatory and tax considerations of each model in order to identify feasible solutions. An additional consideration is to decide if a transitional strategy from existing to emerging or next generation programs is appropriate. Finally, an employer should also try to assess what employee or retiree reactions to this change would be and how PDHB fits with the organization's culture.

Another important step for employers seeking solutions outside their own company is to evaluate the various insurers or other organizations that offer products in the PDHB environment. There are many new entities, as well as existing companies, that have developed innovative PDHB solutions. Employers should consider evaluating these organizations and their approaches against their criteria, objectives for the program, and culture.

Specifically, employers should:

- Determine the relative importance to their organization of each of the key PDHB attributes, e.g., administrative simplification or degree of stewardship
- Determine whether to develop a home grown approach, contract with its current insurer, or engage another outside vendor offering an innovative approach
- Decide on plan design, including number of plan options, as well as scope and level of coverage. Consider whether to differentiate between different types of employee healthcare need, e.g., catastrophic, preventive, routine, in program design. Consider whether or not to require employees to purchase insurance

Perform Financial Modeling

Clearly, one of the critical components of any evaluation process, and particularly so in a PDHB models, is the short- and long-term financial consequence of various courses of action. Therefore, employers should:

- Develop baseline financials identifying current costs and projections, assuming no changes in benefits.
- Determine what level of core contribution the company will provide now and in the future under a PDHB model.
- Develop cost projections based on various PDHB plan designs that have been chosen and various enrollment scenarios.
- Consider the impact of the financial and actuarial issues, as described earlier in this document, including selection and risk adjustment. Make modifications as warranted to the program design.
- Evaluate, compare and contrast these cost projections to determine which PDHB approaches are most consistent with the company's financial and business objectives.

Evaluate Results and Select a Specific Approach

Selecting the appropriate PDHB approach from the alternatives identified should take into account the range of factors discussed above. The right choice for an organization - as in any benefit evaluation process - is the one that achieves the proper balance among:

- The most appropriate plan design
- The company's financial and human resource objectives
- Satisfactory employee access to healthcare
- Quality of healthcare
- Administrative requirements as an employer
- Legal, regulatory and taxability issues

Some employers may, based on the outcome of their evaluation, decide to develop Request For Proposals, (RFP) to evaluate and select a specific vendor.

Implement and Communicate the Program

Once a plan and, if appropriate, a vendor, is selected, employers can proceed with implementation, consisting of the following key steps:

- Identify an implementation team and develop an implementation timetable
- Finalize the program design and contractual arrangements
- Develop a comprehensive education and communication plan (see following discussion in “Critical Success Factors”)
- Formulate administrative policies and procedures
- Write Summary Plan Descriptions (SPDs)
- Modify systems, including interfaces with vendors and web-enabled components
- Conduct enrollment

Depending upon the PDHB model chosen and the complexity of the organization, these steps can range from reasonably simple to rather intricate. Of all the steps listed above, an effective communications and education program, as discussed below, is perhaps most critical.

Monitor the Performance of the Program

It is prudent to measure the performance and progress of any new program. With PDHB in particular, where certain objectives are very specific, monitoring may be especially critical. Moreover, if an employer has chosen a transitional approach to PDHB, it is important to evaluate interim results against goals as the company’s long-term strategy unfolds. Other steps included in this phase might include:

- Formulate performance guarantees with the selected vendor
- Gauge the extent to which the selected PDHB approach is meeting the objectives set for it at inception
- Evaluate the financial impact, including anti-selection, of employee enrollment selections
- Measure employee satisfaction with the program

Critical Success Factors

Employers seeking to implement successful PDHB approaches will have to navigate several important challenges effectively. These include:

- Employee education and communication
- Current and future contribution strategy, including dependent subsidies
- Funding approach, e.g., self insured or insured

In addition, if an employer decides to offer PDHB as a new retiree benefit, there are specific challenges to be considered for that group.

Employee Education and Communication

There are two important aspects of communicating a new PDHB plan to employees:

- Managing increased employee information needs; and
- Managing employee acceptance of PDHB

PDHB places an increasing burden on the challenging process of educating employees about their benefits and how they operate. In order to maintain or improve employee satisfaction, employers implementing PDHB will also need to consider the extent to which their employees are ready to take on new responsibilities. PDHB may present some potential employee relations challenges.

Not only will consumers have to make more decisions under PDHB approaches, but they may also have to make decisions that they have not made before. In addition to evaluating or designing healthcare plans, employees may also need to evaluate how much money to spend on insurance versus how much to save, or to make decisions regarding access to providers.

Employees may have to build their own networks of providers – selecting from a panel offering discounts or otherwise attractive financial terms. In such a situation, or in the case

where an employee is deciding how to spend a PHA, he or she will need to make the very types of cost and quality judgments from which they have been insulated in today's healthcare benefits programs.

Employees' information needs grow commensurately with additional decision-making responsibility. Even though many employees do not fully understand their current health plans, they will face a more complex decision-making process under PDHB. Education and communication efforts, e.g., enrollment meetings, brochures, websites, etc. must be more comprehensive and effective for PDHB programs to be understood by employees. Diverse employee populations only make this more challenging. Fortunately, advances in information technology, especially the Internet, have dramatically increased the potential effectiveness of education and communications initiatives.

Employees will also need information to help them accept PDHB approaches. Employers are concerned that employees may be uncomfortable with the added burden of more complex choices and may even feel that PDHB is a takeaway.²² Creating employee acceptance of PDHB, as opposed to just comprehension, will take careful consideration as well. Given the complexity and current lack of awareness surrounding PDHB, this may be one of employers' biggest challenges. As employers evaluate the level of healthcare benefit plan stewardship they wish to maintain, they will need to decide on their role in providing healthcare decision support to their employees. As with other administrative functions, employers vary as to the resources they apply, what they do internally and what they buy from outside.

Access to the Internet

The Internet will be a major source of decision support assistance made available to employees. The Internet promises to be a key to enabling more consumer choice with less administrative complexity. Decision support tools can be provided by the PDHB vendor or purchased stand-alone. The success of decision support depends on the content and transactional capabilities and whether consumers will use the tools.

Research has shown that healthcare sites are among the most frequently visited by consumers. However, consumers have, to-date, been reluctant to use the Internet to purchase insurance, and even more reluctant to purchase health insurance through the web.

Contribution Strategy

There are three aspects of contribution strategy that are important:

- Establishing the core contribution amount
- Establishing how future increases will be determined
- Dealing with explicit subsidies, e.g., dependent, geographic

Establishing The Core Contribution Amount

Setting a contribution strategy takes on additional levels of importance under PDHB. While employers pay attention to contribution strategy today, their plan design and delivery efforts focus predominantly on health plan quality, employee access, benefit levels and overall cost. Since PDHB does not require the employer to purchase a specific set of benefits for employees, it is important to establish a core contribution that supports the desired coverage level. This may require more in-depth analysis than is required today to ensure the company contribution will meet employee needs and company financial objectives. Moreover, it will depend on the company's philosophy and various objectives.

For instance, a typical strategy may be to provide a core contribution equal to 80% of the cost for the most efficient Point-of-Service (POS) product in a specific geographic area. Under this scenario, employees would have to pay the difference to purchase a plan option more expensive than POS. Likewise, choosing a less expensive option would potentially leave dollars for other programs the employer makes available, e.g., a Personal Health Account.

Not unlike the process used to design flexible benefits programs popular a decade ago, employers will have to figure out what combinations of choices they want employees to be able to make and set the core contribution accordingly. An additional layer of complexity - if a Personal Health Account is offered too - is determining the appropriate combination of funding between insurance coverage and self-directed dollars an employer wants to support.

Establishing How Future Increases Will Be Determined

It is also important for employers to establish, and, generally, to communicate to employees, the company's intentions for adjusting its core contribution in the future. Since the benefit is no longer a specific benefit plan under PDHB, but rather an amount of money to purchase benefits, an employer's plans for increasing its contribution over time will be particularly important to employees. Possible strategies include adjusting contributions based on average medical trends for the baseline option, i.e., POS in the example above, or another measure that adjusts for inflation.

Explicit Subsidies

Under PDHB, it likely will become necessary to establish different, explicit, contribution levels for employees with different coverage requirements related to their family status, or based on where they live. Today, the prices employees pay for healthcare benefits, i.e., employee contributions often mask the employer's underlying financial commitment to specific groups. Moreover, that these subsidies have been behind the scenes has likely squelched a lot of controversy that might have otherwise surfaced. Even though certain subsidies are very common practice today, for example, larger core contributions to employees with families, the PDHB methodology may be more likely to prompt some employees to regard these subsidies as inequitable. Employers will need to anticipate and respond to these employee perceptions by devising a coherent approach to the issue and communicating it effectively.

Funding Approach

PDHB raises new considerations for employers who currently self-insure their healthcare benefit programs. As mentioned previously, the principal reasons employers self-insure today include:

- the exemption afforded by ERISA from state insurance laws, premium taxes and benefit mandates
- better cash flow; and
- avoiding a portion of insurer's profit or risk charges

Despite these advantages, the self-insurance methodology may not be as compatible with certain PDHB models as are fully-insured arrangements. Though risks can be mitigated with reinsurance or other methods, some employers may wish to weigh the relative advantages and disadvantages of maintaining a self-insured approach that may be more difficult under certain PDHB models. As noted earlier, there are also components of certain PDHB models, i.e., Personal Health Accounts that may not easily fit into the fully-insured environment.

Implementing New Retiree Healthcare Benefit Programs

For employers that currently do not offer retiree healthcare benefits, it is worth noting again, that certain PDHB models using PHAs may offer employees a vehicle to save pre-retirement healthcare funds (either the employer's or the employee's contributions) to smooth their transition into Medicare. There is the potential to set aside less funding and to vary it from year to year. Such flexibility could be attractive to employers willing to contribute to retiree health benefits but unwilling or unable to assume the cost or FAS 106 liability associated with more comprehensive benefits.

Yet to be explored are opportunities to convert current retiree health benefits to menus and accounts established under PDHB. Such conversion might be appealing to both employers and retirees and assumes increased choice, reduced administration and retained tax advantages.

Certain existing retiree healthcare programs, such as those that have implemented a core contribution, are already a

form of PDHB; however, many employers may be unable to make changes to their retiree healthcare programs. Some current and future retirees have agreements that set forth specific benefits as a result of early retirement programs, collective bargaining agreements, or binding “promises” by the employer. For employers facing these circumstances, PDHB may not be a viable option in the short term, if ever, for their current retirees.

In implementing a PDHB program that includes retirees, most of the challenges employers will encounter are similar to those they would face today if they were to make any change. To some degree, these challenges may be more complex due to the number of potential options available. Some of the key factors include that:

- Retirees are usually geographically dispersed
- Some retirees reside in different locations depending on the season
- Education and communication of new and potentially complex choices may pose special challenges for older retirees

While some issues remain the same as highlighted above, other issues, like those outlined below, may benefit from new options that could be developed under the PDHB framework introduced in this Guide.

- **A majority of an employer’s retirees are Medicare-eligible and, thus, their benefits must coordinate with Medicare.** Moreover, retirees may have spouses or family members who are not Medicare-eligible. This raises questions about which are appropriate plan options to offer retirees. For instance, managed care plans - whose plan features typically include copays, as opposed to deductibles and coinsurance - typically coordinate poorly with Medicare. Moreover, families with both Medicare-eligible and non-Medicare eligible members may have different coverage needs. Allowing family members to make different plan selections is administratively more cumbersome and is thus, not common practice today. For PDHB plans, it is probable that more flexibility will be available and offer a better use of total funds available to couples

- **Some retirees are enrolled in Medicare HMOs.** Medicare + Choice enrollees introduce special issues. This is because the federal government is involved in the financial transaction between Medicare + Choice plans and beneficiaries (i.e., who may be retirees who enrolled through their employer). In addition, employers often make a contribution to supplement Medicare+Choice on behalf of their retirees who enroll. Under some PDHB approaches, retirees enrolled in a Medicare+Choice plan seeking to participate in the PDHB program may have to change to another plan option. However, in others, like the healthcare “supermarket” approach, Medicare+Choice plans may be an available option and could provide for a potentially seamless change for a retiree considering an employer’s PDHB program

- **Comprehensive prescription drug coverage is particularly important to seniors.** Retiree prescription drug expenses can be equal to over half or more of the total expenses covered by Medicare supplemental policies that include drug coverage. Some PDHB models will likely include “coverage” options that closely mirror today’s. Others, like the Personal Health Account, may offer new avenues for retirees to prepare for at least some of their likely prescription drug needs. Likewise, retirees have both risk and need for long term care protection that can be met by PHAs

In summary, PDHB may introduce particularly attractive concepts for retiree health benefits on behalf of:

- Employers struggling to fund and manage current promises
- Employers willing to contribute to retiree medical expenses but unwilling to assume comprehensive, unpredictable, and long-lasting obligations
- Retirees who could benefit from more flexibility and choice in their current retiree health benefit programs
- Employees who could choose to save a portion of their current employer contributions and their own pre-tax dollars toward future needs including bridge policies at early retirement, spousal coverage, Medigap, long term care and prescription drugs

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Conclusions

The confluence of various factors has brought us to an important crossroads in the healthcare debate. Escalating costs, multi-stakeholder dissatisfaction with managed care, the growing burden and liability associated with employer-offered health benefits, the growth in the uninsured and the erosion of retiree health benefits have intensified the search for new solutions to these and other well-known challenges in our healthcare system.

With “bottom-up” forces such as consumerism, and Internet innovation at work to fan the spark, now, more than ever, may be the time to explore and nurture promising alternatives like the patient-directed healthcare approaches discussed in this Guide.

Patient-directed healthcare approaches take many different forms, each with their own unique characteristics and advantages. Together, the patient-directed approaches presented in this Guide address some of the most problematic aspects of the current employment-sponsored system for employers, consumers, and providers alike. These include:

- Consumers’ generally low financial stake in the healthcare decisions they make
- Limitations on consumers’ choice in the selection and retention of their health plan, benefit design, or healthcare provider
- Lack of flexibility for consumers to choose between insurance and other savings vehicles to fund their current and future healthcare needs
- The considerable, and growing, responsibility employers assume to administer the health benefit programs they offer
- The problems associated with poor portability and continuity that beleaguer the uninsured and retiree populations in particular.

Employers seeking new avenues to provide affordable, accessible, and quality healthcare coverage to their employees should consider how integrating a consumer-directed approach could help them meet their health program objectives and increase employee satisfaction. Employers can design an approach that encompasses all or just some of the patient-directed elements discussed in this Guide depending on their philosophy, and can decide to phase-in changes over time.

Policymakers should take note that patient-directed approaches could play a vital policy role in helping assure quality, promoting cost-effectiveness and increasing coverage of the uninsured and retirees. Moreover, the concept of patient-directed healthcare is an attractive complement to the range of tax credit proposals perennially under consideration in Congress.

Because it effectively addresses the principal shortcomings in our current employment-sponsored system and is both suitable for different local markets and accommodating to a range of employer philosophies, patient-directed healthcare as it is discussed in this Guide, needs to be part of the overall prescription for healthcare reform. The concept of patient-directed healthcare is an incremental, market-based delivery approach that is consistent with our nation’s pluralistic value system and offers a compelling alternative to more drastic and invasive healthcare reform options. We hope that employers consider introducing the concepts discussed in this Guide in a way that suits their and their employees’ needs best. We furthermore hope that policymakers encourage this budding trend by helping to remove the legal and regulatory barriers that would stifle further innovation and employer interest.

End Notes

- 1 R. J. Mills, Health Insurance Coverage: 1999, (Washington: U.S. Census Bureau, September, 2000),
- 2 The NewsHour with Jim Lehrer, Kaiser Family Foundation, National Survey of the Uninsured (April, 2000)
- 3 PricewaterhouseCoopers LLP Defined-Contribution Healthcare Is It In Your Future? (November, 2000).
- 4 Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans
- 5 Towers Perrin 2001 Healthcare Cost Survey.
- 6 Employer Health Benefits 2000 Annual Survey, Kaiser Family Foundation and Health Research and Educational Trust
- 7 See, for example: Greg Scandlen, Patient-Directed Healthcare Health Insurance, Policy Backgrounder No 154, National Center for Policy Analysis (October 26, 2000), p. 2.
- 8 U.S. Census Bureau, Current Population Survey (March, 2000).
- 9 Harris Interactive, Strategic Health Perspectives 2000 Survey Report, (November, 2000). Employers with self-defined “defined contribution” plans projected 6.8% increases in employee contributions for 2001 compared to 6.6% increases for employers with “defined benefit” healthcare plans.
- 10 Pooling funding into single plans for multiple wage earners may also have the salutary effect of eliminating the need for costly and inefficient coordination of benefits (COB) administration.
- 11 LOMA Human Resource Department Management Report (November, 1997)
- 12 PricewaterhouseCoopers LLP, Healthcast 2010, November, 1999
- 13 PricewaterhouseCoopers LLP Defined-Contribution Healthcare Is It In Your Future? (November, 2000).
- 14 A New Direction for Employer-Based Health Benefits, KPMG, LLP, publication 99-12-05, November, 1999
- 15 Greg Scandlen, National Center for Policy Analysis, Policy Backgrounder No. 154, October 26, 2000.
- 16 While plan designs may have high deductibles and large amounts of other consumer cost-sharing, we assume in our examples, unless otherwise stated (e.g., in the High Deductible, that most plans today have relatively modest cost-sharing provisions that tend to insulate consumers from the true costs of healthcare goods and services.
- 17 Some employers, for example, fund one amount for “employee-only” enrollees and then perhaps an additional 50% of that amount for employees with spouses and an additional 25% of that amount for dependents. Clearly, these percentages vary considerably depending on employer preferences and objectives.
- 18 A second type of PHA in use today is the medical savings account (MSA). Authorized for small employers under HIPAA in 1996, MSAs are in many ways similar to FSAs, but must be offered in conjunction with a high deductible health plan and differ in regard to contribution limits, portability and several other features. MSAs are discussed more fully in the Appendix.

19 Voluntary employee reductions in pay, in exchange for employer contributions to premium (Premium Conversion Accounts), are widely used and achieve the end result of “pre-tax” employee contributions to premiums, but are not part of Sec. 125 FSAs. Sec. 125 Funds may not be used to pay for insurance premiums.

20 Since there is no tax deduction for deposits into the account, such accounts typically are not funded.

21 Hall, Mark A., Wicks, Elliot K., and Lawlor, Janice S., “HealthMarts, HIPCs, MEWAs, AND AHPs: A Guide For The Perplexed”; Health Affairs, Jan/Feb 2001.

22 PricewaterhouseCoopers LLP Defined-Contribution Healthcare Is it in Your Future? (November, 2000).

23 According to October 1999 figures from the IRS, 44,784 MSAs were established; the IRS did not update its figures for 2000. Insurance companies maintain that the number is higher. For example, Golden Rule Insurance Co. has indicated that it issued 46, 456 policies with a combined account total of \$39.3 million.

24 General Accounting Office, Health Insurance Regulation: Varying State Requirements Affect Cost of Insurance, GAO/HEHS-96-161 (August 1996).

Notes

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold (or provided) with the understanding that the publisher is not engaged in rendering legal, accounting or other professional service. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

– From a declaration of principles jointly adopted by a Committee of the American Bar Association and a Committee of publishers and associations.

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Appendices

Today's Tax and Regulatory Framework

Current Law

Federal and state laws have a substantial impact on healthcare benefits offered by employers. Among the federal laws governing the provision of healthcare benefits are the Internal Revenue Code (IRC), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Employee Retirement Income Security Act (ERISA). In addition, states have enacted myriad laws governing health insurance.

Federal Level Regulation

Provisions under the IRC govern the federal income tax treatment of funds used for health insurance, medical, and related expenses. These provisions affect employers and employees. ERISA imposes requirements on employer-sponsored health benefit plans, including reporting and disclosure requirements, fiduciary responsibilities, and administrative requirements. Employee health benefit plans must also meet coverage continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and portability, coverage, and related requirements under HIPAA.

Most of the preceding federal law provisions preempt or apply independently of state law. However, in some circumstances, entities may be subject to state, and/or federal law. For example, HIPAA includes provisions requiring health insurance issuers in small group and individual insurance markets to meet certain state guaranteed issue, guaranteed renewal, and related requirements. Additionally, Multiple Employer Welfare Arrangements (MEWAs) are subject to state law and in some cases may also be governed by ERISA.

Taxability and Deductibility

Overview

Current law includes substantial tax incentives for providing health benefits through an employer. Generally, employers are allowed to fully deduct their costs of providing healthcare and employees receive the healthcare coverage and benefits tax free. This is in contrast to today's tax rules that apply if the employer is not involved and the individual purchases healthcare coverage. In that situation, the individual is only able to deduct the cost of healthcare expenditures that exceed 7.5 percent of adjusted gross income. Healthcare reimbursement from individually paid health insurance is tax free.

Federal Tax Treatment of Health Insurance

	Employer - Purchased	Individually - Purchased
Premium Deductible to Purchaser?	Yes	Only if > 7.5% of Adjusted Gross Income*
Taxed as Income to Employee?	No	Not-Applicable
Insurance Payments Taxed as Income to Recipient?	No	No

**When combined with other healthcare expenditures*

Employers' tax deduction. Current law allows employers to deduct the cost it pays on behalf of employees' healthcare. Under IRC Section 162, an employer's contributions to a group health insurance plan are deductible as ordinary and necessary business expenses. When an employer makes contributions to a welfare benefit fund the contributions are deductible under IRC Section 419 which limits the amount of deductible contributions that can be made to accumulate reserves for future years. For active employee medical benefits, reserves are limited to the amount of claims incurred but unpaid as of the end of a taxable year. For retiree medical benefit costs, the permitted reserve is determined on an actuarial basis, without taking into account the anticipated costs of healthcare inflation, and funded over the working lives of covered employees.

Employees' tax exclusion. Current law allows employees to exclude from their gross income healthcare costs paid by their employer. Under IRC Section 106, contributions by an employer to pay for healthcare coverage are not considered part of an employee's taxable income, and, under IRC Section 105, benefits received by employees from employer-provided healthcare programs are tax-free.

It is a matter of interpretation, however, as to whether employer contributions to a Personal Health Account that may be used currently or accumulated for future use receive favorable tax treatment for employees. Some informal comments from the IRS indicate that such accumulations may be tax free when ultimately received as medical benefits under certain conditions. However, according to the IRS, the tax treatment is more questionable if the employee is given the choice to use the amounts in a subsequent year for some benefit other than health, such as life insurance or cash. In contrast, Congress has allowed medical savings accounts (MSAs) to provide for such flexibility, in that cash is a permissible alternative to health benefits. (Please see the discussion on MSAs below for more details).

Health benefits not financed by an employer. IRC Section 104 permits an individual to receive benefits tax free under a medical insurance policy if the individual, rather than an employer, has paid all the premiums. Individuals may deduct healthcare payments to the extent the payments exceed 7.5 percent of adjusted gross income. Self-employed

individuals may deduct 60 percent of their health insurance premiums from their taxable income in 2000 and 2001, 70 percent in 2002, and 100 percent in 2003 and thereafter.

Tax Deductibility of Health Insurance Premiums for the Self-Employed	
Year	% of Premiums Deductible
2000	60%
2001	60%
2002	70%
2003	100%
2004 and After	100%

Funding Vehicles

Tax law and tax policy exercised by the Internal Revenue Service have helped shape the methods for funding healthcare. Many employers purchase health insurance from carriers to cover their employees. Some employers self-insure healthcare coverage, and some of those employers fund the coverage through making contributions to a Voluntary Employees Beneficiary Association (VEBA) – which most often takes the form of a tax-exempt trust. An employer's tax deduction is limited to the cost of current coverage and a limited deduction for incurred but unreported or unpaid claims and for funding retiree health benefits. Other than these costs, an employer is unable to obtain a deduction for currently funding future benefits. For example, an employer could not currently deduct contributions made today for healthcare benefits not used until some future year. Also, VEBAs used for funding retiree medical benefits are subject to gross deductible limits and unrelated business income tax, thus reducing their tax efficiency.

Another funding mechanism used currently is what is known as a 401(h) account. A 401(h) account is a sub-account that is permitted to be part of a pension plan. The 401(h) account is used to pay for retiree medical expenses. Deductible employer contributions are limited to a percentage of contributions otherwise made to fund the pension plan. If

a pension plan has surplus assets, that is, assets that exceed its pension liabilities, it is permitted, under prescribed conditions, to transfer a portion of the surplus to the 401(h) account to be used for the current year’s retiree medical expenses.

A few employers have funded retiree medical benefits through a dual purpose profit sharing plan, that is, a profit sharing plan (which can include a 401(k) plan) with a sub-account dedicated to the accumulation of amounts to pay for retiree medical expenses. Questions regarding the taxation of these benefits have prevented widespread use of this vehicle, although some employers apparently are confident that properly structured retiree medical benefits paid from these dual purpose plans would be tax free.

Other vehicles for funding retiree health benefits include corporate owned life insurance, trust owned life insurance and trust owned health insurance.

Cafeteria Plans/Section 125

The term cafeteria plan is a generic term covering a number of arrangements that offer employees the ability to choose among two or more benefits. IRC Section 125 is the authority that allows the choice between taxable (usually cash) and nontaxable benefits to take place without triggering adverse tax consequences, e.g., taxation of otherwise nontaxable benefits just because the employee could have taken cash. Section 125 imposes a number of conditions in order to receive this favored tax treatment. For example, the nontaxable benefits are restricted to certain benefits such as healthcare, dependent care and group term life insurance. As a general rule, cafeteria plans are not permitted to offer deferred compensation. This prohibition extends to nonqualified deferred compensation arrangements, such as supplemental retirement benefits, as well as deferred welfare benefits, e.g., post-retirement medical or life insurance. There are two limited exceptions to the general prohibition. Cafeteria plans are allowed to offer a 401(k) plan, and educational institutions are allowed to offer post-retirement group term life insurance.

The terms cafeteria plan and section 125 plan are sometimes used interchangeably to describe several types of flexible benefit arrangements, including flexible spending accounts (FSAs). FSAs are accounts funded on a pretax basis through employee salary reductions; sometimes, employer contributions are also made to FSAs. Amounts deposited in these accounts are used to provide reimbursement for certain types of expenses, such as medical expenses incurred by the employee during the year. Under the Section 125 rules, any amounts unused at the end of the year must be forfeited. This forfeiture requirement, which is frequently referred to as the “use-it-or-lose-it” rule, keeps FSA amounts from being carried over to subsequent years.

Medical Savings Accounts

HIPAA amended the IRC to provide, on a pilot project basis, for favorable federal tax treatment of medical savings accounts (MSAs). The MSA pilot project that was due to expire on December 31, 2000 has been extended for two years.²³

A medical savings account is a trust or custodial account established to pay qualified medical expenses for eligible individuals in conjunction with a high deductible health plan. MSAs can only be sponsored by a small employer (50 or fewer employees) or held by a self-employed individual.

High Deductible Plans Used with MSAs

	Individual	Family
Permitted Deductible*	\$1,600 - \$2,400	\$3,000 - \$4,500
Maximum Out-of-Pocket Expenses*	\$3,200	\$5,850

**Adjusted annually for cost-of-living*

High deductible health plan: HIPAA, as amended, defines a high deductible health plan as a health plan with an annual deductible between \$1,600 and \$2,400 for individual coverage and between \$3,000 and \$4,500 for family coverage. Out-of-pocket expenses cannot exceed \$3,200 for individual coverage and \$5,850 for family coverage. The annual deductible amounts and out-of-pocket expense amounts are adjusted annually for cost of living.

Eligible employee/participant: An employee or self-employed individual is considered eligible if he or she is covered under a high deductible health plan and does not have other health coverage except for:

- accidents
- disability
- dental care
- vision care
- long-term care
- insurance for a specified disease or illness
- certain other forms of specific insurance

Contributions: The maximum annual contribution that can be made to an MSA is 65 percent of the deductible under the high-deductible plan for individual coverage or 75 percent of

Maximum Annual Contribution to MSA *	
Individual	\$1,040 - \$1,560
Family	\$2,250 - \$3,375

**65% of deductible for individuals;
75% of deductible for families;
Maximum deductibles adjusted annually for cost of living*
the deductible for family coverage. No other dollar limits or maximums apply.

Payments made to an MSA by a small employer are excludable from gross income unless made through a cafeteria plan. If an employer makes a contribution to an MSA, contributions by an individual account holder are not deductible.

Portability: MSAs are portable, that is, if a participant changes jobs, the MSA does not remain with the employer, rather, it stays with the employee. If the individual continues to pay premiums after leaving employment, the premiums are deductible subject to certain limits.

Distributions: Distributions from an MSA for the medical expenses of the employee or his or her spouse or dependents generally are excludable from income. However, in any year for which a contribution is made to an MSA, withdrawals are excludable from income only if the individual for whom the expenses are incurred is eligible to make an MSA contribution at the time the expenses are incurred. Distributions that are not for medical expenses may be included in income and are subject to an additional 15 percent tax unless made after age 65, death, or disability.

COBRA

COBRA generally requires employer group health plans to offer a temporary extension of health coverage (COBRA continuation coverage) to employees, spouses, and dependent children (qualified beneficiaries), at their own expense, in certain instances where their coverage under the plan would otherwise end. Qualified beneficiaries must be offered coverage:

- 1) for up to 18 months (29 months if the employee or a covered dependent becomes disabled within 60 days) due to an employee’s reduction in hours (other than leave under the Family and Medical Leave Act (FMLA)), termination (except for gross misconduct), or unequivocal notice of intent not to return following FMLA leave
- 2) for up to 36 months due to an employee’s death, divorce, legal separation, or application for Medicare coverage, or a dependent’s loss of dependency status; and
- 3) for a retiree’s life due to bankruptcy proceedings filed by his or her employer.

COBRA does not apply to small employers, companies with fewer than 20 employees and, generally does not apply to governmental plans and plans maintained by churches.

For COBRA purposes, a MEWA that is not collectively bargained constitutes a separate plan maintained by each separate employer. Such plans that are collectively bargained are generally treated as a single plan, unless it has multiple benefit options or funding arrangements.

Federal/State Regulation

In addition to the tax rules discussed above, certain areas of employee health benefits may be subject to federal and/or state law, depending on the circumstances. This issue most frequently arises in the context of HIPAA's portability provisions and group purchasing arrangements.

HIPAA

HIPAA amended ERISA, the IRC, and the Public Health Services Act (PHSA) concerning healthcare coverage offered by health insurance carriers and employer-sponsored group health plans. HIPAA also amended the PHSA concerning health insurance products offered in the individual and the small group markets.

Group coverage: For group health plans and health insurance issuers in small and large group markets, HIPAA:

- maximum preexisting condition exclusion periods
- requires the group health plan or issuer to give credit against the exclusion for prior creditable coverage
- prohibits discrimination based on health status; and
- requires guaranteed renewability, subject to certain exceptions.

State laws regulating issuers of group health insurance generally are not preempted except to the extent that any state standard or requirement prevents the application of HIPAA's requirements. However, for state laws affecting preexisting condition limitations, HIPAA does not supersede (subject to certain exceptions) any provision of State law governing issuers which establishes a standard or requirement applicable to a preexisting condition as defined in HIPAA and which differs from the standards or requirements for HIPAA's preexisting condition requirements.

Small group (2-50 employees) requirements include:

- guaranteed access
- guaranteed renewal
- portability
- limitations on preexisting condition exclusions; and
- a prohibition on discrimination based on health status.

Individual coverage: In the absence of acceptable state reforms, HIPAA imposes minimum federal requirements. These include a requirement that health insurance issuers participating in the individual insurance market offer a choice of at least two insurance policies without any preexisting condition exclusions to qualified individuals as defined in HIPAA. Issuers must guarantee the renewal of an individual policy at the option of the individual, subject to certain exceptions.

HIPAA generally does not impose any rating restrictions on group or individual health insurance policies.

Group Purchasing Arrangements

In an effort to obtain more affordable health coverage for small employers, several types of group purchasing arrangements have been organized. These arrangements can be divided into three broad categories: state-sponsored health insurance purchasing cooperatives, MEWAs, and multi-employer plans (plans sponsored by a joint board of union and management representatives, also known as Taft-Hartley plans).

State-sponsored purchasing cooperatives: Since the early 1990s, many states have begun sponsoring Health Insurance Purchasing Cooperatives, sometimes referred to as HIPCs. These alliances usually offer plans, which often include a variety of types such as managed care options, to qualifying employers whose employees are then able to enroll in plans of their choice. HIPCs are generally subject to state insurance regulations such as:

- premium taxes,
- premium rating restrictions
- benefit mandates

Purchasing alliances in California, Florida, and Texas must offer a uniform benefit package and must guarantee coverage to any qualifying employer.

MEWAs: A MEWA is broadly defined under ERISA to include an arrangement established to provide medical or other welfare benefits to the employees of two or more employers. MEWAs may or may not be subject to the provisions of ERISA, e.g., reporting, disclosure and fiduciary rules, depending on a variety of factors, including the degree of employer involvement.

MEWAs are also subject to state laws, but the degree depends on whether the MEWA is fully insured or not. If fully insured, the MEWA is subject to state laws regulating insurance, e.g., reserve and contribution requirements. If not fully insured, state laws apply if not inconsistent with ERISA. The level of state regulation varies significantly.

Each of the states researched for this report has rules specific to MEWAs and limits the type of trade, industry, or professional associations that may sponsor a MEWA. Four states' treatment of MEWAs are shown below as examples

California: California requires that any MEWA that is not fully insured be treated as an insurer and meet licensing requirements, financial standards, e.g., reserves, and standards of conduct, e.g., unfair trade practices, as insurers. MEWAs eligible to conduct business in the state must meet other requirements as well, such as being nonprofit and providing notice that it is not protected by the state's guaranty fund.

Florida: MEWAs in Florida must get a certificate of authority from the insurance commissioner, file annual actuarial statements, and meet solvency requirements. As in California, MEWAs must meet additional rules, such as being nonprofit and certain notice and disclosure requirements.

Illinois: In Illinois, MEWAs must be fully insured (self-funded MEWAs are treated as unauthorized, illegal insurers) and are subject to small group market rating requirements.

Minnesota: MEWAs operating in Minnesota are subject to Minnesota's small group market requirements, e.g., rating, mandated benefits, and are subject to reserve requirements, must file financial statements and meet other insurance requirements.

State Regulation

Under the McCarran-Ferguson Act of 1945, states have the authority to regulate and tax the business of insurance, and, as indicated above, myriad state insurance laws have been enacted pursuant to this power. Some state laws address the content of health insurance coverage, e.g., mandated benefits, MSA rules and others focus on the conditions under which health insurance may or must be offered, e.g., guaranteed issue, guaranteed renewal. Still others target the price or cost of health insurance e.g., premium rating restrictions, or address the business operations of an insurance company, e.g., reserve requirements, rate filing requirements, premium taxes. The following charts present a snapshot of significant health insurance laws in seven states: California, Florida, Illinois, Minnesota, Pennsylvania, New York, and Texas.

Mandated Benefits, Providers and Administrative Services

All states mandate the inclusion of certain benefits and certain types of providers, e.g., chiropractors and podiatrists, in health insurance policies. The General Accounting Office reported in 1996 that on average, states have enacted laws mandating about 18 specific benefits.²⁴ The most common benefit mandates are for preventive services, such as mammograms and well child care, or for treatment of mental illness or substance abuse.

Coverage for mammograms is mandated by all seven states researched, and each of the states but Illinois requires coverage for well child care. All seven states require offering or providing coverage for mental illness treatment and substance abuse services.

Small Group Market Requirements

Most states have enacted small group market reform laws that impose a range of premium, benefit design, and related requirements on any health insurance coverage offered to small employers. Most states require insurers to offer all plans to all employers in the small group market and to guarantee that such coverage will be renewed at the option of the small employer. Most states also regulate the manner in which small group premiums may be set, such as by

limiting the factors that may be considered in setting premiums, i.e., community rating or modified community rating, or restricting the degree to which premium rates may vary among small groups. An example of the latter is in Texas, where premium rates charged to similar small employers may not vary from an index rate by more than 25%, and the index rate for any class of business may not exceed the index rate for any other class by more than 20%. One unintended consequence of these reforms has been the departure of many insurers from the small group market.

Premium Taxes

State premium taxes for health insurers across the country vary from 1% to 4%, though most states have premium tax rates of about 2%. Health insurance policies in California are subject to a 2.35% premium tax, and in Minnesota they are subject to a premium tax of 2%.

Preemption of State Laws

ERISA allows employers to escape state premium taxes and regulation and mandated benefits if their health benefits programs are self-insured. Larger employers typically self-insure their health plans, but self-insuring is generally not an option for small employers. They lack a sufficient number of potential enrollees over which to spread the financial risks of their employees' healthcare costs. Employers that have chosen to self-insure typically purchase stop loss insurance to protect themselves from catastrophic losses. States seek to regulate stop loss insurance as well. Florida includes stop loss insurance in its definition of health insurance, and New York prohibits insurers from selling stop loss insurance to small groups. In states that do not regulate stop loss insurance, a self-insured employer is not protected from cancellation or steep premium hikes.