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CONSUMER-DRIVEN HEALTH CARE ARRANGEMENTS GET A BIG BOOST FROM MEDICARE REFORM LEGISLATION

Consumer-driven health care: What is it? And why is it suddenly such a hot topic in employee health care arrangements?

Let's start with some short, simple answers to those questions and then use the rest of the article to lengthen and complicate those answers.

What is consumer-driven health care? The term *consumer-driven health care* has no single meaning, but generally refers to high-deductible health insurance coupled with a health care reimbursement or spending account. The employee can use the health care account to pay for medical expenses not otherwise paid for by the high-deductible insurance policy.

Why is consumer-driven health care all of a sudden such a hot topic? There are two reasons. First, with health care costs—and the employer's share of them—continuing to spiral sharply upwards, consumer-driven health care arrangements offer a mechanism that might constrain employee medical spending, limit employer costs, and improve the quality of health care, all at the same time. (Well, it could happen.)

Second, the Medicare overhaul legislation that Congress enacted last fall includes a provision allowing employers that sponsor high-deductible health insurance to offer their employees substantial new tax benefits in the form of tax-free Health Savings Accounts ("HSA"). (We will see that before this legislation, the health spending accounts were generally notional, unfunded accounts; in contrast, the HSA is a funded account, similar to an IRA, except that withdrawals are not taxed when used for medical care.)

Those are the nutshell answers. Now for the rest of the story.

OUR MERGER

On January 1, 2003, Adams and Reese LLP and Lange, Simpson, Robinson & Somerville LLP merged, creating the largest law firm in Alabama, Louisiana and Mississippi. With a total number of attorneys approaching 300, the firm has offices in Birmingham, Baton Rouge, Jackson, Houston, Mobile, New Orleans and Washington DC.

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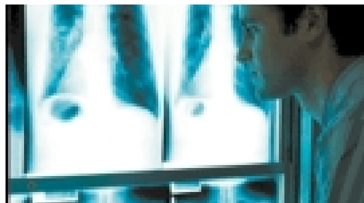
I. A Brief History of Employer-Provided Health Care

For more than half a century, this nation has provided most non-elderly health care through employer-provided health insurance. The reasons for this are, to some extent, historical serendipity; for example, wage controls in the 1940s made non-wage compensation, including employer-provided health care, attractive in both union and non-union settings. But to a larger extent, the nation's dependence on employer-provided health plans has been driven by the Internal Revenue Code's privileged treatment of such arrangements. Under the Internal Revenue Code, neither employer-paid premiums into health care plans nor medical reimbursement payments from those plans constitute taxable income to employees.

From the 1950s through the 1980s, the predominant way for an employer to provide health coverage for employees was a traditional fee-for-service arrangement (generally provided by an insurance company). As is often pointed out, the problem with this arrangement is that the employee is the consumer of medical services but not the payor and thus has little incentive to be a careful cost-and-quality-conscious consumer. Such arrangements pushed medical costs up and up, year after year. What made matters worse, people who studied health care argued, was that much of this spending was for marginally useful medical services that did little to improve the overall quality of health.



In the consumer-driven health care model, the employee receives a high-deductible insurance policy but also receives an unfunded account from which he can pay for medical services not covered by the insurance policy.

In the 1990s, both the White House and the private sector proposed solutions to these problems. The White House solution was a system of universal health care, with the government acting as the ultimate consumer of medical care for the nation (deciding how much to spend and which medical services to buy). And the private sector pushed managed care, where insurance companies became the ultimate consumer (deciding how much to spend and which medical services to buy). The White House solution failed in the forum of public debate, and the managed care solution left employees angry at denied care and ultimately failed to stem the rising tide of medical costs.

II. Consumer-Driven Health Care, Beyond the Nutshell

Into the breach stepped a new idea: consumer-driven health care, which is designed to make the employee a more frugal and medically savvy consumer of health care. The idea is simple: make the employee spend (or at least feel as if she's spending) her own money for medical care—or to put it another way, provide the employee economic incentives to shop wisely for medical care. And then give the employee the tools to shop wisely.

How do we provide financial incentives to employees to be intelligent consumers of medical services?

There are numerous strategies.

One such strategy is the use of co-pays, an approach used by most fee-for-service plans. But the problem with co-pays is that while they may discourage some consumption of services at the margin, they do not encourage comparison shopping among competing providers or among treatment options.

Another strategy is to offer employees only catastrophic, i.e., high deductible, health insurance and let them spend their own money on health care up to the deductible amount. But this approach has some problems. First, the employee generally cannot deduct his own expenditures for tax purposes (unless they exceed 7.5% of his income). Second, and more troubling, some employees would put off necessary medical care if they had to pay for such care from their savings rather than with funds specifically earmarked for medical care.

Consumer-driven health care improves upon this approach. The employee receives a high-deductible insurance policy but also receives an unfunded account (the "medical reimbursement account") from which he can pay for medical services not covered by the insurance policy. (The IRS gave such accounts a tax green light: The IRS ruled that such accounts would not constitute taxable income to the employee.) And since expenditures from such accounts are limited to purchases of health care, employees should be willing to seek necessary medical care.

(The Medicare overhaul legislation will generally allow the accounts to be funded. This will be discussed later in this article).

Consumer-driven health care arrangements have spawned a plethora of design variations. But most arrangements credit the employee's account each year with less than the deductible on the insurance. (If the account credit equals the deductible, the plan becomes, in essence, a fee-for-service plan, with first-dollar coverage and little incentive to check overconsumption.) For example, an employer might provide a $1,000 medical account and an insurance policy with a $1,500 deductible. The employee's first $1,000 of expenses would be paid for out of the account; the employee would pay the next $500 in expenses (this is sometimes referred to as the deductible gap); and the insurance policy would pay any additional expenses.

Some consumer-driven health care arrangements allow some or all of any unused account balance to carry over to future years until the employment bond is severed. (Plans without such features can encourage a spend-it-or-lose-it frenzy at year's end.) A few plans go further, and specify circumstances under which former and retired employees can continue to use the account to pay medical benefits. Some consumer-driven arrangements allow the account to pay for any medical services, while others limit expenditures to certain covered services (generally the same services that would be covered by the insurance policy once deductible limits are reached). Some consumer-driven arrangements provide payment for some preventive care, such as an annual checkup.

But all consumer-driven arrangements have one thing in common: creating incentives for the employee to be a prudent and intelligent consumer of health care.

Where do employees get the tools to make intelligent health care decisions?

Neither fee-for-service nor managed-care health care arrangements equipped employees to be wise consumers of health care. Doctors made health care purchase decisions in fee-for-service plans and insurance companies in managed-care plans. Employees must be given new tools to allow them to become astute health care consumers.

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The most important tool is almost certainly good information, about cost, about quality, and about alternative treatments. The major sellers of consumer-driven health care arrangements are seeking to make such information available to participants, often on line. In addition, some consumer-driven health care arrangements make health care coaches available to employees.

Are there any problems with the consumer-driven health care model?

The consumer-driven health care arrangement is certainly not without issues.

Here are some of the major concerns:

1) Most of the costs of fee-for-service and managed-care programs are generated by a relatively small group of employees (it is estimated that in any given year, 20% of the participants in a health care plans will generate about 80% of the costs). Some critics of consumer-driven health care plans have argued that such plans—by providing all employees with health care account balances—may end up encouraging health care consumption by employees who were only modest consumers under fee-for-service and managed care arrangements, thus increasing rather than reducing costs. Similarly, some have argued that such accounts will shift health care resources to healthier individuals and increase annual costs for individuals with chronic conditions.

2) If employers offer consumer-driven health care plans as an option to fee-for-service or managed care plans, healthier employees will choose the consumer-driven plan, leaving the other plans to cover the employees with more expensive health care issues. This will push up the cost of the other plans.

3) As noted, participants in consumer-driven health care arrangements must have access to good information on the quality and cost of health care. At present, such information is not readily available, although

there are several promising projects underway that will increase the amount of available information. Moreover, some employees may not have the experience, background, and time to make good consumer choices among competing health care options.

4) Employees often resist being forced into a new type of health care program, potentially creating morale problems.

5) It is not entirely clear how COBRA applies to the health account portion of a consumer-driven health care arrangement.

Do consumer-driven health care arrangements save costs?

The experience to date, although a bit sketchy, suggests that such plans can hold down health care costs. Last year, for example, costs for employer-sponsored health care costs increased by about 15%, but employers adopting consumer-driven health care arrangements saw their costs rise by only about 5%.

Some have been skeptical about whether such savings are the result of the consumer-driven model. It is possible that most of the savings came from the substitution of generic for brand-name drugs, a result that can be effected in traditional fee-for-service and managed care plans through adoption of high co-pays for brand-name prescriptions when a generic is available. It is also possible that some of the savings comes from self-selection, i.e., healthier (and less expensive) employees selecting a consumer-driven health care arrangement when the employer provides employees with a choice of such an arrangement and a traditional fee-for-service and/or managed care plan.

III. The Medicare Bill and the Health Savings Account: New Spur for Consumer-Driven Health Care

Last fall Congress enacted and the President signed into law the Medicare Prescription Drug Improvement and Modernization Act of 2003. One of the provisions in that legislation amended the Internal Revenue Code to create Health Savings Accounts. An HSA, which looks like a special-purpose, super IRA, is available to individuals who are covered by a high-deductible insurance policy (a policy that has an annual deductible of at least $1,000 for individual or $2,000 for family coverage, and deductibles no larger than $5,000 and $10,000, respectively) and who do not have other types of health care coverage.

An individual, or an employer, can make annual contributions to an HSA up to the amount of the deductible (but no more than $2,600 if the policy covers only an individual, or $5,150 if the policy covers a family). Individuals between age 55 and 64 can make additional annual contributions up to $500. The account's assets can be invested in mutual funds or other assets.

Health Savings Account tax benefits are substantial and we believe many employers will consider replacing their current health care plans with a high-deductible insurance policy and HSA.

Distributions from the account are tax-free if used for qualifying medical expenses. Other distributions are subject to income tax and, if made prior to age 65 for reasons other than death or disability, to a 10% excise tax. An expense is a qualified medical expense if it is paid for medical care (as defined in Section 213(d) of the Internal Revenue Code), or is used to pay for COBRA coverage, long-term care insurance premiums, or health insurance at any time an individual is receiving unemployment benefits. Individuals who have attained age 65 may also direct their HSA to pay Medicare Part A or B premiums, or Medicare HMO coverage, or for employer-sponsored retiree coverage.

In short, the HSA tax benefits are substantial. Indeed, they are sufficiently attractive that we believe many employers will consider replacing their current health care plans with a high-deductible insurance policy and HSA. We also believe that for some firms, the requirements for establishing an HSA under the Medicare bill will play a substantial role in the design of many (but not all) future consumer-driven health care arrangements.

Next month's newsletter will explore the HSAs and the requirements for establishing them in greater depth. In that article, we will compare the benefits and drawbacks of an HSA/high-deductible insurance arrangement with those of other forms of consumer-driven health care plans.

TIPS AND TIDBITS

Increased Section 415 and Elective Deferral Limits for 2004

Due to cost of living adjustments, the maximum allocation to a defined contribution plan for 2004 jumps from $40,000 to $41,000 and the maximum retirement benefit from a defined benefit plan from $160,000 to $165,000.

In addition, under EGTRRA, the 2001 law that increased limits generally, the maximum elective deferral to a section 401(k) plan is increased from $12,000 to $13,000.

Some other important limits have also increased: catch-up contributions to 401(k) plans for 2004 will be $3,000 (a $1,000 increase from 2003) and plans will be permitted to consider up to $205,000 in compensation (a $5,000 increase from 2003).

Increase in Social Security Taxable Wage Base

The IRS announced that the Social Security taxable wage base for 2004 will be $87,900 (up from $87,400 in 2003).

The IRS Giveth, the IRS Taketh, the Congress Restoreth: Medicare Bill Cures Problem for Flexible Spending Account Debit Card Payments to Health Care Providers

In May, the IRS ruled that medical flexible spending accounts could allow employees to pay for eligible medical expenses with a special debit card, thus offering employees convenience and reducing paperwork for the employer. The same revenue ruling that permitted an FSA to issue debit cards, however, erected a practical roadblock to their doing so: the revenue ruling indicated that employers who sponsor FSAs would have to report payments (in excess of $600 per year) on Form 1099s to medical providers paid by the FSA through debit cards. For many employers, this requirement would create more problems than the debit card would solve.

In November, however, Congress delivered an early Christmas present: a provision (included in the massive Medicare legislation) that relieves employers from having to file 1099s for FSA payments to medical providers.

Cash Balance Plan Woes Continue

First a district court in Illinois rules that most cash balance plans violate age discrimination rules. Then a Seventh Circuit panel holds that cash balance plans sometimes have to pay separated employees more than their account balances. (That case recently settled.) And now Congress includes in an appropriation bill a provision prohibiting the Department of Treasury from finalizing proposed regulations that were generally regarded as supportive of cash balance plans. What does this mean for employers? It at least means that employers who are considering adopting a cash balance plan should consider waiting until the legal situation surrounding such plans is clarified.

Do Your PBGC Recordkeeping On-Line

The PBGC will introduce on-line recordkeeping beginning on February 3. Plan sponsors using this service will be able to file and pay premiums, file plan terminations, and other tasks on line.

NEW GUIDANCE AND LEGISLATION

Department of Treasury Issues "Relative Value" Regulations for Comparing Optional Forms of Benefits in Pension Plans

The Internal Revenue Code provides that the default form of benefit under a pension plan must be a qualified joint-and-survivor annuity for a married participant and a life annuity for an unmarried participant. Pension plans may, and generally do, offer optional forms of benefits, such as a lump sum payment or an annuity other than the default form of benefit. If a plan offers optional forms of benefits, it must provide a participant with a notice that describes the "effect" of selecting an optional form of benefit. Regulations have long provided that the notice must disclose the relative value of the available forms of benefits.

Until last year, the Regulations did not specify a method for comparing the values of the benefit forms and plans used various approaches, including simply stating the monthly amount of an annuity option and the dollar value of a lump sum. A participant generally could not use such figures to make meaningful comparisons between benefit options without complicated calculations, often requiring the services of an actuary.

In October 2002 the Department of Treasury proposed, and in December 2003 adopted, regulations prescribing methodologies for comparing the relative value of different forms of benefits. In general, the final regulations require that the value of each optional form of benefit be compared to the value of the default form of benefit (i.e., the qualified joint and survivor annuity). The new regulations also restated and consolidated other rules related to participant elections of benefit options under a pension plan.

The new Regulations apply to distributions that have annuity starting dates on or after October 1, 2004, and to qualified pre-retirement survivor annuity explanations provided on or after July 1, 2004.

Department of Labor Issues Q & As on Small Plan Audit Waiver Regulation

The Department of Labor's website now includes, in question and answer format, information on the audit waiver for certain small pension plans. The address for the Q & As is http:/www.dol.gov/ebsa/faws/faq_auditwaiver.html.

Congress Clarifies Interest Rules on Plan Loans for Members of Uniformed Services

The Soldiers' and Sailors' Civil Relief Act of 1940 has long provided for interest-rate relief for members of the uniformed services on active duty on pre-service loans. How the Act applied to interest on loans from retirement plans was never entirely clear. Late last year, however, Congress enacted the Service Members Civil Relief Act, which amended the earlier provisions and in doing so clarified how it applied to loans from retirement plans. Plans that permit loans should review the Act and how it will affect plan administration.

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We will try to address your question or topic in a future newsletter.

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