



Consumer-Driven Healthcare

As employers continue to face increasing health insurance premiums, many are looking for a solution to bring costs under control. Consumer-driven plans, in theory, appear to offer some relief. There has been a lot of media attention and hype surrounding these plans, but the reality is that not a significant number of organizations have enrolled yet.

We are closely watching the industry to see what happens and will share the findings with you. In the meantime, you may be interested in an overview of consumer-driven plans.

What exactly is a consumer-driven plan?

The premise is that if consumers have a financial stake in the way their healthcare dollars are spent, they will make more economical decisions. While there are a few different models that exist, we will cover the most prevalent plan design currently available.

In this plan, individuals have access to an account, usually funded by the employer, to pay for day-to-day medical expenses. A high-deductible insurance plan is also in place to take over in the event the account is exhausted.

So two things are happening simultaneously when a person incurs medical expenses: (a) services are being paid for by the funds in the account and (b) claims for these same services are submitted to the insurance plan and applied toward the deductible.

You may be wondering why individuals would have an incentive to spend wisely. Well, the funds in the account only cover part of the deductible, usually about half. The individual has to pay for the other half before the insurance plan will start paying for claims. There are two ways a person can avoid covering the deductible out of personal funds:

- (1) If possible, try to use the funds from the account to cover all medical expenses in a given year. Examples of some prudent spending decisions include substituting generic for brand name prescriptions and eliminating discretionary medical services.
- (2) Unspent funds can be carried over from year to year, so it is possible to accumulate enough in the account to cover 100% of the deductible in the future. Individuals are therefore encouraged to save now in order to cover the cost of more serious, medically necessary services that they may need later.

In addition to paying for the deductible, the funds in the account can be used to pay for other medical expenses not covered by the insurance plan. For instance, individuals can pay for dental and vision care services from the account.

What are the main features of a consumer-driven health plan?

There are two components to the plan: (1) an account (HSA) or arrangement (HRA) and (2) a high-deductible health insurance plan. Outlined below are the major

differences between HSAs and HRAs.

HSA (Health Savings Account)

Who funds account:	Employer and/or employee
Who owns account:	Employee
Limit on contribution:	100% of deductible or \$2600 individual/\$5150 family, lesser of
Eligible expenses:	Medical expenses as defined by the IRS, insurance premiums in certain situations.
Non-medical expenses:	Subject to income taxes and 10% penalty. Employee contributions are can be made with pre-tax dollars through a Section 125 plan. Employers also get a deduction for contributions. Reimbursements to employees are tax-free.
Tax treatment:	
Health Insurance Plan:	Must be offered with a high-deductible plan (minimum of \$1000 individual/ \$2000 family)
Important Note:	Prescription drug coverage must be subject to the deductible.

HRA (Health Reimbursement Arrangement)

Who funds account:	Employer only
Who owns account:	Employer
Limit on contribution:	None
Eligible expenses:	Medical expenses as defined by the IRS, insurance premiums in certain situations.
Non-medical expenses:	Not eligible
Tax treatment:	Cannot be set up under a Section 125 plan, so contributions are not deductible for employer. Reimbursements are tax-free for employees.
Health Insurance Plan:	Can be offered in conjunction with any or no health plan.

How are consumer-driven plans administered?

There are a couple of different ways to set up these plans. First, an employer can set up a contract with TPA (third party administrator) for the HSA or HRA portion. The employer would pay administrative fees in addition to funding the accounts. A separate contract would also be set up with an insurance company, and the employer would be billed a monthly premium for the high-deductible plan.

Second, an employer can simply sign a contract with an insurance company that packages the account and insurance plan together. The employer would receive a bill with a monthly premium. This premium factors together the administrative fees, account funds, and insurance cost.

How much less is a consumer-driven plan compared to a regular health insurance plan?

This is a difficult question to answer given the limited data available. A recent study has shown positive results with employees selecting cost-effective healthcare and eliminating some discretionary services. If this trend continues, we are hopeful that the rates for these plans will increase at a slower pace. In the meantime, some insurance companies have begun to price their consumer-driven products more competitively, offering some

savings compared to other health care plans.

What's next?

It will be interesting to monitor the success rate of these plans over the next few years. We are keeping a close eye on the latest developments and will keep you posted as industry data is reported. In the meantime, you may want to view a quote at your next renewal to see if your company can save money. Your RSI Benefit Consultant will be talking to you about these plans and can help you determine whether or not your organization is ready for consumer-driven healthcare

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