Employee Benefits Report

Millennium ADMINISTRATORS

900 Ashbourne Way • Suite B • Schwenksville, PA 19473
sales@millennium-tpa.com • 610-222-9400 • fax: 610-222-9448 • www.millennium-tpa.com

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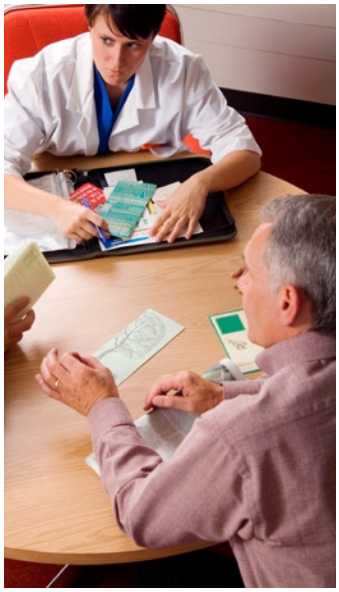
CDHP Scorecard: Few Takers, Unfulfilled Potential

When first introduced a few years ago, consumer-driven health plans (CDHPs) promised to empower consumers by letting them design their own health plans with a range of options at every stage of treatment and prevention.



Slow start for CDHPs

Add in a number of tax advantages and you'd think everyone would be flocking to CDHPs, but a survey recently released by the Employee Benefits Research Institute (EBRI) found that only 3 percent of the U.S. adult privately insured population were enrolled in CDHPs in 2008. This represents an increase from 2.5 million people in 2007 to 4.2 million in 2008. An additional 11 percent, or 13.4 million adults, had a health plan with a deductible high enough to make them eligible for a health savings account, or HSA. Of these individuals, 5.6 million said that they were eligible for an HSA but did not have such an account.

What Is a CDHP?

A consumer-driven health plan is structured to give consumers more direct control over — and direct exposure to — their ordinary medical expenses. These plans typically combine a fund from which consumers pay their routine medical expenses with a high-deductible health plan (HDHP) that protects them from catastrophic medical costs. The fund can be a Health Savings Account (HSA), health reimbursement arrangement (HRA) or flexible spending account (FSA). An individual can set up an HSA on his/her own behalf, but the only way you can participate in an HRA or FSA is if your employer sponsors one.

Elusive savings?

Another survey by Milliman Inc. found that CDHPs do not produce the dramatic savings over more traditional plans that you might expect. A recent Milliman analysis of employer programs that offer employees a choice of CDHPs or non-CDHPs shows that when offered as a new choice, CDHPs deliver a modest 1.5 percent in savings over non-CDHPs, based on typical risk- and benefit-adjusted factors.

"This is not surprising, because the information for health consumers to be more savvy buyers is not readily available," said Bruce Pyenson, principal and consulting actuary, Milli-

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January 16, 2010 is the deadline for all employers covered by the Family and Medical Leave Act (FMLA) to post the new "General Notice" in a conspicuous place with all other required postings. Further, if their employee handbook refers to the FMLA policy it must also be amended or corrected to reflect the new final regulations. The revised poster is available from the Department of Labor Web site (www.dol.gov/esa/whd/fmla/finalrule/FMLAPoster.pdf.) Does the FMLA apply to your company? Does the employee in question qualify for FMLA leave? The Department of Labor has compliance information posted at www.dol.gov/esa/whd/regs/compliance/1421.htm, or contact us for information.

The Internal Revenue Service has released the 2009 version of Publication 15-B, the *Employer's Tax Guide to Fringe Benefits*. It contains information for employers on the employment tax treatment (FICA and FUTA) of various fringe benefits, including accident and health coverage, dependent care assistance, group-term life insurance, moving expense reimbursements, Health Savings Accounts (HSAs), and transportation benefits. For more see www.irs.gov/pub/irs-pdf/p15b.pdf.

Can Telemedicine Rescue the Healthcare Industry?

Don't be surprised if one day soon you meet your healthcare provider via a teleconferencing call or a specialist monitors your vital signs in real time from hundreds of miles away. Telemedicine, or telehealth, uses electronic information and telecommunications to provide long-distance clinical healthcare, patient and professional health-related education, and public and private health administration.

This much is clear: Telemedicine can help improve the quality of care and clinical outcomes, all while reducing costs. Telemedicine can also increase the speed of a diagnosis where improved outcomes depend on rapid diagnosis, as in the management of acute strokes. In addition, telemedicine technologies deployed in ambulances can help speed diagnosis and the initiation of important, potentially lifesaving interventions.

Other benefits:

- Reduction in hospital admissions from emergency departments
- Reduced wait times for outpatient consultation
- Increased productivity of health care staff
- Reduction in patient travel time and expenses

From a cost perspective, telemedicine has the potential to shave $4.28 billion (see sidebar) annually from America's healthcare bill, according to a study by the University of Texas Medical Branch.

So why, then, aren't we seeing providers racing to deploy telemedicine technologies?

Despite positive clinical and economic findings, a number of barriers are preventing full adoption. The major obstacle, according to a report by the U.S. Commerce Department's Office of Technology Policy, is that telemedicine doesn't easily fit into the economic model in which third-party payors (private insurers or government programs) pay for most healthcare treatments, rather than the patient.

While individuals may have little difficulty recognizing a telemedicine intervention as cost-effective, a third-party payor usually reimburses on the basis of pre-set rules that don't take into account the cost and cost savings of telemedicine. Current insurance reimbursement policies tend to favor traditional medicine, including face-to-face consultations, and may not adequately compensate providers for telemedicine services.

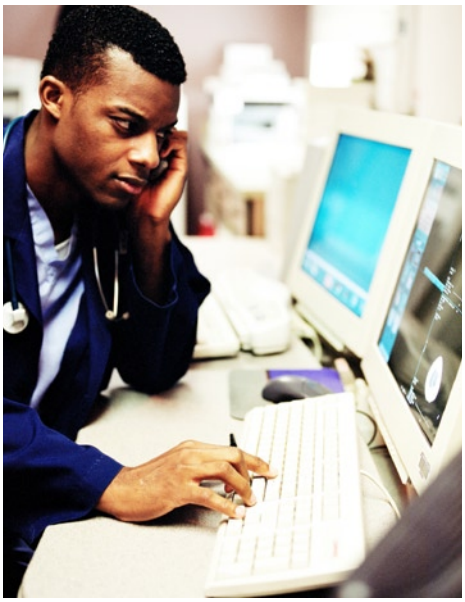
Additionally, providers must bear the cost of required infrastructure investments, which can be substantial.

Full integration of telemedicine into the U.S. healthcare system will depend on the industry's ability to address certain key barriers, especially insurance reimbursement models; concerns about liability in cases involving telemedicine interventions; and licensure rules that prevent healthcare providers from offering telemedicine consultations across state lines.

Some policy recommendations from University of Texas Medical Branch and other industry analysts:

- Develop a standardization of Medicare

RESCUE—continued on Page 3



How Much of a Savings?

As the infrastructure for telemedicine matures, so will the savings that telemedicine has to offer. Within five years, analysts expect to see:

- **A 38 percent reduction in transfers from one hospital emergency department to the emergency room at a second hospital, for a cost savings of $537 million annually.**
- **A 79 percent cut in transfers from correctional facilities to physicians' offices and a 42 percent reduction in transfers to emergency rooms, which would generate a combined cost savings of $270.3 million a year.**
- **A 14 percent cut in transfers from nursing homes to emergency rooms, for a cost savings of $327 million a year.**
- **A 68 percent cut in transfers from nursing homes to physicians' offices, for a cost savings of $479 million.**
- **A $3.61 billion savings as a result of physician-to-physician consults, primarily from a 45 percent reduction in unnecessary or redundant tests.**

After accounting for additional costs, the reduction in transfers, office visits and tests, telemedicine promises to deliver a net annual savings of $4.28 billion in the United States alone. ■

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man Inc. "Until members can compare and shop for providers' quality and cost, CDHP savings are likely to remain limited to the reduced utilization expected from high-deductible plans," Pyenson added.

The bottom line: CDHP enrollees in 2008 continued to report no difference in satisfaction with quality of care compared with those in traditional plans, and savings were insignificant. These factors, more than any others, may be reason for the plans' slow growth. ■

RESCUE—continued from Page 2

and Medicaid reimbursements across states.

- Identify and develop policies that encourage reimbursement for telemedicine services from private insurers and company health plans.
- Review liability laws to determine whether they need adjustments to clarify their application to telemedicine services.
- Review the medical licensing system to determine whether adjustments are necessary to eliminate barriers that will slow the adoption of telemedicine.
- Explore state and local initiatives that would accelerate the implementation of telemedicine through cost-sharing and pooling resources.
- Promote enhancement of existing information technology that will facilitate and support telemedicine and complementary services.
- Encourage broadband adoption and the deployment of smart networks that provide fast, reliable and secure transmissions for telehealth services.

Telemedicine's combination of sophisticated videoconferencing, electronic medical records, proven disease management protocols and telemonitoring can revolutionize medical care. The challenge lies not in the technology, but the processes and policies that govern healthcare delivery and payment. ■

How They Work: CDHPs in Action

In a typical CDHP, an employer places a sum of money each year (up to $3,000 for an individual or $5,950 for a family, with additional catch-up contributions of up to $1,000 for individuals over 55) into a health savings account (HSA). Employees own these funds, which they can use to pay medical expenses. To qualify for the HSA, the employee must have a high-deductible major medical policy that meets certain criteria. (See the U.S. Treasury's Web site at www.ustreas.gov/press/releases/hp975.htm.)

What sets CDHPs that use HSAs apart from traditional coverage is the rollover. The employee may carry over any unused balance in the HSA, to which the employer will then typically add the following year's contribution. This rollover feature is crucial to changing behavior. If unused funds disappear every year, consumers rationally view them as an evaporating asset they should spend, thereby driving up costs. But since unused funds accumulate, consumers learn to spend the money judiciously, balancing the costs of preventive measures in the short run with long-term savings for possible crises. This also lowers the odds of incurring larger expenses in the long run.

Moreover, an HSA's savings are portable. Individuals can take their accumulated HSA balances with them when they change employers or retire. This feature transforms health benefits from an annually evaporating asset into a lifelong savings plan for almost any approved healthcare expense.

And perhaps most attractive, health savings accounts are triple tax advantaged — tax-free, or tax deductible, when contributed; tax-free as they grow (funds can be invested); and tax-free at withdrawal if spent on qualified medical expenses (whether one day after the money is deposited or 20 years later). These advantages will undoubtedly inspire financial services providers to create new ways for individuals to maximize lifelong capital accumulation across categories (retirement, health care, life insurance, disability, higher education), as well as to mix and match these funds at different stages of life. ■

RETIREE—continued from Page 4

with having a 50 percent, 75 percent or 90 percent chance of having enough savings to cover health insurance premiums and out-of-pocket health care expenses in retirement.

Until fairly recently in history, most workers had the responsibility of paying for their own healthcare during retirement. The fact that the elderly had greater financial needs but less financial protection than younger workers led to the passage of Medicare. Nearly 90 percent of Medicare beneficiaries have some form of additional insurance coverage to supplement Medicare Parts A and B.

Surprise ending

Many workers are generally unprepared for both healthcare expenses in retirement and other retirement expenses. In fact, many individuals will need more money than the average amounts listed above, because this analysis does not factor in the savings needed to cover long-term care expenses, nor does it take into account the fact that many individuals retire prior to becoming eligible for Medicare. And individuals who choose to work during typical retirement years and receive health benefits from their employer will need to save less than the average amounts listed above.

This much is certain: ensuring retirement income security is certain to become even more challenging in the future, as employers continue to scale back retiree health benefits and policymakers begin to address expected shortfalls in the Medicare program by shifting more responsibility for costs to Medicare beneficiaries. For an analysis of your company's retiree benefit program and responsibilities toward Medicare beneficiaries, please contact us. ■

Retiree Health Benefits in Jeopardy

Here's a sobering thought: Most active workers will never be eligible for health insurance in retirement through a former employer. A report just released by the Agency for Healthcare Research and Quality (AHRQ) found that only 13 percent of private-sector establishments offered health benefits to early retirees in 2005, down from 22 percent in 1997.

Furthermore, 13 percent of private-sector establishments offered health benefits to Medicare-eligible retirees in 2005, down from 20 percent in 1997. The trend among large employers — those most likely to offer health benefits — is down as well.

The statistics prompt the question, how will retirees pay for health benefits in their golden years? Another report by the Employee Benefits Research Institute calculated the dollar cost of healthcare for retirees:

For Women:

- Women retiring at age 65 in 2009 will need anywhere from $98,000–$242,000 in savings to cover health insurance premiums and out-of-pocket expenses in retirement if they are comfortable with a 50 percent chance of having enough money, and $164,000–$450,000 if they prefer a 90 percent chance.
- Women with subsidized retiree health benefits will need $98,000 if comfortable with a 50 percent chance of having enough savings to cover health care expenses in retirement.
- Women with unsubsidized retiree health benefits who want a 90 percent chance of having enough savings will need $266,000.
- Women who supplement traditional Medicare with Medigap and Medicare Part D and who have relatively high prescription drug expenses will need $242,000 if comfortable with a 50 percent chance of having enough savings, while those who prefer a 90 percent chance of having enough savings would need $450,000.

For Men:

- Men with subsidized retiree health benefits will need $68,000, if comfortable with a 50 percent chance of having enough savings to cover health care expenses in retirement; $134,000 if they want a 90 percent chance of having enough savings.
- Men with unsubsidized retiree health benefits who want a 90 percent chance of having enough savings will need $217,000.
- Men who supplement traditional Medicare with Medigap and Medicare Part D and who have relatively high prescription drug expenses will need $173,000 if comfortable with a 50 percent chance of having enough savings; to increase their odds to 90 percent, they would need $378,000.

Younger people will need even more savings. Men currently age 55 who plan to retire at 65 will need an estimated $114,000 to $634,000; women will need $164,000 to $754,000. Which end of the range they fall on depends on the source of their Medicare supplement coverage, employer subsidies, prescription drug use, and their comfort level

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Medicare Coordination Does Not Violate ADEA, Rules Court.

Earlier this year, a New York state court ruled that an employer that changed its retiree health plan to reduce premiums for Medicare-eligible retirees by amounts payable under Medicare did not violate the Age Discrimination in Employment Act (ADEA).

In the case, *LeFevre v. Niagara Mohawk Power Corp,* older retirees claimed the employer's action discriminated against them, because the employer paid more in premiums for younger retirees who were not eligible for Medicare. Under the revised retiree health plan, older retirees ended up paying more in premiums and a larger percentage of their premiums than younger retirees who were not yet eligible for Medicare.

The ADEA protects individuals who are 40 years of age or older from discrimination based on age with respect to any term, condition or privilege of employment, including benefits. The Older Workers Benefit Protection Act of 1990 amended the ADEA to specifically prohibit employers from denying benefits to older employees. However, in limited circumstances, an employer may reduce benefits based on age, as long as the cost of providing reduced benefits to older workers is the same as the cost of providing benefits to younger workers.

The ADEA applies to all employers with 20 or more employees. For more information, see the U.S. Equal Employment Opportunity Commission Web site at www.eeoc.gov/types/age.html ■