Pharmacy and Health Savings Accounts

CDHPs: As Enrollment Goes Up, a Time to Tune Up

One of the clearest findings of Mercer’s annual National Survey of Employer-Sponsored Health Plans is that more companies are thinking of adopting a consumer-directed health plan (CDHP) approach, and more employees are enrolling in CDHPs at the companies that offer them. The authors discuss the advantages for organizations that offer CDHPs, as well as outline key considerations for companies looking to update, optimize and align their CDHPs with the realities of health care reform. They also explain how CDHPs go hand in hand with wellness and health management strategies, both of which increase collaboration between employees and employers to control costs and give employees more personal responsibility for better outcomes.

by Sander Domaszewicz | Mercer and Jay Savan, CEBS | Mercer

Many employers have had their consumer-directed health plan (CDHP) strategies in place for some time, but the new era of health care reform—now that the Patient Protection and Affordable Care Act (ACA) is being implemented—has changed the game for employees and employers in terms of making better health care choices and looking more seriously at the benefits of CDHPs. While more companies are thinking of adopting a CDHP approach, more employees are enrolling in CDHPs at the companies that offer them.

That’s one of the clearest findings of Mercer’s annual National Survey of Employer-Sponsored Health Plans, which is conducted using a national probability sample of public and private employers with at least ten employees (2,842 employers completed the survey in 2013). With results representative of more than 105 million full- and part-time employees, the current survey, conducted in late summer 2013, revealed enrollment in CDHPs is now on par with that of health maintenance organizations (HMOs).

Let’s consider some of the numbers. Nationally, enrollment in CDHPs rose from 16% of covered employees in 2012 to 18% in 2013 (Figure 1). This is the same portion that enrolled in HMOs, whose enrollment stayed stable in 2013 after dropping from 20% the year before. Even more notably, in the Midwest, CDHP enrollment is now more than double that of HMOs (27% compared with 10%).

As ACA moves forward and the employer shared responsibility requirement becomes reality, CDHPs are an important option for employers looking for a cost-effective plan to make extending coverage to additional employees more affordable. According to the Mercer survey, the average cost of coverage in a CDHP paired with a tax-advantaged health savings account (HSA), including any employer account contribution, is 17% less than coverage in a preferred provider organization (PPO) and 20% less than in an HMO: $8,482 per employee, compared with $10,196 for PPOs and $10,612 for HMOs (Figure 2). This difference can be attributed partially to benefit value and selection,
FIGURE 1

CDHP Enrollment Pulls Even With HMO Enrollment in 2013
Percentage of all covered employees enrolled in each plan type

*Combined in 2008 due to declining offerings of enrollment in POS plans. Includes traditional indemnity plans beginning in 2013.
Source: Mercer’s National Survey of Employer-Sponsored Health Plans.

FIGURE 2

HSA-Based CDHPs Cost 17% Less than PPOs and 20% Less than HMOs in 2013

Source: Mercer’s National Survey of Employer-Sponsored Health Plans.
but data shows there is also a healthy measure of consumerism and behavior change driving lower HSA costs.

CDHP adoption and enhancement will also be a key strategy for employers that need to find a way to lower cost in 2018, when they will be required to pay a 40% excise tax on health coverage that costs more than $10,200 for an individual or $27,500 for a family. Mercer estimates that about one-third of employers currently are at risk for triggering the excise tax in 2018 if they make no changes to their most costly plan. Nearly two-thirds of all large employers and about one-third of small employers say they expect to offer a CDHP within three years (table).

**A CDHP Tune-Up**

With so much movement toward CDHPs and clear advantages for organizations that offer them, companies looking to update, optimize and align their CDHP programs with the realities of health care reform should keep sight of some key considerations. For one thing, ACA has had a significant impact on flexible spending arrangement (FSA) contributions; employees can now contribute only $2,500 to a health FSA (although employers can contribute additional funds). Further, U.S. Department of the Treasury’s recent ruling permitting rollover of FSA funds, within limits, adds complexity and another point of decision to the role these devices play in a consumer-focused strategy. And it appears that employee contributions to FSAs are always included in the excise tax calculation, making the ability to contribute to HSAs outside of benefits channels potentially that much more appealing.

Then there’s the issue of health reimbursement accounts (HRAs), through which an employer may pay for certain health care expenses for employees or their dependents for the current benefit year, up to a defined amount. Although most HRAs (at the employer’s discretion) allow the unused amounts to be rolled over to subsequent years, the employee generally loses access to the funds if he or she terminates employment with the company sponsoring the HRA.

Relevant to this are recent guidelines under the Public Health Services Act (PHSA), which prohibits annual or lifetime benefit limits on group insurance. Under the new guidance, the Department of Labor states that an HRA must be “integrated” with a group health plan such that the combined benefit meets PHSA requirements. An HRA offered apart from group health insurance (a.k.a. a standalone HRA) does not comply with the prohibition on benefit limits under PHSA. Thus, in 2014, employees are not permitted to use a standalone HRA to purchase coverage on the individual market and have it qualify as being integrated with the individual health coverage to satisfy PHSA requirements. As a result of these and other considerations, the overall attractiveness of HRAs as a benefits tool has remained somewhat limited, with large plan sponsor adoption growing from only 8% in 2009 to 10% in 2013—while HSAs grew from 14% to 32% over that same period.

### TABLE

<table>
<thead>
<tr>
<th>Number of employees</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>Very likely to offer in 2016</th>
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<tbody>
<tr>
<td>Small employers</td>
<td>9%</td>
<td>15%</td>
<td>16%</td>
<td>20%</td>
<td>22%</td>
<td>23%</td>
<td>34%</td>
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<tr>
<td>(10-499 employees)</td>
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<td></td>
<td></td>
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<tr>
<td>All large employers</td>
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<td>23%</td>
<td>32%</td>
<td>36%</td>
<td>39%</td>
<td>64%</td>
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<tr>
<td>Employers with 5,000 or more employees</td>
<td>35%</td>
<td>41%</td>
<td>42%</td>
<td>45%</td>
<td>51%</td>
<td>55%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Source: Mercer’s National Survey of Employer-Sponsored Health Plans.
In contrast, such key aspects of CDHPs as HSAs, into which employees and employers may contribute funds, are relatively unaffected by health care reform and will remain an effective way for employers to control benefit plan cost. HSA-qualified health plans generally offer lower premiums and tax advantages for employees and employers. But it’s crucial that employers provide strong education and communication programs regarding such advantages in order to encourage CDHP participation.

Indeed, the potential for CDHPs (both HSAs and HRAs) as accumulation vehicles is expansive. For example, apart from their common practice of making automatic payroll contributions to HSAs, employers can provide opportunities for employees to earn variable or conditional HRA or HSA funds by, for example, taking part in programs that monitor compliance with prescription drug regimens, or for participating in wellness/health management programs aimed at preventing disease or managing existing conditions. Interest is reflected in the sharp growth of conditional HSA funding by large employers that put money into the accounts, shooting from 11% in 2012 to 20% in 2013.

But employers need to consider there are always a variety of cohorts in the employee population, and their needs and attitudes tend to differ, often widely. For those whose earnings fall below certain thresholds, the tax-saving benefits of CDHPs and HSAs matter little if at all, since these low earners may pay minimal or no taxes. Thus, a tax-protected health savings or reimbursement account may not seem particularly valuable to them, yet they will be acutely aware of the high deductible for health care costs their CDHPs include.

For employers, there’s an opportunity to incentivize such employees by offering, for example, a critical illness benefit or hospital indemnity rider for compliance with prescription drug regimens or wellness programs. In fact, the Mercer survey noted some significant growth in the use of enhanced preventive prescription drug coverage by large employers: a rise from 31% of them in 2012 to 42% in 2013 for HSA-based plans. This trend reflects an increasing commitment to value-based plan design that meets the needs of the broad-based employee populations of large companies, especially for employees with chronic conditions who benefit most from more affordable and adaptable plans.

Combined with their HSAs, such incentives and higher value services may go a long way toward encouraging these employees to consider the lower premiums and accumulation opportunity presented by HSA-compatible plans. Again, communication is key to the success of such approaches, especially given that the flexibility of HSAs allows employees who may be cash-strapped to access the accounts for nonmedical issues such as emergency auto repairs, or even for consumer purchases by young plan participants whose relative healthiness may lessen their sense of urgency regarding the preservation of a health savings fund. Using HSA distributions for such expenses results in a 20% excise penalty and ordinary income taxation, defeating the purpose and value of these vehicles.

Strong communication, along with the proper tools and resources to help employees manage their HSA spending, is the key to a successful health care consumerism strategy, and data show that CDHP plan members will make more informed decisions. According to the 2013 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 50% of those surveyed in a CDHP plan with an HSA account asked for generic over brand-name drugs vs. 47% in a high-deductible, non-HSA plan and 37% in a traditional no- or low-deductible plan. And 28% of CDHP plan members said they developed a budget to manage health care expenses vs. 17% and 15% in the high-deductible and traditional plans, respectively. Importantly, 25% of the surveyed CDHP members used online cost-tracking tools provided by their health plans vs. only 13% and 12% of the high-deductible and traditional plan members, respectively.

This affirms that employees with the wherewithal to make the best choices are much more willing to engage and become better health care consumers, even as we acknowledge that personal financial situations and the account portion contributed by the employer also are important. And
since no two HSA plans are precisely the same, there can be a wide variety of funding scenarios. The best practice for human resources benefit leaders is to offer both an insurance coverage portion and an HSA, because both are required for real success.

**CDHPs Meet Wellness**

If anything, the rise in enrollment in CDHPs goes hand in hand with the emphasis on workforce wellness/health management as one of employers’ top strategies for controlling health spending. But according to the 2013 Mercer National Survey of Employer-Sponsored Health Plans, while most employers believe health management programs are making a difference, proving the programs’ return on investment (ROI) remains a challenge for many. The largest employers are the most likely to have formally measured the ROI of their health management programs (46% of employers with 20,000 or more employees), and nearly nine of ten of these employers say their programs have had a positive impact on medical plan trends.

Clearly, such trending marks the surges in wellness programs and CDHPs as important works in progress for the health care reform era. And perhaps because they are seeing results, employers are increasingly willing to invest in the success of these programs. Over half of large employers with health management programs now use financial incentives to encourage higher participation: 52%, up from 48% in 2012 and 33% in 2011.

These incentives often are substantial. Among employers that offer lower premium contributions to employees completing a health assessment, the median reduction in the annual contribution required for employee-only coverage is $250. And employers often include incentives for a number of healthy actions, potentially multiplying these types of rewards for engaging. In addition, a growing number of employers are providing incentives for achieving desired outcomes, instead of (or in addition to) incentives for participating in programs. In 2013, 20% of large employers use outcomes-based incentives, up from 18% in 2012.

The statistics are impressive and point to a fundamental truth: An increasing embrace of personal responsibility on the part of employees is fueling better outcomes. There is also an increasing awareness that health care is a form of consumerism that demands the increasing collaboration of employees and their employers. The rise and evolution of CDHPs is proof of this awareness—and in today’s uncertain dawn of health care reform, that’s a reason for considerable hope.

**AUTHORS**

**Sander Domaszewicz** is a principal and senior consultant in Mercer’s Health & Benefits Services, based in Newport Beach, California. He is Mercer’s national practice leader for consumerism and leads engagement efforts for the Total Health Management group, specializing in emerging benefits strategies. He can be contacted at sander.domaszewicz@mercer.com.

**Jay Savan, CEBS,** is a Mercer partner who focuses on advising large clients on the design, financing, administration and communication of their employee health and benefit plans. Based in the Atlanta, Georgia office, he assists public and private employers in maximizing the return on their investment in people through innovative employee benefit strategies. Savan recently was identified as Most Innovative Consultant in CDHC Solutions Magazine’s first annual list of “CDHC Superstars.” He can be contacted at jay.savan@mercer.com.

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