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TALENT • HEALTH • RETIREMENT • INVESTMENTS

Why Would You Want A Consumer-Driven Health Plan (CDHP)?

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Washington, DC

MARSH & McLENNAN COMPANIES

Need a reason to change
Align consumer behaviors with health care

- Behavior is the greatest factor in determining health and you change individuals' behaviors by providing them with …

More financial stake in health care choices

- Plan design
- Health accounts
- Incentives
- Transparency to the real cost and quality of treatment

+

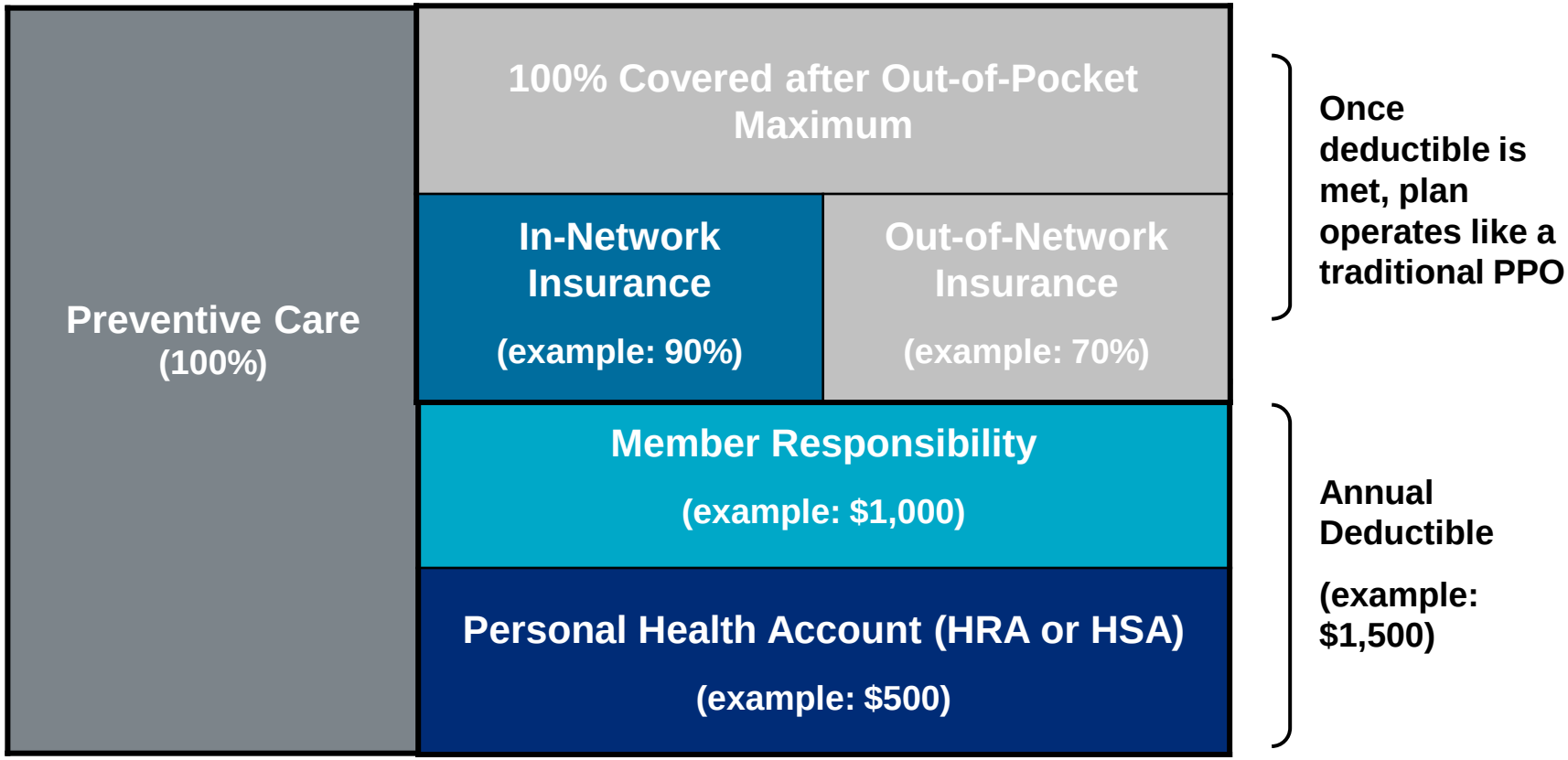
More resources and tools to manage health and wellness

- Curriculum focused on basic health education
- Wellness programs and tools
- Quality assessment tools
- Treatment cost estimators
- Online resource for quickly accessing personalized information

Overview
What is Consumerism and what are Consumer-Directed Health Plans (CDHP)?

- **Consumerism** – any activity that encourages or empowers informed or responsible spending or use of healthcare related goods or services
- **CDHP** – a plan, typically a PPO with a high deductible and an “account” (e.g., Health Savings Account (HSA) or Health Reimbursement Account (HRA)) that provides employees with incentives to be active participants in their healthcare consumption
- It is a plan under which employees spend money from their HSAs (or HRAs) to pay for health care services. Once the high deductible is met, services are covered by traditional insurance.

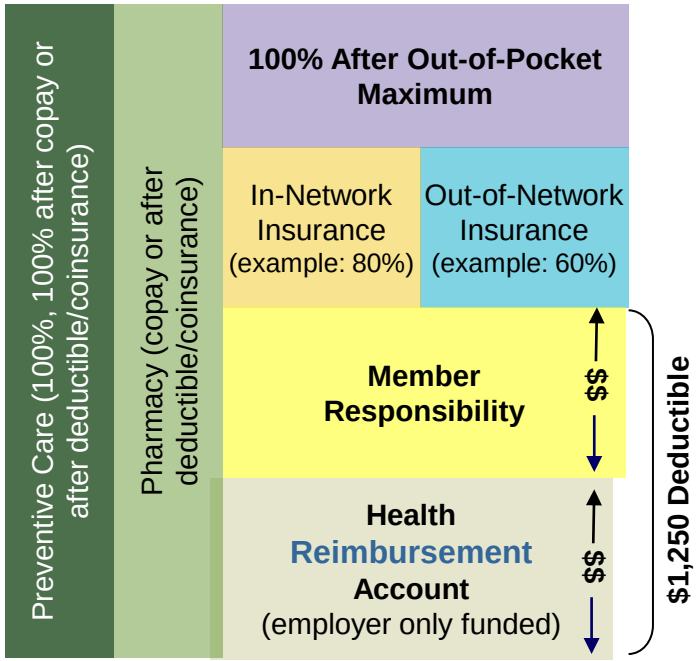
Consumer Directed Health Plans
How do they work?



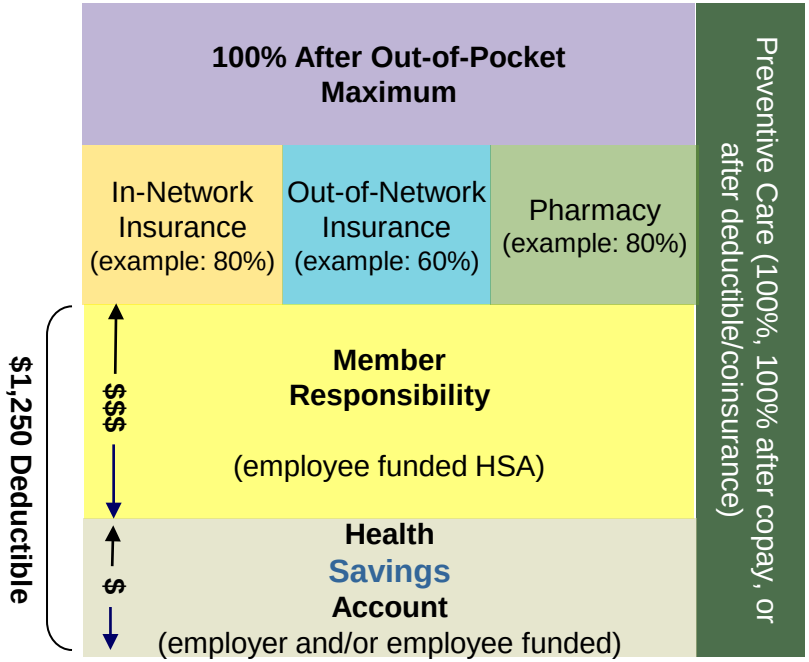
Strategy & Planning - Account-based health plans

Health Reimbursement (HRA) vs. Health Savings Accounts (HSA)

HRA



HSA

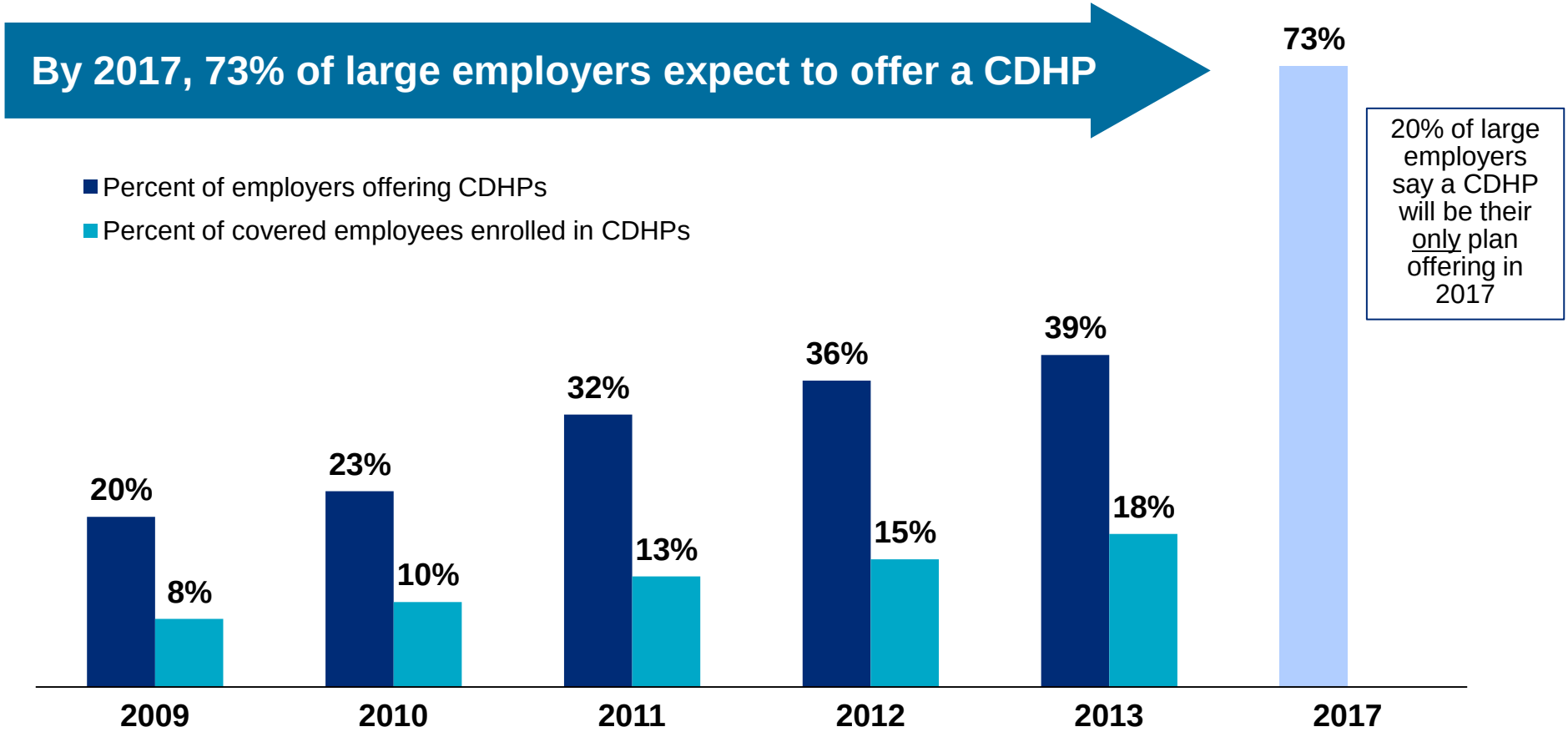


- HRAs are typically notional accounts or a promise to pay
- HRAs are often not portable nor invested
- Funds roll over and are non-taxable for health purposes; HRAs cannot be used for non-health costs
- HRAs are only employer-funded
- HRAs have extremely flexible and widely varying employer-defined designs (e.g., Rx, copays, eligible expenses, etc.)
- Only distributions (not contributions) are tax-deductible

- HSAs are funded, individually owned accounts
- HSAs are portable, earn interest, and can be invested
- Funds roll over and are non-taxable (federally) for health purposes; HSAs can be used for non-health costs
- HSAs can be funded by employees and employers
- HSAs have federal mandated design parameters (e.g., Rx copays, deductible/out-of-pocket limits)
- Annual tax deductible limit: is a flat dollar amount of $3,350 for Individual and $6,650 for Family for 2015

Use of consumer-directed health plans is likely to accelerate over the next three years

Large employers



CDHPs have become mainstream

Provide a low-cost plan to newly eligible employees

Encourage employees to use the health care system wisely

Provide a tax-favored vehicle for retirement savings

Avoid the excise tax

Employer Shared Responsibility
How the Payment Will Work in 2015

1. Did you average 100 or more full-time and full-time equivalent employees in 2014?

   (Aggregate controlled group members)

No → You will not be subject to a shared responsibility payment.

Yes ↓

2. Do you offer a health plan to substantially all (70%) full-time employees (FTEs) and their dependent children (not spouses/domestic partners)?

   (Disaggregate controlled group members)

Yes → 3. Does the health plan offered to FTEs satisfy standards for both: (1) affordability (employee-only contribution for plan ≤ 9.5% of an employer affordability safe harbor or 9.56% of employee's household income), and (2) minimum value (60%)?

Yes → 4. Do you have any FTEs to whom you do not offer a health plan?

No → You will not be subject to a shared responsibility payment.

No ↓

You will pay:

$2,080* x (total # FTEs – first 80 FTEs)

Applies if at least one FTE receives tax-subsidized benefits for exchange coverage.

$2,080

Non-offering Employer Payment

No ↓

You will pay the lesser of:

$3,120* x FTEs receiving tax-subsidized benefits for exchange coverage

or

$2,080* x (total # FTEs – first 80 FTEs)

$3,120

Offering Employer Payment

Yes ↓

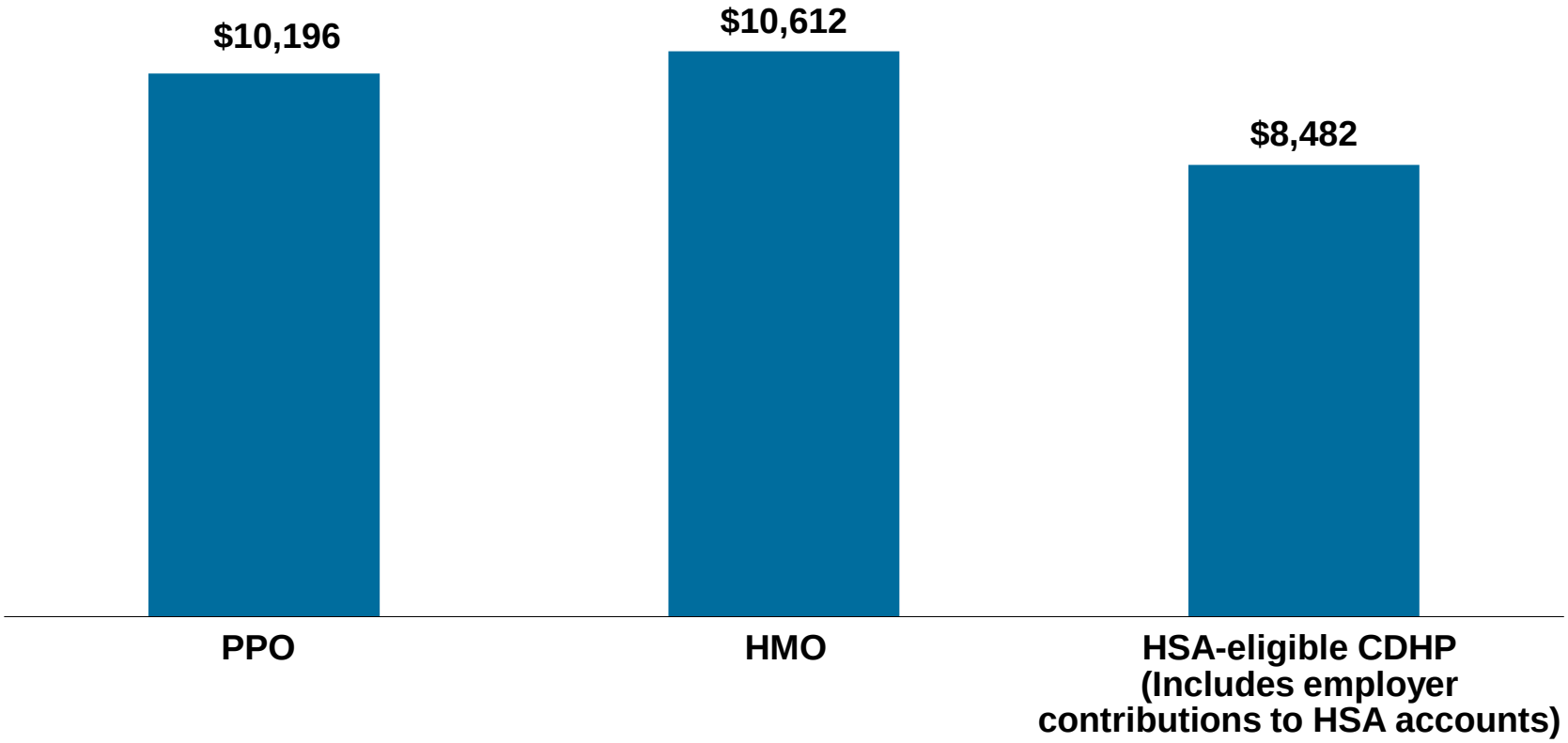
Notes

- Box 1: Beginning in 2016, applies to employers with 50 or more full-time and full-time equivalents. Employers must meet certain rules to use 100 (vs. 50) count for 2015.
- Box 2: Beginning in 2016, the percentage increases to 95%.
- Non-offering employer payment: Beginning in 2016, the total number of FTEs will be reduced by 30, not 80.

* Mercer estimate based on 2015 HHS inflation adjustment. Payments will increase annually to reflect the projected average national increase in health insurance premiums.

CDHPs typically pass the 60% “test” but cost about 20% less than PPO and HMO coverage

Medical plan cost per employee



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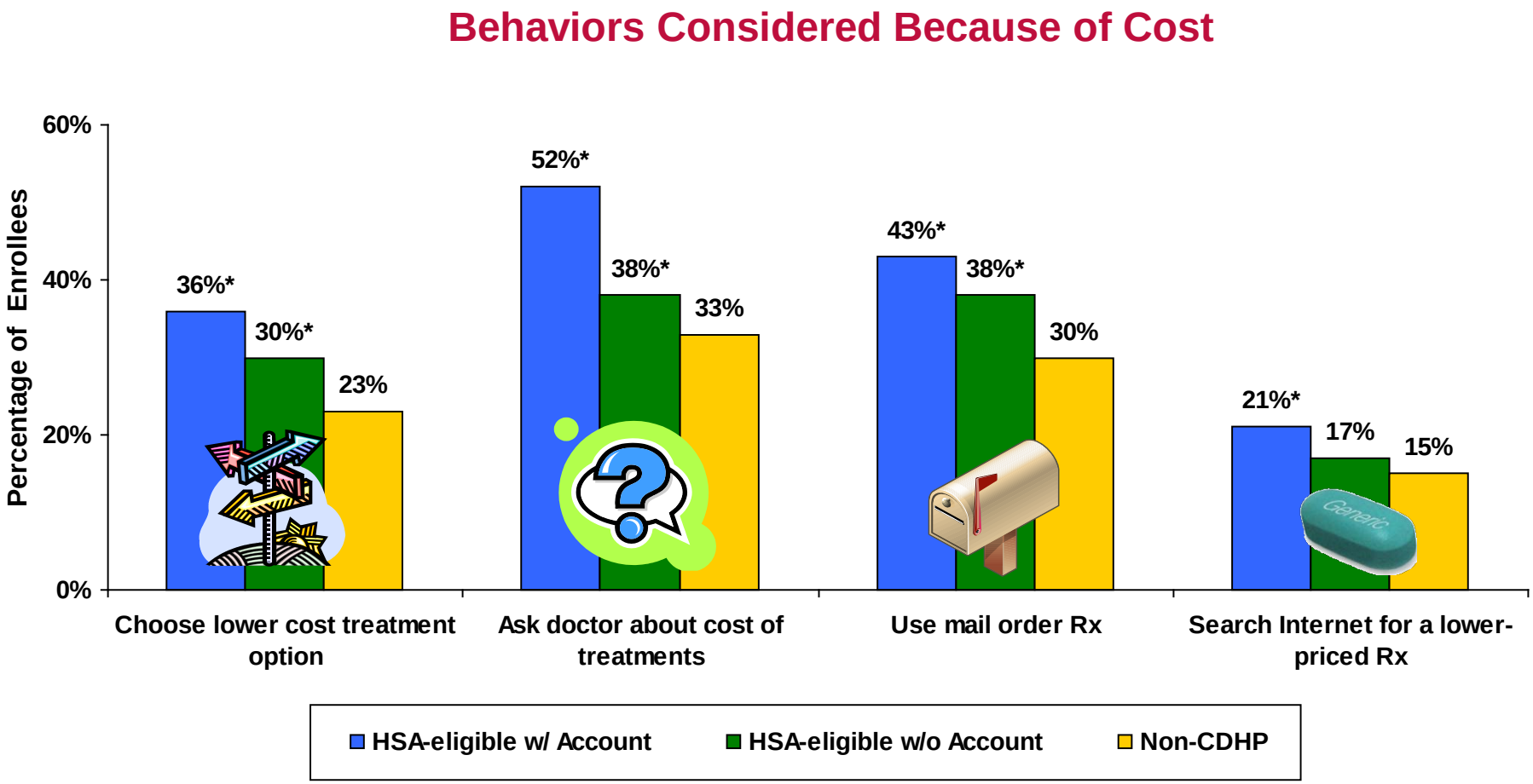
EMPOWERING BENEFITS

Medical/Rx Plan Designs

Medical Plan Design Grid	$0 Deductible Plan		$350 Deductible Plan		$800 Deductible Plan		$1,500 Deductible Plan		$2,500 Deductible Plan	
HRA or HSA Eligible?	HRA		HRA		HRA		Either HRA or HSA[3]		Either HRA or HSA[3]	
Location of Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible										
• Individual	None	$1,500	$350	$2,000	$800	$2,400	$1,500	$3,000	$2,500	$4,500
• Family	None	$3,000	$700	$4,000	$1,600	$4,800	$3,000	$6,000	$5,000	$9,000
OOP Max (incl. ded)[1]										
• Individual	$1,500	$3,000	$2,000	$4,000	$2,400	$4,800	$3,000	$6,000	$4,500	$9,000
• Family	$3,000	$6,000	$4,000	$8,000	$4,800	$9,600	$6,000	$12,000	$9,000	$18,000
General Coinsurance	100%	70%	80%	60%	80%	60%	80%	60%	70%	50%
Physician										
• Preventive	100%	70%	100%	60%	100%	60%	100%	60%	100%	50%
• PCP / Specialist	$15 / $25	70%	$15 / $30	60%	80%	60%	80%	60%	70%	50%
Hospital Facility										
• Inpatient	$200	70%	80%	60%	80%	60%	80%	60%	70%	50%
• Outpatient	$100	70%	80%	60%	80%	60%	80%	60%	70%	50%
Emergency Room (waived if admitted)	$100	$100	$100, 80%	$100, 80%	80%	80%	80%	80%	70%	70%
Retail RX[2]										
• Generic	$5		$10		70% ($10/$20)		80%		70%	
• Formulary Brand	$20		$30		70% ($25/$50)		80%		70%	
• Non-Formulary Brand	$50		$60		55% ($40/$80)		80%		70%	
Mail-Order RX[2]										
• Generic	$12.50		$25		70% ($25/$50)		80%		70%	
• Formulary Brand	$50		$75		70% ($62.50/$125)		80%		70%	
• Non-Formulary Brand	$125		$150		55% ($100/$200)		80%		70%	
Actuarial Value	92%		87%		81%		74% (HSA-eligible) 77% (HRA-eligible)		64% (HSA-eligible) 69% (HRA-eligible)	

NOTE: Plan designs subject to change based on forthcoming PPACA regulations; plan designs subject to state mandates (if insured)
1: All copays (office visit, ER, hospital, and Rx), coinsurance, and deductible apply to the OOP maximum.
2: Preventive Rx (as defined under HSA regulations) for the $1,500 and $2,500 deductible plans is covered at the in-network coinsurance level prior to meeting the deductible.
3: HSA-eligible designs are subject to deductible and OOP maximum requirements dictated by IRS, including true family structure, integrated pharmacy, and minimum deductible/maximum OOP maximum levels; actuarial values are based on an HSA design.

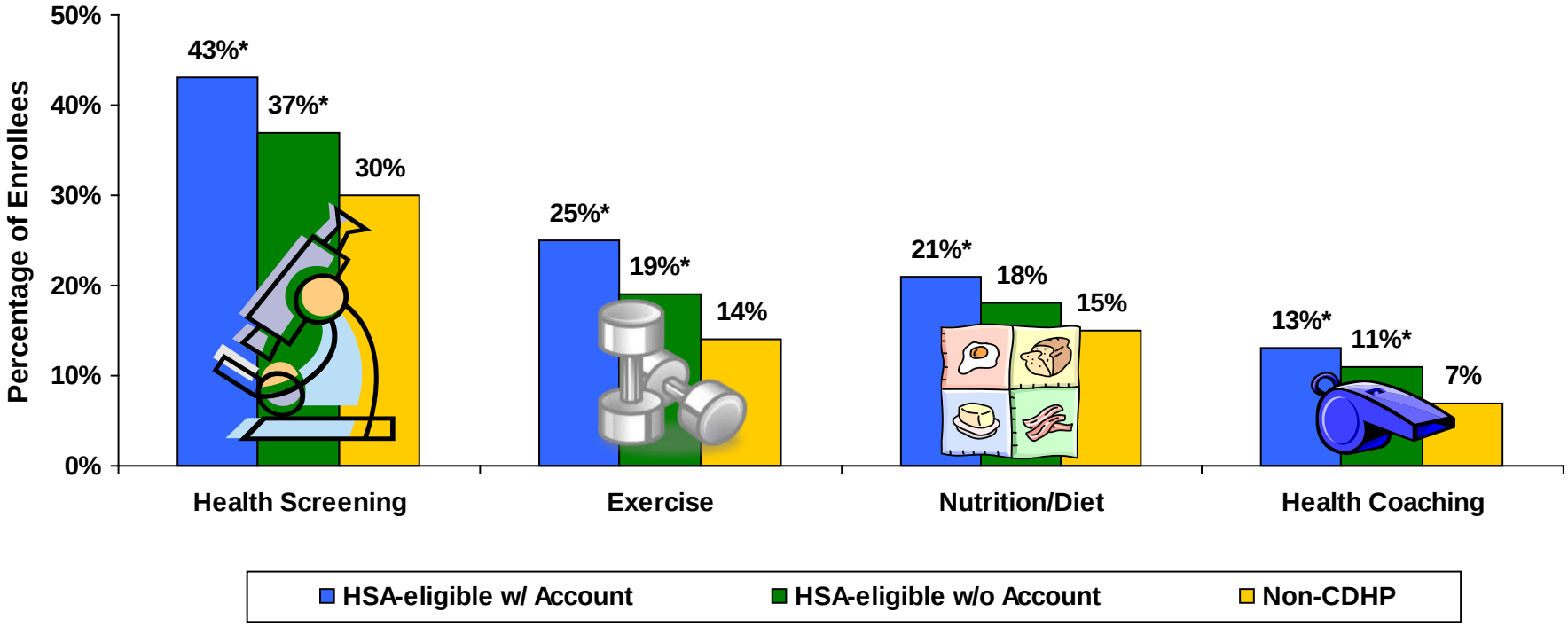
HSA study results: cost-sensitive behaviors



* Statistically different from non-CDHP without Account results at a 95% confidence level
Sources: 2008 BCBSA CDHP Member Experience Survey

HSA study results: more engaged in health

Participation in Health or Wellness Programs



*Statistically different from HSA-eligible results at a 95% confidence level
Note: Participation among those offered health or wellness program
Sources: 2008 BCBSA CDHP Member Experience Survey

CDHP utilization as a percent of open access plan utilization
Blue Cross and Blue Shield of Minnesota

Emergency room visits / 1,000	89%
Professional encounter / PMPY	99%
Professional RBRVS / PMPY	98%
X-ray / lab services / PMPY	99%
Script days / PMPY	84%
Script counts / PMPY	89%
Inpatient admissions / 1,000	98%
Inpatient days / 1,000	96%
Preventive visits / 1,000	111%

Source: Selection, utilization and quality in a consumer directed health plan, Amy R. Wilson, Ph.D., Society of Actuaries, Spring Meeting 2009, June 2009

Health and Wealth

Source: *Investment News,* December 30, 2007

Health and Wealth
Employer Perspective

	Healthcare	Retirement
Employer Perspective	**Evolution of Employer Role** - From managed care to account based/ consumer directed plans **Designing Plans to Drive Behavior** - Defined contribution approaches, exchanges, focus on wellness/health management	**Evolution of Employer Role** - From traditional pension plans to defined contribution plans **Designing Plans to Drive Behavior** - Increased use of auto features, re-design of match formula

Health and Wealth
Employer Perspective

Healthcare	Retirement

Employer Perspective

Issues Impacting <u>Both</u> Plans

- Employers must decide how to allocate limited dollars among various benefit programs
- Concerns over rising cost of healthcare and employees challenged in saving for retirement
- Healthcare reform requirements have been in the forefront, so retirement plans may have taken a back seat
- Employers face issues of workforce renewal

Health and Wealth
Parallels

- No question that health care and retirement are intersecting more
- Increased concern for both employers and employees:
  - Rising costs of health care
    - Premiums
    - Out-of-pocket expenses
  - Employees challenged in saving for retirement
- Organizational decisions on retirement and health plan strategies are often made independently without coordination
- Coordinating programs could help communicate the interconnections to employees more effectively

Health and Wealth
Employee Perspective

Healthcare	Retirement

Employee Perspective

Issues Impacting <u>Both</u> Plans

Employees have more responsibility for outcomes:

- Must decide how to allocate dollars between premiums, FSAs, HSAs and retirement accounts
- Health Care: Movement toward a defined contribution approach and larger role for account-based / consumer-directed health plans
- Retirement: Employee actions determine retirement readiness

Increased concerns over saving enough for retirement and paying for health care, pre- and post-retirement

- Concerns over rising cost of healthcare and employees challenged in saving for retirement

Health and Wealth
Employees Need Help

The shift of risk and responsibility from employers to employees is taking place in the health arena, as well as in retirement

Growing prevalence of and participation in health savings accounts (HSA's)[1]

	2006	2011
Percentage of those with employment-based health benefits offered a HDHP or CDHP*	33%	37%
Percentage of those with employee-only CDHP coverage contributing at least $1,500	21%	44%
Percentage of those with family CDHP coverage contributing at least $1,500	36%	54%

* HDHP = High-deductible health plan; CDHP = Consumer-driven health plan

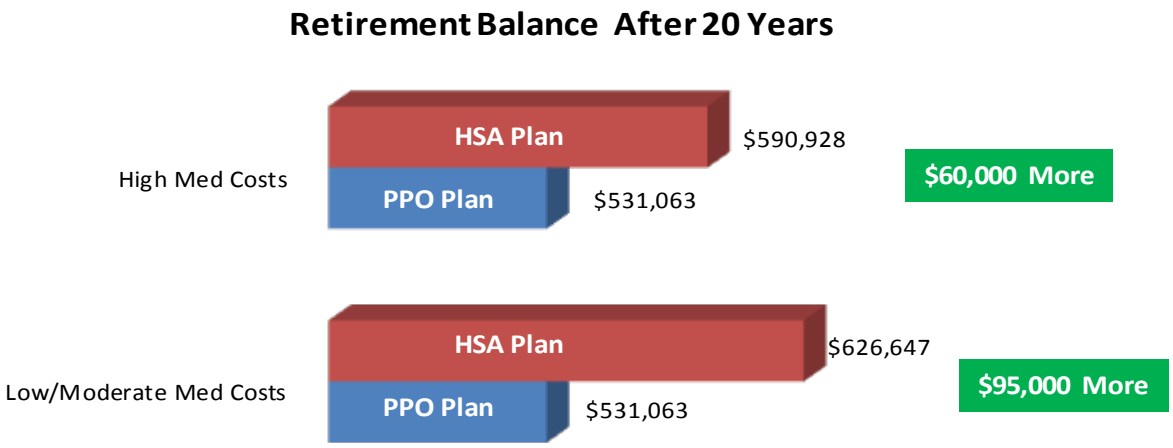
Those making both HSA and 401(k) contributions were found to have higher average 401(k) balances than 401(k)-only savers[2]

Help for employees in planning their financial future must encompass both retirement and healthcare

1 - EBRI Notes, February 2012; 2 – Fidelity study of 2011 contributions

The Health-Wealth Connection—making wise choices in health care can affect your retirement savings

- Every dollar you spend on medical plan payroll contributions or out-of-pocket expenses reduces the amount you can save toward retirement
- Most employees are over-insured; they choose medical plans with lower deductibles, lower copayments, but higher premiums and payroll contributions
- **By switching from a PPO Medical Plan to a Health Savings Account Medical Plan, our employee can retire at age 65 with $60,000 to $95,000 more in her account**



To illustrate our point, here's our hypothetical employee:

Age = 45
Medical coverage = Family
Annual salary = $80,000
Retirement savings rate = 5%
Employer match = 200%
Retirement age = 65
Annual salary increase = 2.5%
Annual rate of plan return = 5%
Starting retirement balance = $0

Medical plan assumptions:

- Employer contributes $12,820/yr to either plan; PPO annual premium = $16,950, H S A = $14,274; employee pays difference
- Employee out-of-pocket medical costs = $1,000/yr, moderate = $2,000/yr, high = $3,000/yr
- Data source: 2012 Mercer National Survey of Employer-Sponsored Healthcare Media Industry Cut
- Figures exclude employee contribution to spending account


I have no idea what you're talking about...
...so here's a bunny with a pancake on its head.

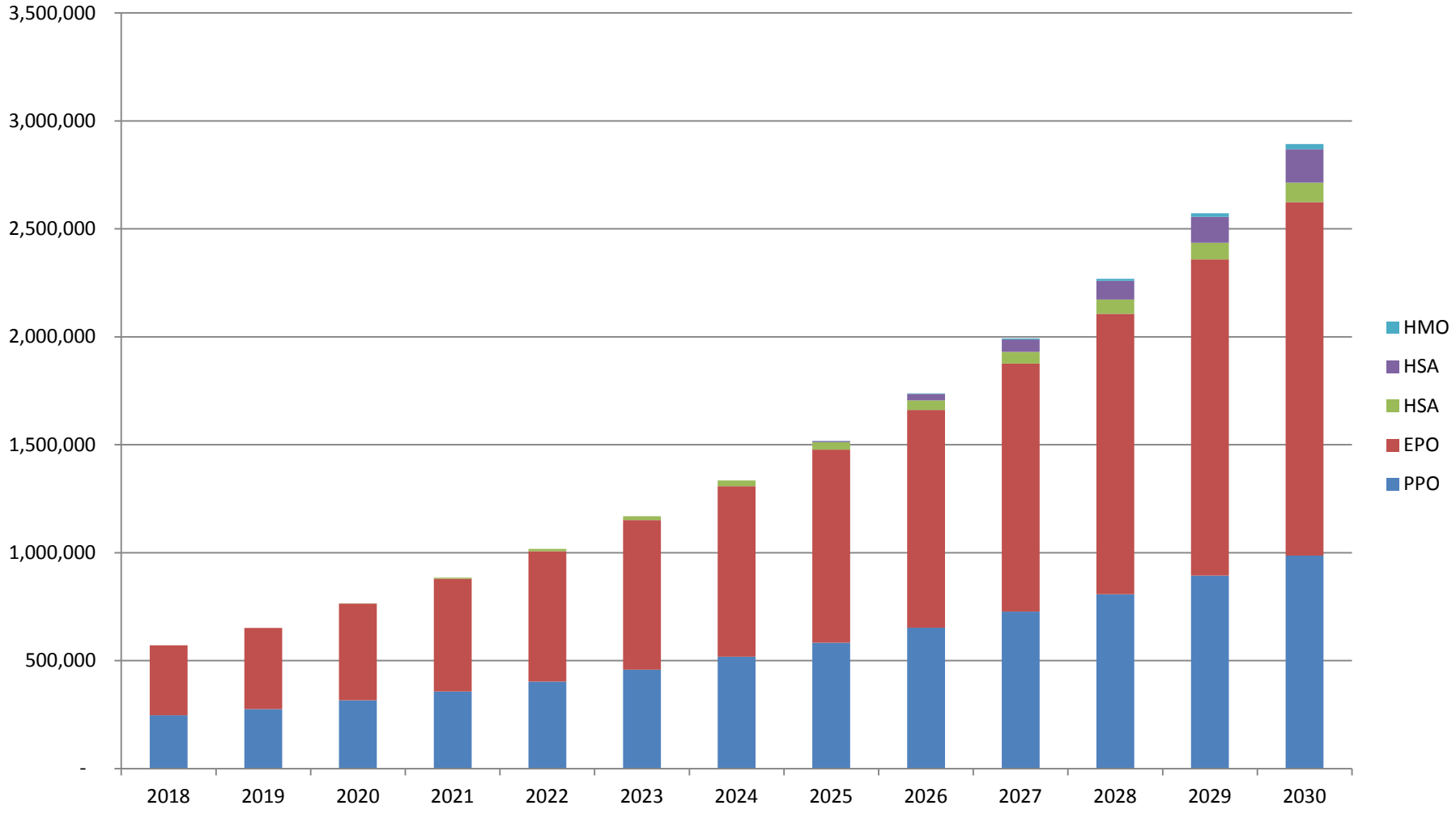
Excise Tax in 2018

What is the Excise Tax?

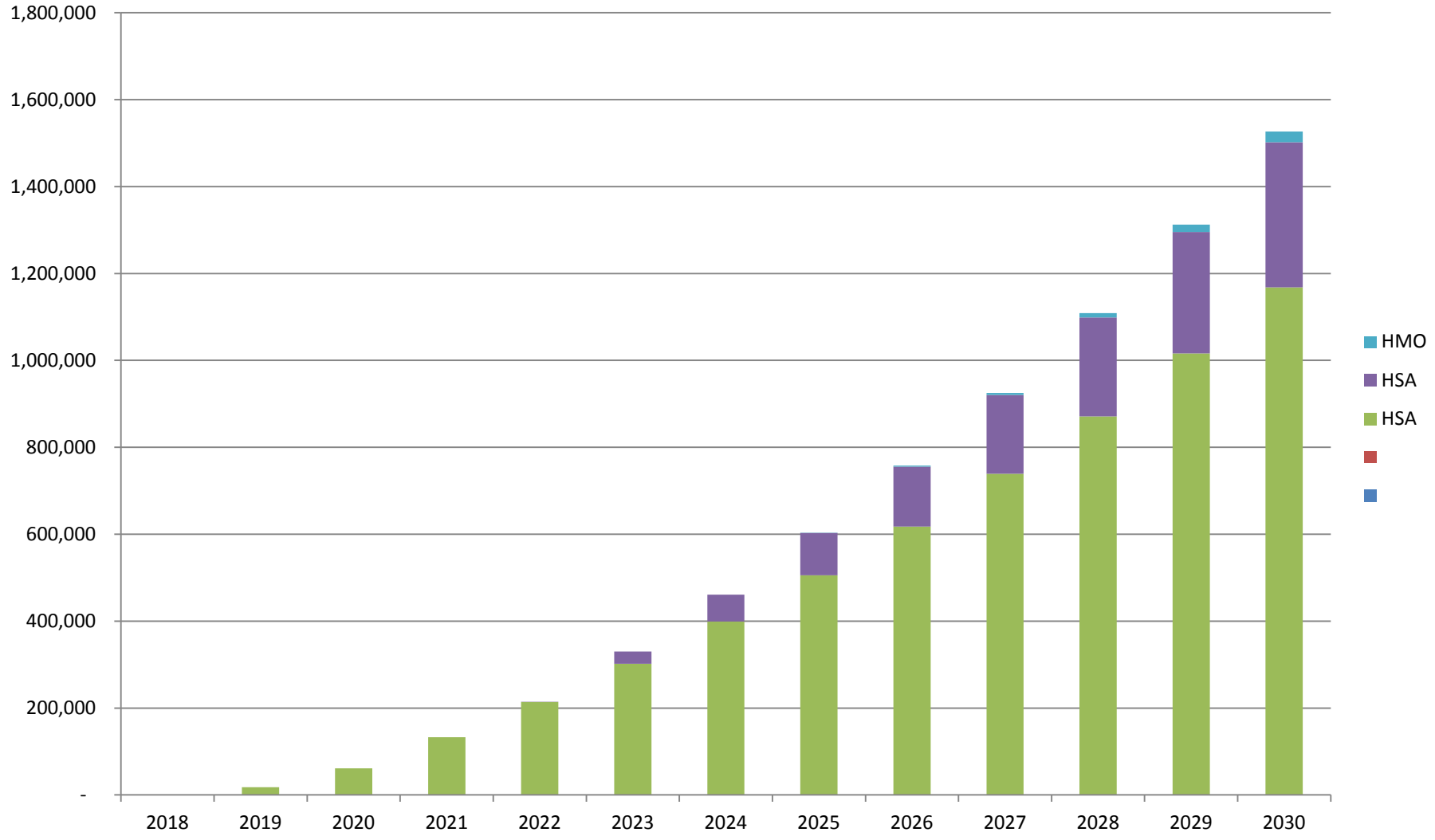
- 40% excise tax on “high cost” coverage, including medical, health FSA contributions, onsite medical clinics, and employer contributions to HSAs
  - Does not include stand-alone insured dental and vision coverage or certain other coverage types
- Initial cap set at $10,200/single and $27,500 family
  - Higher thresholds ($11,850/$30,950) for retirees and workers in high-risk professions
  - Higher threshold ($27,500) for single multiemployer plan coverage
  - Indexed to CPI (for 2019 only, CPI+1%)
- Aggregate cost determined using a methodology similar to that used for determining applicable COBRA premiums
- Employers must determine aggregate cost
  - Insurers responsible for tax for insured coverage
  - Benefit administrators responsible for tax for self-insured coverage
  - Employers responsible for tax for HSA contributions

Excise Tax

Before……



Excise Tax
…and after



Medical Plans
Comparison of HSAs and HRAs

	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
Eligibility	Individuals (employees) with qualified high-deductible health plans (HDHP)	Employees whose plan sponsors make one available
Ownership	Employee-owned	Plan sponsor-owned
Health Insurance Requirement	Qualified HDHP required	None except by plan sponsor design
Contributions	Plan sponsor, employee, or both	Plan sponsor only
Annual Contribution Limits	• For 2014, IRS annual limit: $3,300/$6,550 • Catch-up contributions of $1,000 age 55+	None legally required; plan sponsor sets contribution amounts
Funding	Account is fully funded, can be invested and earns interest	Notional account or promise to pay; typically is not "credited" with interest
Funds Rollover	Allowed	Allowed, plan sponsor can establish limits
Portability	Fully portable, can take to new job or into retirement	Plan sponsor discretion (typically no), COBRA rights apply
Qualifying Expenses	Miscellaneous IRC 213(d) expenses, limited health premium reimbursements	Miscellaneous IRC 213(d) expenses, unlimited health premium reimbursements, plan sponsor determined
Nonqualified Withdrawals	Yes, but taxable, plus 20% penalty. No penalty after age 65, death, or disability	Not allowed
Combine with FSA	FSA must be "limited purpose"	Order of fund use must be established by plan sponsor
Claims Substantiation	Not required (only on IRS audit)	Required
Financial Partner	Required	Not Required
Claim Processing	Debit card or automatic (best vendors)	Automatic (best vendors)

Medical Plans
HRA vs. HSA Design Considerations

	HSA	HRA
Pharmacy coverage	Prescriptions must be subject to the deductible. Rx out of pocket expenses must be applied to plan OOP maximum calculations	Prescriptions do not have to be subject to the deductible.
Plan Sponsor Expense Recognition	If plan sponsor funded, upon account deposit	Claims incurred basis
Account Funding Timing	Discretion of funder (plan sponsor and/or employee), per paycheck pro-ration most prevalent	Beginning of plan year full amount credit most prevalent
Establishing Accounts	Employee must establish account by completing required process	Plan sponsor established through “ledger” transaction with benefit administrator in enrollment process
Administrative Considerations	Works best if connected through payroll and includes employer funding, but not required	Requires employer admin and funding of account to exist; subject to COBRA and other plan rules
Encouraging Consumerism	Very effective at engaging employees to become more involved and informed about how they allocate their own money	Depending on design and use provisions, can be very effective; those with caps to accumulation, no portability and copays for office visits/Rx may diminish impact

HSAs generally working in marketplace

Lower organization's benefit cost 60%

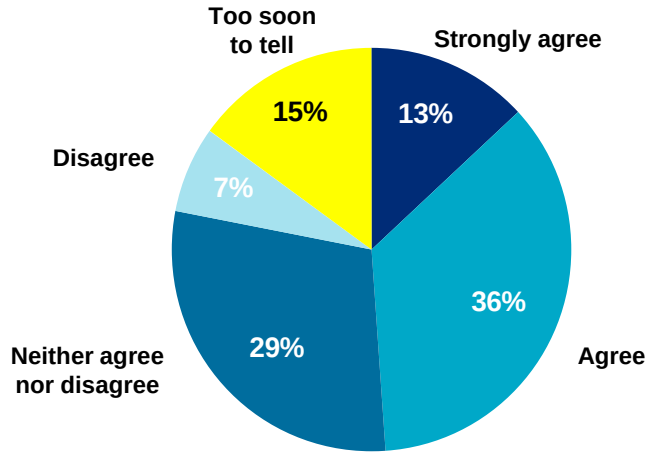
Promote health care consumerism 47%

Improve package of benefit offerings; add choice 42%

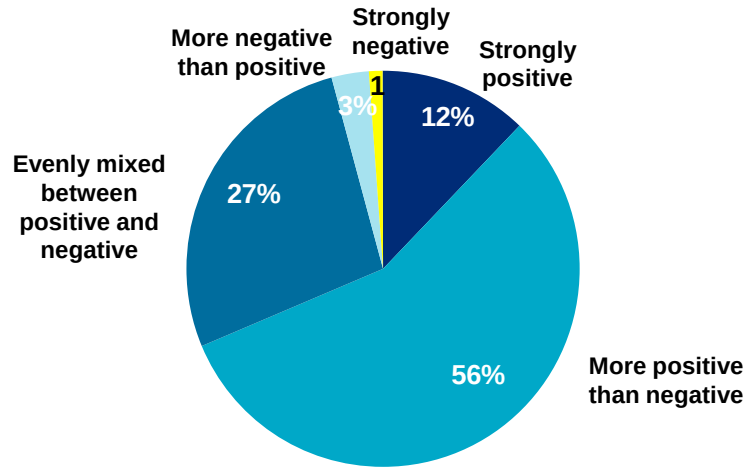
Provide funding vehicle for retiree medical 37%

Provide tax effective savings vehicle 31%

Employer reaction to HSAs "most important objectives have been met"

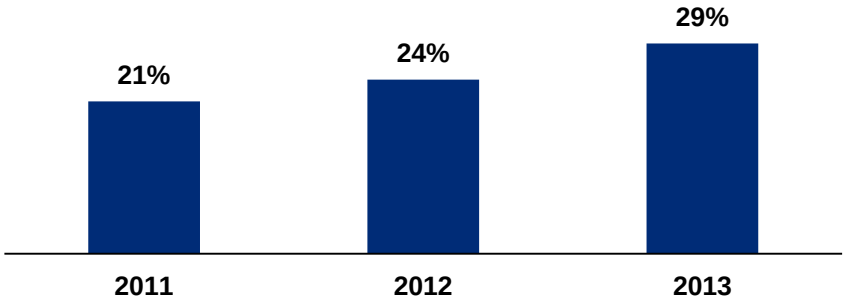


Employee reaction to HSA plans

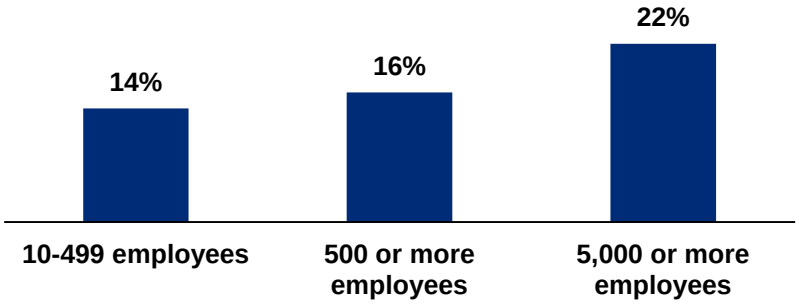


Employers working to build enrollment in CDHPs
Large employers

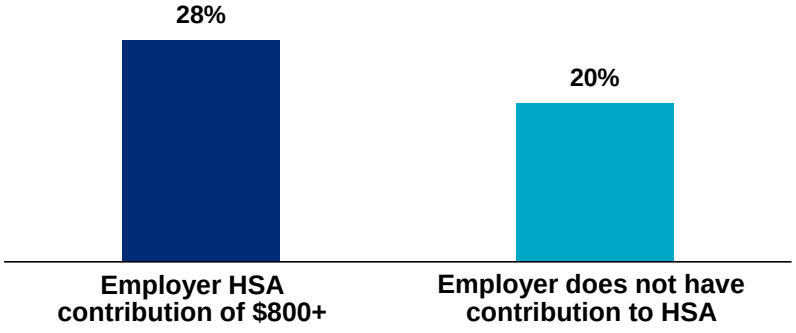
HSA-based CDHP enrollment rises over time
% choosing CDHP when offered w/other medical plans



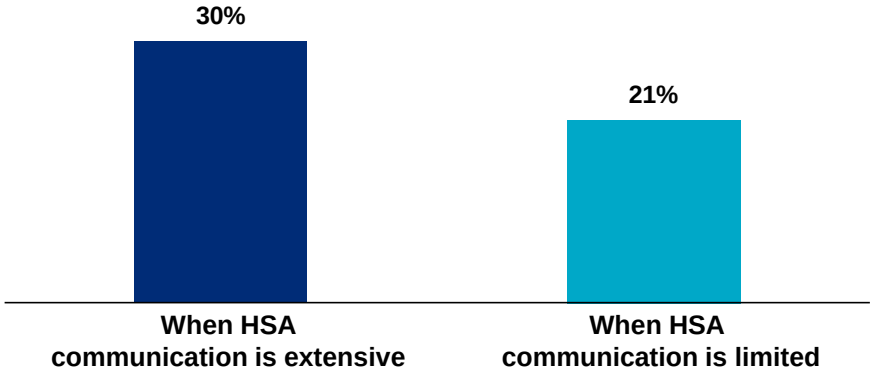
Expect to offer a CDHP as full replacement 3 years from now



Employer HSA funding drives enrollment . . .
% choosing HSA when offered with other medical plans



. . . but extensive communication is also important
% choosing HSA when offered with other medical plans



Keys to success with CDHPs

- **Define Success** Define success up front, including how it will be measured
- **Committed Stakeholders** Leadership (and all stakeholder groups) committed and involved up front and throughout, creating a documented multi-year strategy – don't waver
- **It Takes a Village** Broad project team – be inclusive, consult others - benefits/HR, management, payroll, IT, employee champions, vendors, consultants, influencers
- **Time Is Shorter Than You Think** Start now - allow enough time prior to launch to "build the platform" for change – design program and educate employees
- **Break the Inertia** Break the inertia for better engagement and impact – full replacement, significantly subsidize the plan, eliminate options, go beyond status quo
- **No One Likes Surprises or Secrets** Comprehensive communication and education strategy, be honest, be positive and be personal
  - Educational seminars on consumerism strategy and details on how the CDHP works
  - Rx and chronic illnesses are sensitive topics
  - Multi-channel, many opportunities, before, during and after open enrollment (think point of need)
  - Why change, what are we doing, what "it" is, how it works, what should you do (differently), what's in it for you
- **Continuous Improvement** Measure results, analyze data and be willing to adjust

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