“CONSUMER DRIVEN” HEALTH PLANS

As health care costs continue to escalate, “consumer driven” health plans continue to attract employer interest. In most cases, a consumer driven health plan (CDHP) is a high deductible health plan (HDHP) combined with one of two tax advantaged spending accounts: a Health Savings Account (HSA) or a Health Reimbursement Account (HRA). Plan members use money from their spending account to pay for medical care, including prescription drugs. When the account money is depleted, plan participants must pay for medical care out-of-pocket until the plan’s high deductible is met. Once the deductible has been met, the HDHP functions like a traditional major medical plan.

Supporters of these plans claim that giving health care consumers more of a financial stake in their medical care decisions will inject a dose of competition into the health care marketplace and better contain costs. Opponents, including AFSCME, understand that the accounts are part of a larger conservative agenda to dismantle employer-based health insurance coverage in order to shift risk from employers to employees, and to provide tax shelters for the healthy and wealthy. Following is more specific information on these plans.

HEALTH SAVINGS ACCOUNTS

- What is a HDHP? - In 2024, a HDHP is a health plan with deductibles of at least $1,600 for single coverage and $3,200 for family coverage. Typically, the deductibles are considerably higher than the minimum levels. Total out-of-pocket expenses (deductibles, co-payments, etc.) cannot exceed $8,050 for an individual and $16,100 per family. The deductible and out-of-pocket limits are indexed annually for inflation. The deductible must apply to all services and medical expenses, including most prescription drug expenses, other than expenses incurred for preventive care. HDHPs can provide first dollar coverage for specified preventive care services. In July 2019, the Internal Revenue Service (IRS) expanded the list of preventive care benefits that HDHPs paired with HSAs can cover on a pre-deductible basis to include specific treatments and services targeted at certain chronic conditions such as diabetes, asthma and heart disease. In 2022, the IRS extended the telehealth safe harbor that allows HDHPs paired with HSAs to cover telehealth services before the deductible is met for 2023 and 2024 plan years. It also allowed HDHPs to cover selected insulin products prior to the deductible beginning after 2022. The Treasury and Health and Human Services departments will periodically review the list of preventive care/services that may be covered pre-deductible.

- What is a HSA? - A HSA is an individual health spending account that is owned by the employee and may be used for the payment of current and future medical expenses, or as retirement income.

- Who is eligible to participate in a HSA? - HSAs are available to anyone not enrolled in Medicare who is covered under a HDHP, who is not covered by other health insurance (except for insurance that provides preventive care or specific disease coverage), and who cannot be claimed as a dependent on someone else's tax return. Although individuals enrolled in Medicare are prohibited from contributing to a HSA, they may continue to use funds from their existing HSAs after age 65.

- Who can contribute to the HSA? - Individuals and/or employers can make pre-tax contributions in amounts equal to the HDHP deductibles but not more than $4,150 for individuals and $8,300 for families in 2024 (employer and employee contributions combined). These amounts are also adjusted annually for inflation. The following table illustrates how this works.

	HDHP Deductible	**Maximum HSA Deposit (2024)**
Single Coverage	$1,400	$1,400
	$2,500	$2,500
	$3,000	$3,000
	$4,000	$4,000
	$5,000	$4,150
Family Coverage	$2,800	$2,800
	$6,000	$3,500
	$6,000	$6,000
	$8,500	$8,300
	$10,000	$8,300

Individuals age 55 and older can also make additional "catch–up" contributions. The maximum annual catch–up contribution is $1,000 in 2024.

- Employers must contribute the same amount to all employees in the same dependent coverage tier (single/family). HSAs must be funded through a trust or custodial account similar to a deferred compensation or 401(k) account.

- What can the HSA funds be used for? - Funds from the account can be used to pay for qualified medical expenses (medical care and prescription medications), and premiums for long-term care insurance. Qualified expenses, when covered under a traditional health insurance policy, include most benefits ordinarily not considered as taxable income to employees. HSA funds may not be used to pay health insurance premiums except when receiving unemployment compensation, COBRA coverage or retiree health insurance (including Medicare Part B premiums). Funds may not be used for Medigap premiums.

- What is the tax treatment of HSA funds? - HSA funds are fully vested and may be carried over from year to year and are portable from employer to employer. Funds

are not subject to taxation as the account grows or when it is used to pay for eligible medical expenses. HSA participants can use accumulated funds to pay for qualified medical expenses during their working career or retirement. Distributions for non-health expenses are subject to income tax and a 20 percent penalty. However, the penalty does not apply after death, disability or after an individual attains Medicare eligibility (age 65).

HEALTH REIMBURSEMENT ACCOUNTS

- What is a HRA? - HRAs are conceptually similar to HSAs but are completely controlled by the employer. HRAs are also used to pay for qualified medical expenses but may be used to reimburse employees for the purchase of health insurance as well. Unlike HSAs, there is no requirement that these accounts be pre-funded, vested or linked to a HDHP. An employer may, but is not required to, specifically set money aside in a trust or other fund for covered individuals; often, employees are reimbursed for eligible medical expenses from general operating funds. There are special types of limited purpose HRAs, such as Excepted Benefits HRAs (EBHRAs) and Individual Coverage HRAs (ICHRAs). EBHRAs allow employers to finance additional medical care such as copays, deductibles and expenses not covered by a primary plan even if the employee is not enrolled in an employer health plan. For 2024, EBHRAs have a contribution limit of $2,100. ICHRAs allow employers to reimburse employees for the cost of purchasing individual coverage in an Affordable Care Act (ACA) marketplace. ICHRAs do not have a contribution limit. Although not required, HRAs are often accompanied by a high deductible health plan.

- Who is eligible for participation and who funds HRAs? - HRAs are only available through an employer and must be funded solely by the employer. The employer owns the account, unlike HSAs, which are owned by the individual.

- Can HRA funds be rolled over from year to year? - At the employer’s discretion, money remaining in the account at year’s end can be carried over to the next plan year. If the employer does elect to allow carry-overs, the employer may cap the carry-over amount.

- Are HRAs portable? - Because the employer retains ownership of the HRA, roll-overs to a new employer’s HSA or HRA are at the employer’s discretion. Likewise, the employer decides whether to allow employees to access any funds remaining in his or her account at termination or retirement. If the employer decides to give former employees access to their accrued HRA money, and it’s used for non-medical expenses, such as a severance package, all amounts paid by the entire plan become immediately taxable, including prior medical reimbursements.

There are also two other types of health care pre-tax spending accounts. The first, Medical Savings Accounts (MSAs), are no longer available to new entrants, but current enrollees may continue to participate. The second, Flexible Spending Accounts (FSAs), also

allow participants to pay for qualified medical expenses with pre-tax dollars. Following is more information on these two types of spending accounts.

MEDICAL SAVINGS ACCOUNTS

MSAs, later called Archer MSAs, are a more limited form of HSA first allowed in the 1990s on an experimental basis. MSAs were limited to small businesses or self-employed individuals and failed to gain popularity. While existing MSAs may continue, new ones cannot be established. Existing MSA accounts can be rolled over into HSAs.

FLEXIBLE SPENDING ACCOUNTS

A FSA is a type of cafeteria plan authorized under Section 125 of the Internal Revenue Code. FSAs allow employees to pay for qualified benefits, such as medical or dental expenses, on a pre-tax basis. A FSA can stand on its own or be incorporated into a more comprehensive cafeteria plan. While FSAs are also tax advantaged plans, they are typically used to pay for premiums and out-of-pocket expenses in conjunction with a regular health insurance plan (not a HDHP) and are, therefore, not technically considered CDHPs.

CAN CONSUMER DRIVEN HEALTH PLANS CONTAIN COSTS?

Experts question whether consumer driven plans will save money or simply shift more health care costs to employees. The following are several reasons that CDHPs are unlikely to contain health care costs:

- HDHPs with HSAs do not control costs — they simply shift costs onto workers. The upfront premium savings these plans provide are due to the large increase in employee out-of- pocket requirements before plan coverage begins.

- Once an individual meets the plan's out-of-pocket maximum, the plan covers expenses in full. The bulk of health benefit costs are incurred by a small minority of patients with high health care expenses. Cost containment efforts should focus on individuals with high claims, typically those with chronic illnesses. Instead of focusing on the care coordination and disease management needed to lower the incidence and lessen the impact of chronic disease, HDHPs with HSAs simply serve as a disincentive for low-cost beneficiaries to stay healthy and provide no brakes at all on the soaring costs generated by chronic disease.

- CDHPs coupled with HSAs promote adverse selection. These plans are almost always offered as an alternative to traditional medical coverage. Since they assume they can keep their overall health plans costs low by low utilization of any health care services, younger and healthier individuals will be more likely to choose HDHP coverage over a traditional plan. This leaves older and perhaps less healthy workers in the traditional plan, causing those premium costs to spiral. Once a younger/healthier participant enters a life stage where they may need more medical care, it is likely they will choose to enroll in a more traditional plan. This type of

"adverse selection" undermines the entire concept of insurance, which is to spread risk over the broadest possible pool in order to keep costs in check. If we segment risk pools by segregating older workers and younger workers and allow participants to change enrollment as they age or suffer from higher health care needs, the risk pool is distorted. When the less healthy are the only ones left in the traditional plan, the cost per person will eventually increase, making coverage unaffordable for many.

- CDHP members are expected to shop for health care with the same kind of consumer savvy that many of us use to buy a car or flat-screen TV. However, the available information on health care, both price and quality, is not nearly as transparent or as easily accessible as information available for the purchase of other consumer goods. Information is limited at best, difficult to interpret and impossible to access for those lacking a computer. Though workers, and all consumers, should be partners alongside their providers in health care decisions, the sole onus of making prudent health care decisions should not be on them and should not be guided solely by economic considerations. Some studies tracing the impact of giving consumers greater control over their health care dollars and treatment decisions have been done. While people did use fewer services, they were not able to determine when they really needed care and when they didn't, so they just cut back indiscriminately. Research demonstrates that participants in HDHPs reduce both high and low value care and some studies indicate that participants respond to higher deductibles by avoiding health care and skipping their medications.

PITFALLS

If the employer insists on implementing a CDHP option, the union should attempt to negotiate the following protections:

- The negotiated plan should provide first-dollar coverage of allowable preventive care, without payment of the deductible. The ACA generally requires plans, including CDHPs, to cover certain preventive services without any cost sharing, and it may be possible to cover some additional preventive services without a deductible or other cost sharing. Certain prescription drugs and services targeted at chronic conditions, such as those used to prevent a heart attack, help someone quit smoking or control diabetes, also count as preventive care.

- As noted earlier, CDHPs coupled with HSAs create the potential for adverse selection and encourage segmentation of an employer's risk pool. If the CDHP is offered alongside other traditional health plans such as Preferred Provider Organizations (PPOs), the union should suggest (bargain if permitted) that the risk pools of all plans offered be consolidated and that the premiums be set based on actuarial value of each plan. This would prevent risk segmentation and mitigate the possibility of skyrocketing premiums in the traditional plans.

- The union should be sure that medical services paid for with spending account dollars are subject to in-network discounts.

- CDHPs do not provide high-end medical users with any incentives to control costs once the out-of-pocket maximum is met. The HDHP should include appropriate disease and case management programs to ensure that available health care dollars are spent effectively and appropriately.

- CDHP advocates claim that individuals will make better health care decisions when using their own money to pay for care, but information needed to "be a better health care consumer" is often unavailable or incomplete. Every effort should be made to provide complete and accurate information on the quality of medical providers in the network.

- Because the high deductible must be met before coverage for prescription drugs becomes effective, individuals may not have necessary prescriptions filled. To lessen the impact of this prohibition, employer contributions to the savings account should be as high as possible and deductibles should be set at the minimum allowed by law.

- Advocates of CDHPs say that active employees can save money to pay their retiree health care costs. However, studies have found that the amount that can be saved, if any, will be insufficient to pay those costs. Even so, the employer may use this as an argument to eliminate or decrease current funding of retiree health care.

High deductible plans run counter to emerging approaches to steer health plan participants to high value health care. Rather than imposing high deductibles, leading-edge employers and insurers are developing financial incentives to steer patients to efficient providers and medical services by varying cost sharing depending on these choices. The goal is to avoid large financial burdens on low-income individuals or patients with medical conditions that require expensive treatments, even when delivered efficiently.

For more information on CDHPs, HDHPs, HSAs or HRAs, contact the Research and Collective Bargaining Services Department at (202) 429-1215.

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