

# Benefit Insights

## **Health Savings Accounts: The Latest Chapter in Consumer-Directed Health Care**

Though the debate surrounding the Medicare Prescription Drug and Modernization Act focused on the federal medical program for seniors, the law also created a new type of tax-favored account that may have profound implications for employer-sponsored health care.

These accounts, called Health Savings Accounts (HSAs), offered to individuals who are covered by a high-deductible health plan a tax-favored way to save and pay for medical expenses. Both employers and individuals can contribute to a HSA; individual contributions are deductible; and accrued amounts can be carried over year-to-year and are nonforfeitable. These advantages, coupled with the desire on the part of many employers to move toward a more consumer-directed model for the health plans they offer to employees, make HSAs an attractive arrangement to consider.

In order to participate in a HSA, an individual must be covered by a high-deductible health plan, defined as a plan with a minimum deductible of \$1,000 for an individual or \$2,000 for a family, and an out-of-pocket expense limit that is no more than \$5,000 for individuals or \$10,000 for families. Generally, HSA eligibility also hinges on the individual not being covered by any other plan, though coverage under plans such as accident, disability, dental, long-term care, and specific illnesses is permitted.

An employer that offers a high-deductible health plan can establish HSAs for employees who are covered by that plan, or individuals covered by a high-deductible plan can establish a HSA on their own. HSAs must be funded, with amounts held in a trust or custodial-type of account and a bank, insurance company, or other approved administrator acting as trustee. HSA earnings are tax-free.

The employer, the accountholder, or both, may make contributions to a HSA. The annual contribution amount is the lesser of the health plan deductible or \$2,600 for individuals with individual coverage and \$5,150 for individuals with family coverage (these amounts are estimated for 2004 and are adjusted annu-

ally). Individuals age 55 and older can make larger contributions. Employer contributions are excluded from gross income and individual contributions are deductible in computing the individual's adjusted gross income. (An employer can choose to offer a HSA through a cafeteria plan, in which case participating employees would make contributions on a pre-tax basis.) An individual cannot make contributions after becoming eligible for Medicare, although withdrawals continue to be permitted.

Amounts paid from a HSA for "qualified medical expenses" are distributed tax-free. The term "qualified medical expenses" includes most items defined as medical expenses under Section 213 of the tax code, but specifically excludes health plan premiums. However, certain types of health plan premiums can be paid for tax-free from a HSA: COBRA premiums; long-term care insurance premiums; health plan premiums paid by Medicare-eligible individuals (other than those for Medigap policies); and health plan premiums paid by individuals who are collecting unemployment compensation.

Amounts paid from a HSA for anything other than a qualified medical expense are included in the accountholder's gross income and generally are subject to an additional 10% tax (the law provides that distributions made after an accountholder's death, disability, or attaining Medicare eligibility are not subject to the additional 10% tax).

As noted above, an individual has a nonforfeitable right to amounts that have accrued in a HSA. Unused amounts roll over year-to-year, even if the HSA is offered through a cafeteria plan. Upon death, the amount in a HSA can be transferred to a spouse tax-free, but transfers to others are taxable. HSA interests also can transfer tax-free upon divorce.

***HSAs may be established beginning January 1, 2004.***

Because the law creating HSAs is new, certain operational specifics have yet to be addressed, such as who will be respon-

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### **Welcome to Our Newsletter!**

We are pleased to announce the launching of Tobias Client Community. The Community is an innovative web-based resource for Tobias benefits clients. Human Resource staff and benefit administrators can use this new tool to research benefits news, download commonly used forms, review model documents for HIPAA, COBRA, and ERISA compliance, communicate securely with their producer and customer service representative, and much more. Clients can also request a free benchmarking report that will let them know how their plan compares to the plans of others of the same industry, geographic location, and size. For more information on the Tobias Client Community, please contact the benefits group.

**TOBIAS**  
INSURANCE GROUP, INC.

**Tobias Insurance Group, Inc.**  
9247 North Meridian Street, Suite 300  
P.O. Box 90380  
Indianapolis, IN 46290

Phone: (317) 844-7759  
Fax: (317) 844-9910  
Website: <http://www.tobias.com>



## **Understanding the Need for Key Employee Insurance Protection**

You have got a great group of employees working with you, and business could not be better. You know that much of that success is due to one or two people with both skills and personalities that are hard to match. Suppose they were injured and out of work for a while, or worse suppose they died unexpectedly? Would your business survive?

At the death or disability of an owner or key employee of a closely held business, there are five separate groups that will be most concerned about the immediate financial health and future of the business:

- Employees will be concerned about the continuation of the business and their jobs.
- Creditors will be concerned about the effect of the key employee's death on the earning power of the business and its future ability to repay any outstanding indebtedness.
- Suppliers will be concerned about the loss of a customer.
- Customers will be concerned about the ability of the business to continue furnishing its products and services. Will they need to look elsewhere to satisfy their needs?
- Tax collectors will be concerned, but only to the extent that there are sufficient funds to pay the various taxes, even if it means the ultimate sacrifice of the business.

Key employee life and disability insurance policies can help soften the impact of these contingencies.

### **Key Employee Life Insurance**

Typically, your business purchases a life insurance policy on a key employee, pays the premiums, and is the beneficiary in the event of the employee's death. As the owner of the policy, the business may surrender it, borrow against it, and use either the cash value or death benefits as the business sees fit.

In determining how much insurance you'll need, putting a dollar value on a key employee's economic worth may be difficult. Although there are no rules or formulas to follow, several possible methods to determine the insurance amount may be used. The appropriate level of coverage might be the cost of recruiting and training an adequate replacement. Alternatively, the insurance amount might be the key employee's annual salary times the number of years a newly hired replacement might take to reach a similar skill level. Finally, you might consider the key employee's value in terms of company profits; the level of insurance coverage might then be tied to any anticipated profit or loss.

The premiums you pay for key employee life insurance are not a tax-deductible business expense for federal income tax purposes, since your business is the recipient of the benefits. For

the most part, the death benefits your company receives as the beneficiary of the policy are not considered taxable income. If your business is a C corporation, however, the death benefits may increase the corporation's liability for the alternative minimum tax. You should consult a tax professional for information on your circumstances.

### **Key Employee Disability Insurance**

The death of a key employee isn't the only threat to your business. Suppose a key employee is injured or becomes ill, and is out of work for an extended period. Disability insurance on such a key employee is another way you can protect your business against any resultant financial loss.

A critical part of key employee disability insurance policies is the definition of disability. Usually, these policies define disability as the inability of the employee to perform his or her normal job duties due to injury or illness. As with life insurance, your business buys a disability insurance policy on the employee, pays the premiums, and is named as the beneficiary. When the employee is disabled, the insurance coverage pays monthly disability benefits to your business. These benefits can equal a certain percentage of the key employee's monthly salary, up to either a maximum monthly limit or 100 percent of their ir salary. The benefits may be used to pay the operating expenses of the business and to cover the expense of finding a temporary or permanent replacement for the key employee.

The policies typically offer elimination periods (i.e. the waiting period between the disability and when the benefits begin) ranging from 30 to 365 days. Depending on the policy, your business may receive benefits for 6 to 18 months, which would be long enough to allow the key employee to return to work or for the company to replace the key employee.

Depending on the type of coverage purchased, the premiums you pay for the key employee disability policy may or may not be a tax-deductible business expense. If the policy is considered business overhead expense insurance, then the premiums are a deductible expense. While the business would be responsible for paying taxes on any disability benefits received, the business expenses the policy indirectly pays for would result in an offsetting deduction.

Planning ahead can prevent a business from having to liquidate to raise cash and can assure families, employers, creditors, suppliers, and customers that the future of the business is not in jeopardy. By purchasing life and disability insurance on the owner(s) and/or key employees, the business is letting everyone know the financial condition of the business will remain sound despite the loss of a key person.

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sible for determining that distributions are used for qualified medical expenses. However, it is clear that HSAs hold promise for employers that want to better define their contribution for health care and shift to employees more control over how

health plan dollars are spent. If your interest has been piqued by what you've read about consumer-directed health plans, HSAs are worth investigating.

## Wellness by the Numbers: New Studies on the Cost Savings Associated with Prevention

Employers often do not pay a great deal of attention to wellness benefits when renegotiating health plan contracts or searching for a new plan provider. Most of the discussion is centered on premiums, exclusions or prescription benefit co-pay design, usually in search of cost savings or ways to minimize cost increases. Now that new results are available on the effectiveness of wellness benefits, its time to look more closely at the value prevention can bring to your health plan offerings.

### Prevention Lowers Healthcare Costs

A review of news releases in 2000 through 2003 provides many eye-opening examples about the benefits of prevention.

- In 2002, annual medical claims for exercisers were \$200-\$724 less per employee than non-exercisers at Principal Financial Group in Iowa.<sup>[1]</sup>
- GlaxoSmithKline reported significant savings for its corporate health-promotion program called the "Contract for Health and Wellness." Participating employees signed a written agreement to improve health behaviors in five areas: tobacco use, nutrition, activity, stress management/depression, and preventive health practices. The study compared the company's health care costs for 1996, the year before the program was implemented, through 2000. The analysis included information on more than 6,000 continuously employed workers. Health costs dropped by more than \$500,000 in the first year of the program, with total savings of about \$5.5 million over five years. Most of the savings came from reductions in disability benefits.<sup>[2]</sup>
- Steelcase reported on its prevention program that included smoking, exercise, and overweight management of company's high-risk personnel (20% of all employees). Average medical claims were cut in half, lowering medical insurance costs by an average of \$618 per person per year. Cost savings continue as these employees have now moved to the low risk category.<sup>[3]</sup>

The results are compelling enough to suggest that employers must move prevention benefits onto the table when exploring cost reduction in healthcare.

### Prevention Benefits

Look for the following types of prevention benefits in your current plan offerings.

- Smoking cessation programs
- Nicotine replacement programs
- Smoking cessation products
- Nutrition screening and counseling
- Physical activity screening and counseling
- Gym membership
- Yoga, massage and other alternative or complementary medicine options

If they are not currently included, explore costs and request studies on effectiveness. Once appropriate benefits have been added to the plan, advertise those value-added services. Member participation is the only way to turn potential cost savings into actual cost savings.

Finally, request that your insurer develop tracking mechanisms to measure the success of the prevention programming. If the experiences of companies like Steel Case and GlaxoSmithKline are at all predictive, the results should be very satisfying.

[1] Wellness Council of Central Iowa

[2] "Quantifiable Impact of the Contract for Health and Wellness: Health Behaviors, Health Care Costs, Disability, and Workers' Compensation" by Gregg M. Stave, MD, JD, MPH; Lamont Muchmore, MBA; and Harold Gardner, MD *Journal of Occupational and Environmental Medicine* February 2003, Vol. 45, No. 2, pg. 109

[3] Basic Prevention-Related Benefits, NC Prevention Partners, <http://www.ncpreventionpartners.org/basic/eguide.htm>

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### New Drug Application (NDA)

Once clinical testing is complete, the sponsor submits an NDA. The Center for Drug Evaluation and Research (CDER), a division of the FDA, pursues a rigorous evaluation of the proposed drug. The drug may be approved, sent back for additional work or rejected. The Tufts Center for the Study of Drug Development in Boston estimates that about 1 in 5 drugs that enter clinical testing ultimately are approved by the FDA. Consequently, the R&D costs associated with the four out of five drugs that don't get approved are rolled into the price of the one approved drug.

### Gene Research

Recent breakthroughs in the area of gene research have opened up huge new possibilities in the field of drug discovery. These findings are creating tens of thousands of possible compounds for study. In order to pursue these new avenues, pharmaceutical companies are creating strategic alliances with

biotechnology companies and underwriting the cost of their research. They are also partnering to develop huge new information technology platforms that process data from biotech testing in order to eliminate non-viable compound earlier and reduce unnecessary clinical testing costs.

### Patent Expiration

Once a sponsor has patented its new drug (during some early phase of testing) then moved through the approval process, it's a race to get the drug on the market and cover all of the development costs prior to expiration of the patent and introduction of generic alternatives.

### The Trade Off

The new understanding of the gene combined with the tightly controlled drug testing process will lead to many disease cures but the price tag for those cures will continue to grow.

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## **The Role of Drug Discovery in Increasing Drug Prices**

According to the 2003 Segal Health Plan Cost Trend Survey, in 2003:

- Retail prescription drug costs are projected to increase by 19.5 percent for active employees and retirees under age 65; 19.0 percent for retirees age 65 and older.
- Mail order costs are projected to increase by 18.9 percent for actives and retirees under age 65; 19.3 percent for retirees age 65 and older.

Although drug price increases result from a variety of factors such as manufacturing costs, marketing costs and pharmaceutical company overhead, one of the major drivers of increasing prices is the cost of research and development. The pharmaceutical industry succeeds or fails based on its ability to make new drug discoveries, gain FDA approval and successfully market those drugs. Drug development time has lengthened to 12 to 20 years for a product to reach the market. The latest Boston Consulting Group study estimates a cost of \$810 million to bring a drug to market.

There are three major reasons for the length of time and cost associated with drug discovery: the FDA drug discovery procedures, gene research, and patent expiry.

The Food & Drug Administration's (FDA) Regulatory Process

Every new prescription medication must undergo rigidly defined FDA procedures to assure safety and effectiveness prior to being approved for use.

***There are six stages in drug discovery.***

### ***Pre-clinical drug development***

The drug sponsor must demonstrate through a variety of means such as animal testing and compound analysis that the drug is safe for testing in humans. The data is submitted to the FDA as an "IND" or "Investigational New Drug" application.

### ***Review by Institutional Review Board (IRB)***

An IRB, made up of doctors, researchers, community members, must determine that any human testing has been scientifically well-designed, will be conducted on well-informed subjects who have consented to the testing and takes all reasonable precautions to protect subjects from harm.

### ***Phase I Clinical Testing***

Phase I testing is usually conducted on healthy subjects with the goal of determining the drug's effect on the body, any adverse effects, dosage-related effects, etc.

### ***Phase II Clinical Testing***

Phase II testing is focused on drug effectiveness in well-controlled studies on patients.

### ***Phase III Clinical Testing***

Phase III testing clarifies and continues the work of phase II. The testing usually encompasses hundreds to thousands of subjects and can take three to five years to complete.

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9247 North Meridian Street, Suite 300  
P.O. Box 90380  
Indianapolis, IN 46290

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