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Benefit Insights

HSA Enrollment Exceeds 1 Million; Plans Cut Premium Cost, Attract All Ages

As of March 2005, more than 1 million people were covered by health savings accounts (HSAs), according to a survey conducted by America's Health Insurance Plans (AHIP), a national association representing nearly 1,300 companies that offer health insurance (and other types of) coverage to individuals, employers, and public purchasers. This represents more than a doubling of HSA enrollment over the last six months, since September 2004 when AHIP last reported HSA enrollment figures.

HSAs, which were created in late 2003 by the Medicare Prescription Drug and Modernization Act, offer individuals who are covered by a qualified high-deductible health plan (HDHP) a tax-favored way to save for and pay for medical expenses.

For the survey, AHIP conducted a census of its members, and received full membership participation. At the time of the September 2004 census, 29 of AHIP's member companies reported enrollment in the HSA/HDHP plans they offered; by the March 2005 census, this number had grown to 99. This represents almost all of the health insurance plans that offer HSA-eligible coverage, according to the AHIP. Also, 19 additional companies in the current census indicated that they would soon be entering the HSA/HDHP market.

Of the total HSA enrollment of 1,031,000, about half of the covered lives (556,000) were in the individual market; 147,000 were in the small group market (defined as businesses with 50 or fewer employees); 162,000 were in the large group market (businesses with more than 50 employees); and the rest were in the "other group" or "other" category.

Depending on the market, over a quarter to over a third of HSA/HDHP policies represented "new coverage" for the insureds. For example, of the policies sold in the small group market, 27% were purchased by employers that previously offered no health insurance coverage to their workers. In the individual market, 37% of the policies purchased were by those who were previously uninsured.

In the small group market, the annual premium for the HSA/HDHP product averaged $2,792 for single coverage and $7,471 for family coverage. This bought a policy with an average annual deductible of $1,850 single/$4,007 family, and an average annual out-of-pocket limit of $3,247 single/$6,639 family. In the large group market, the annual premium for the HSA/HDHP product averaged $3,607 for single coverage and $6,839 for family coverage. This bought a policy with an average annual deductible of $1,607 single/$3,000 family, and an average annual out-of-pocket limit of $3,190 single/$6,350 family.

The AHIP cites figures from the Kaiser Family Foundation and the Hospital Research and Education Trust to show how favorably the premium for HSA/HDHP coverage compares to the average premium paid for family coverage under a typical employer-sponsored health plan. In 2004, the average premium paid for family coverage under an employer-sponsored health plan was $9,950. As noted above, the average premium for an HSA/HDHP policy for family coverage was $7,471 in the small group market and $6,839 in the large group market.

Though HSAs sometimes are criticized as being appropriate only for young, healthy individuals, nearly half of the people covered by HSA-eligible insurance in the AHIP census were over age 40.

The AHIP census was conducted by the organization's Center for Policy and Research. More information on the census can be found through AHIP's Web site, http://www.ahip.org.

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When FMLA and COBRA Converge: Continuation Rights for Employees on Family and Medical Leave

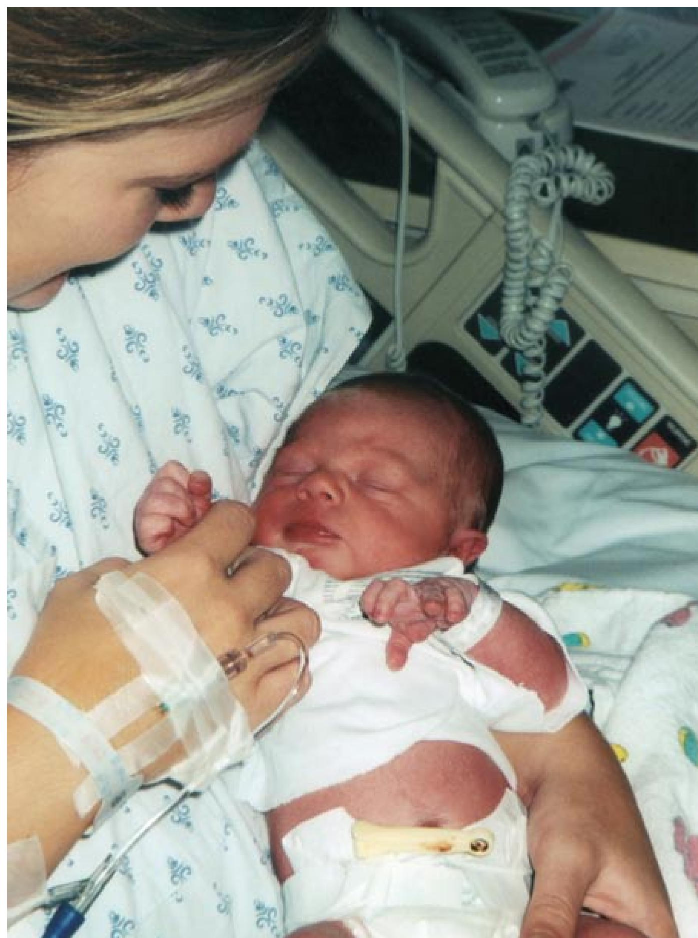
Under the Family and Medical Leave Act (FMLA), businesses with 50 or more workers must provide eligible employees with up to 12 weeks of unpaid, job-protected leave over a 12-month period to care for a new child or for their or a family member's illness. Employees who had health insurance through their employer before taking FMLA leave must be permitted to continue coverage, on the same terms, for the duration of the leave. If an employee on FMLA leave decides not to return to work, how do the provisions of the COBRA continuation of coverage law apply?

Health coverage provided under FMLA is not COBRA coverage, and the taking of a leave under FMLA does not constitute a qualifying event under COBRA. However, according to regulations issued by the Internal Revenue Service (IRS) on the interplay of FMLA and COBRA, a COBRA-qualifying event does occur if an employee on FMLA leave who is covered under the employer's health plan does not return to work at the end of the FMLA leave and would lose coverage in the absence of COBRA. The date of the qualifying event is the last day of the FMLA leave. (However, if coverage under the health plan is lost at a later date and the plan provides for an extension of the required periods, any COBRA maximum coverage periods are measured from the date coverage is actually lost.)

The regulations give examples of how FMLA and COBRA interact. One involves an employee who takes the full 12 weeks of FMLA leave and fails to return at the end of the leave. The employee's COBRA-qualifying event occurs on the last day of the leave, and the maximum COBRA coverage period is measured from that date. In the other example, during the course of a FMLA leave (but before the end of 12 weeks), an employee notifies the employer that she will not be returning to work. This employee's COBRA-qualifying event occurs on date the employee notified the employer that she would not be returning to work, and the maximum COBRA coverage period is measured from that date.

The health coverage that employers are required to provide during a FMLA leave is on the same conditions that coverage was provided prior to the leave. In other words, under FMLA, employees may be required to pay their portion of the premium while on leave, and coverage may be terminated for employees who fail to do so. However, the IRS regulations make it clear that such circumstances do not affect the determination of whether an employee whose FMLA leave has ended experiences a COBRA-qualifying event. The regulations specify that a lapse of coverage under a group health plan during FMLA leave is irrelevant in determining whether a COBRA-qualifying event occurs.

If the employer has paid to maintain coverage for the employee on FMLA leave, COBRA coverage may not be conditioned on reimbursement of the employer's premium payments. This is the case even if, under Department of Labor regulations for the administration of FMLA, the employer has a right to recover such premiums.



The regulations also specify that, in cases where a state or local law requires a longer leave period than that required by FMLA, that longer period is disregarded for purposes of determining when a qualifying event occurs.

Proper COBRA and FMLA administration help keep compliance problems to a minimum. Consult with your benefits broker or consultant to clarify any issues that arise in your workplace concerning these two benefits laws.

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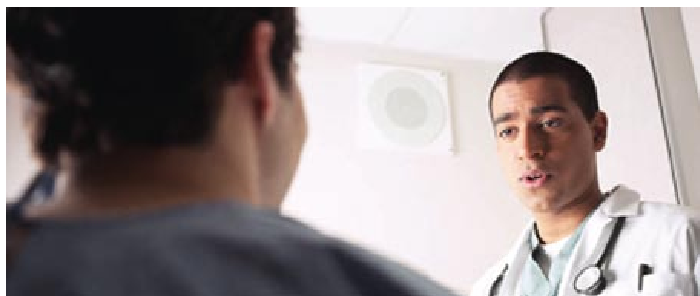
Consumer-Driven Health Care Transforms Patient Role

According to a report from the National Center for Policy Analysis, there is a shift to a consumer-driven health care system, aided by advances in technology, which is motivating and enabling individuals to better manage their own health care. The report, Consumer-Driven Health Care: The Changing Role of the Patient, reviews the traditional health care paradigm and explores why and how individuals increasingly are becoming the primary managers of their own health care.

According to the report, the traditional U.S. health care system, characterized by the role of the third-party payer, gives individuals little incentive to be prudent health care consumers. With the government, employers, or insurers covering about 86% of health care costs, individuals lack the financial incentive to be thoughtful in how they use health care services. This results in overuse of the health care system. For example, the report cites data suggesting that up to one quarter of visits to doctors' offices, and more than half of visits to emergency rooms are unnecessary.



Enter consumer-driven health care, typically characterized by plans in which individuals have some type of personal health account, such as a health savings account (HSA) or health reimbursement account (HRA). Tax-advantaged employee contributions, employer contributions, or both may fund the account. As stated in the report, "People with personal health accounts have economic incentives to manage their own care…they realize economic rewards for making good decisions and bear economic penalties for making bad ones."

Specifically, people with personal health accounts may seek more information relevant to their health conditions and possible treatments; bypass a visit to a doctor in favor of self-treatment; opt for over-the-counter or generic prescription drugs instead of brand-name ones; and in general consume less health care because they are paying for more of the health care that they use with their own money.

This more engaged type of consumer has a "powerful new tool" with the Internet to help find the information necessary for better health care management. The report points out that information "unavailable to ordinary Americans only a decade ago" now can be found on the Web. This includes medical libraries and sites with disease-specific information. Furthermore, most individuals with Internet access (90%) would like the opportunity to consult with physicians via email, a practice that has been hampered by insurers' reluctance to reimburse doctors for online consultations. However, the report notes that this may be changing with the American Medical Association's creation of a reimbursement code for online consultations, and some insurers beginning to reimburse for the service.

Increased health care self-management also is seen in the growing number of medical tests and diagnostic kits available without a physician's order. Sales of over-the-counter tests tripled from 1992 to 2002, the report notes. Consumers can now find tests for HIV, clotting/bleeding disorders, and hepatitis C; a monitor to check for ear infections; kits that check for strep infections and for the onset of menopause; and patient-ordered blood panels that check for a variety of functions.

Similarly, over-the-counter availability of many formerly prescription drugs can enable an individual to self-treat a health condition without seeing a health care professional.

Self-education, self-diagnosis, self-testing and self-treatment can lower an individual's health care costs by avoiding unnecessary visits to the doctor's office or emergency room. Costs can also be lowered by securing the best prices on treatments by comparison shopping and buying over-the-counter or online. When coupled with the motivation an HSA or HRA creates to more carefully budget health care spending, it is clear to see how the role of the individual patient in the health care system will continue to change.

*continued from page 4…*IRS Gives Employees More Time to Spend FSA Dollars

In another example, the same employee incurs $150 of medical expenses during the grace period. The unused $200 from the 2005 plan year will be applied toward this amount, but if the employee incurs no more expenses during the grace period, the remaining $50 will be forfeited under the use-it-or-lose-it rule.

In order for employees to take advantage of this change, an employer must amend the Sec. 125 plan document before the end of the plan year. Employers are not required to adopt this change, or they may extend the period for reimbursement of eligible expenses for less than 2-1/2 months. If an extension is adopted, an employer may also want to examine whether to lengthen any existing run-off period.

Though this change is pertinent primarily to HCFSAs, under Notice 2005-42 it would also apply to dependent care FSAs and other Sec. 125 contributions and benefits, as well. However, the amount an employee has contributed to a HCFSA could not, for example, be used for dependent care expenses incurred during the grace period, or vice versa.

IRS Gives Employees More Time to Spend FSA Dollars

Health care flexible spending accounts (HCFSAs) offer employees the opportunity to pay for health care expenses with pre-tax dollars. An employee participating in a HCFSA chooses the amount to contribute on an annual basis, and that amount is deducted pre-tax throughout the year from the employee's paycheck. As the employee incurs health care expenses that are not covered by insurance, he or she receives reimbursements from the HCFSA, still without paying taxes on the disbursed amounts.

HCFSAs are authorized by Sec. 125 of the tax code (cafeteria plans), and are subject to IRS regulation. These regulations have required employees to use FSA funds contributed in a plan year only for expenses incurred within that year; unspent dollars are forfeited. This has been known as the use-it-or-lose-it rule.

Understandably, the use-it-or-lose-it rule can hamper spending account participation, or cause employees to contribute a conservative amount, no more than the amount of not covered expenses that they feel certain they will have during the year. The actual amount of one's health care expenses is far from predictable, leading many employees to wish at year's end that they had contributed more.

Now, the IRS has made HCFSAs more attractive by extending the period of time over which an employee may incur expenses eligible for reimbursement from the plan year account. While retaining the use-it-or-lose-it rule, the IRS has added 2-1/2 months onto the 12-month plan year as the period of time for eligible reimbursements. As a result, expenses incurred over a 14-1/2 month period, rather than over a 12-month period, will be eligible for reimbursement from a FSA.

Note that this extra 2-1/2 months is not a run-off period. The IRS refers to this extra time as a "grace period." Specifically, Notice 2005-42, in which the IRS announced this change, "permits a grace period immediately following the end of each plan year during which unused benefits or contributions remaining at the end of the plan year may be paid or reimbursed to plan participants for qualified benefit expenses incurred during the grace period."

Notice 2005-42 contains examples of how this extended reimbursement period works. In one example, an employee electing an annual FSA contribution of $1,000 has $200 remaining unused in the FSA account as of December 31, 2005, the end of the plan year. For the 2006 plan year, the employee elects a $1,500 annual contribution. During the grace period of January 1-March 15, 2006, the employee incurs $300 of medical expenses that will not be reimbursed through insurance. The unused $200 from the 2005 plan year will be applied to reimburse this $300 in expenses, with the remaining $100 reimbursed from the 2006 account.

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