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Defined Contribution Health Plans: Let the Buyer Beware

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Health care costs are out of control. Employers faced with annual increases of 10%-30% are willing to explore different alternatives to save money. Recently there has been a lot of interest in defined contribution ("DC") health plans as a way to save.

Each day the press reports that another major employer has jumped on the defined contribution bandwagon. But have you asked how well have these plans been thought through by their eager promoters? Are there pitfalls or hidden traps employers and advisers should be aware of in changing to a DC health model? We think so.

Defeated Expectations

Face it: We have become a nation of socialists with expectations of cradle-to-grave health coverage. The myth of the current system is that employees can pay a \$10 co-pay and a \$200 deductible and that is their fair share.

Employees have no idea that the family health plan for which they pay nothing may well be costing the employer \$9,000 to \$12,000 per year. Even when employees are required to make contributions, those are typically minimal: \$150-\$200 per month will frequently cover their share of premiums.

A change to a DC health plan model says to the employee, "We are putting away \$750 per month for you to spend any way you like for benefits."

That is the good part because employees might finally get a clue as to the real cost!

The bad part is that some employers are using the conversion as a means to shift costs to employees at the time of implementation. This means that the employee's share of costs will go up unless the employee accepts a greater amount of risk. We strongly discourage employers from shifting a greater percentage of their health plan's cost to employees when converting to a DC plan.

Recommendation: Let the new DC health plan operate for a year or two before shifting costs to employees.

Uncertain Tax Laws

While the tax treatment of insurance premiums is a matter of well-settled law, the tax treatment of amounts set aside for employees to use in a consumer-driven health plan is not. The IRS has recently warned about defective models of DC health plans that permit the employee to spend money on medical reimbursements and allow the unused portion of the account to be paid to the employee upon termination of employment. IRS states that this approach will result in all amounts being taxed to the employee whether or not they're spent for medical expenses.

Under a traditional health plan model, employers receive a full tax deduction for premiums paid. Under most DC health plan models, employers lose part of that deduction for the portion going into the employees' medical accounts.

Which non-discrimination requirements apply to employee medical accounts? Several sections of the Internal Revenue Code potentially require non-discrimination testing: 79, 105, 125, 419 and 505. How do those apply to DC health plans?

The IRS has announced that it is reviewing defined contribution health plans and will be issuing guidance in the near future.

Recommendation: Obtain the advice of a CPA or tax attorney intimately familiar with taxation of employee benefits before implementing such a plan.

Hidden Liabilities

One issue that has not been addressed by most DC health arrangements is the new and unexpected forms of liability. Several of the DC models combine a high-deductible health plan with “phantom accounts” for employees. In fact, the savings from switching to a high deductible may not actually exist anywhere, since those funds are frequently under the employer’s control. If the employer has a cash crunch, it may well access the funds “set aside” for employees. Who is then liable to pay those medical claims?

Let’s say that my company purchases a group health plan from Blue Cross. On the renewal date the BC representative explains that the company can save \$100,000 per year by switching to a high-deductible health plan, and that BC will keep track of employees’ claims and bill the company each month for the portion of the \$100,000 required to pay those claims.

The savings are retained in the company’s bank account so that during the slow season, we use up the cash in our bank account. Then September 11th comes along and my company tanks, but employees have continued to incur medical claims for which they are entitled to payment. The employees have a Blue Cross health card, plus an accounting showing how much they have utilized and how much they have left. The fact that the accounting comes from a third-party administrator and not Blue Cross is no consolation to the employee: he will simply sue the employer (now defunct), Blue Cross and the TPA. And he will win.

The problem is that any DC health model that does not require that the employees’ funds be set aside out of control of the employer is creating a liability for the insurer and for the administrator of the accounts.

Recommendation: Require that employees’ funds be set aside into actual accounts outside of the employer’s control.

Cost Shifting or Actual Savings?

The critics of defined contribution health plans have universally criticized the arrangement as a way of shifting costs or cost increases to employees from employers. There is no real appeal to simply telling employees that if they don’t obtain needed medical care they can keep the savings. Yet that is what many of the DC health models do.

In the early 1990s during the Hillary-care scare, employers’ costs had gone out of control and managed care seemed like a solution to the problem of runaway costs. Many employers switched to HMOs and virtually all health plans implemented elements of managed care. They achieved a one-time savings, but the escalating cost spiral started up again within a couple of years.

If DC health plan models are employed without implementing true cost-saving initiatives, the result will be the same: a one-time savings, then back on the treadmill. Only now, since employers have decided that they will limit their funding commitment, employees will be hit with ever-escalating and unaffordable cost increases.

Recommendation: Employers should implement a method of creating savings for both the employer and the employees.

How can actual long-term savings be achieved?

At first blush, the employer's task should be simple: keep the employee healthy until he reaches 65 and then dump him on Medicare. Most major illnesses occur beyond age 65 and those things that don't can be tested for. Each DC health plan should do several of these elements in order to be successful:

- Create an economic incentive for employees to be healthy.
- Do a health risk assessment for each employee and educate them on the steps to take to become or remain healthier.
- Provide education for employees and families relative to health, fitness, diet, checkups, etc.
- Require employees to have checkups and screenings appropriate to their age, gender and health.
- Include a disease management program as part of the plan. Include wellness and employee assistance as part of the plan.
- Provide consumer information on medical providers and procedures.

Ultimately what is required is to turn our nation into informed health care consumers. When that has been accomplished, the rest of the problems with the system will solve themselves.

Recommendation: Plan for the long-term savings that can be achieved by employees becoming healthier and more highly motivated.

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