



## Medicare Part D for Plan Sponsors: Where Have We Been, What Have We Learned, and Where Do We Go From Here?

by Troy Filipek

**Many plan sponsors of retiree prescription drug coverage** are reconsidering their options for 2007 and 2008. Early indications from national surveys are that the “path of least resistance” under Medicare Part D—applying for the retiree drug subsidy (RDS)—is losing traction as plan sponsors learn more about other Part D options.

### Where Have We Been?

For 2006, plan sponsors had four main options under Medicare Part D:

- Keep existing prescription drug coverage and apply for the RDS;
- Wrap coverage around an individual Part D plan;
- Purchase group coverage directly through a Medicare Advantage (MA-PD) or prescription drug plan (PDP) under an employer group waiver plan (EGWP); or
- Drop prescription drug coverage.

Some plan sponsors maintained coverage without applying for the RDS or adopting any of the other options listed above. Many of these plan sponsors likely had a small covered population (fewer than 50 lives) or had benefit levels below those required for the RDS. (Refer to the sidebar on p. 2 for further description of these options.)

### What Have We Learned in One Year?

As with any new government program, there have been growing pains as plan sponsors and health plans gained familiarity with Part D. Lessons learned along the way include:

*All plan sponsors must do something.* Many plan sponsors assumed they could ignore Part D if they did not offer retiree prescription drug coverage. However, if any Medicare-eligible individuals, spouses, or dependents are covered under the active plan, the plan sponsor must issue a creditable coverage certification to help them avoid late-enrollment penalties in the future.

*Communication is crucial.* The introduction of Medicare Part D caused significant confusion among seniors in the latter half of 2005

and beginning of 2006. Seniors with retiree pharmacy coverage were no exception and had to digest the information provided by their former employers as well as the federal government. When plan sponsors had to make plan design changes to qualify for a particular option, they often scrambled to handle the necessary implementation and reporting challenges, and communicate the plan changes to covered retirees. Communication was often the most neglected of these tasks, leaving many retirees frustrated and confused. To avoid these problems this year, plan sponsors should: communicate early and often through multiple vehicles; understand that retirees require extra hand-holding and prefer traditional forms of communication, such as printed materials and brochures; ensure that Medicare-eligible actives receive creditable coverage notices and alert them to the financial penalties they face for going without creditable coverage; and understand that dual-eligible members (people who are both Medicare- and Medicaid-eligible) may require special attention.

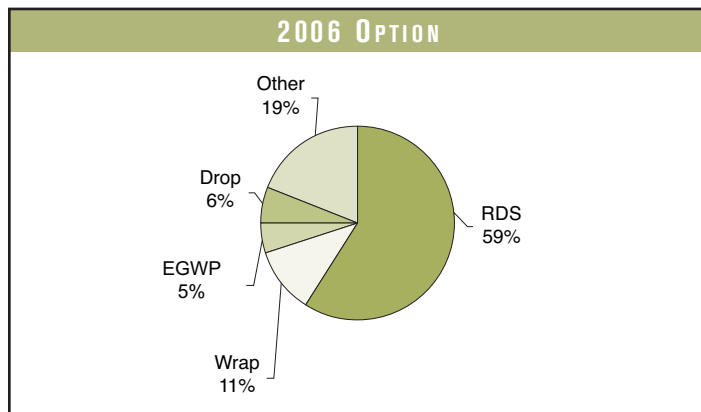
*All options require some effort from plan sponsors.* Many plan sponsors initially viewed the RDS as the path of least resistance based on guidance from the Centers for Medicare and Medicaid Services (CMS). However, this option requires detailed eligibility reporting, actuarial equivalence testing, and claim cost submission for eligible expenses. In the end, some of these same plan sponsors found the process costly, cumbersome, and not always worth the effort, even with the cost relief provided by the RDS. This was often the case for plan sponsors with a small number of retirees, because the administrative overhead cost and effort necessary for the RDS option does not vary much with group size.

*There is not a one-size-fits-all solution.* To make an educated decision on the optimal approach, consideration of all Part D options is crucial. Many plan sponsors opted for the RDS because it seemed the easiest course of action, but doing so may have left money on the table. For example, while the RDS is attractive to many for-profit organizations (because the subsidy is tax-free), it is less so to tax-exempt organizations. Also, as mentioned above, the addition of administrative costs influences the financial comparison between all options. Plan sponsors

MEDICARE PART D OPTIONS

OPTIONS	ADVANTAGES	REQUIREMENTS	COMMENTS
<p><b>Retiree Drug Subsidy Option (RDS)</b></p>	<ul style="list-style-type: none"> <li>• Maintains the current benefit plan(s)</li> <li>• Can use the same administrator, insurer, and/or pharmacy benefit manager</li> <li>• Allows plan sponsor to realize fairly predictable savings while assessing other, potentially more complex approaches</li> </ul>	<ul style="list-style-type: none"> <li>• Plan sponsors must engage a qualified actuary to certify eligibility for the 28% tax-free RDS on allowable retiree costs between \$250 and \$5,000 (2006 values, indexed annually) (the actuary must attest that the plan sponsor provides coverage at least as rich as the Medicare Part D benefit (creditable coverage) and contributes a sufficient premium contribution toward coverage for RDS eligibility)</li> </ul>	<ul style="list-style-type: none"> <li>• Will likely remain, at least for the immediate future, the preferred option for offering retiree prescription drug coverage</li> <li>• Due to the tax incentives, for-profit plan sponsors gain the most benefit from the RDS</li> <li>• Large plan sponsors (1,000+ retirees) used this approach more frequently in 2006, probably because they offered richer benefit designs that met the RDS standards for coverage</li> </ul>
<p><b>Wraparound Supplemental Plan</b></p>	<ul style="list-style-type: none"> <li>• Provides a benefit equivalent to current coverage at a lower cost</li> <li>• Easy to communicate the benefit structure to retirees because of its similarities to Medicare Part A and B wraparound plans</li> </ul>	<ul style="list-style-type: none"> <li>• Must coordinate benefits between primary and secondary plan sponsors</li> </ul>	<ul style="list-style-type: none"> <li>• Plan sponsors offer secondary coverage and condition the coverage on the retiree's enrollment in individual Part D (The secondary coverage could fill in coverage gaps (i.e., Medicare's deductible and coverage gap) and/or reduce retiree cost-sharing)</li> <li>• Attractive to tax-exempt organizations because of the ability to achieve greater cost savings than the RDS</li> <li>• The major stumbling point with this option in 2006 was the uncertainty of coordinating benefits between the primary and secondary coverage in the initial year; some pharmacy benefit managers were unable to provide this capability in 2006; CMS has created a clearinghouse for coordination of coverage that should increase the viability of this option in 2007</li> </ul>
<p><b>Employer Group Waiver Plan (EGWP)</b></p>	<ul style="list-style-type: none"> <li>• Largely maintains the current benefit plan(s)</li> <li>• Eliminates coordination of coverage issues by using a single pharmacy administrator</li> <li>• Retain control over the benefit plan through formulary and medical management, if becoming own EGWP</li> </ul>	<ul style="list-style-type: none"> <li>• Must add federal catastrophic benefit</li> <li>• Must have deductible less than the standard Part D deductible</li> <li>• Must have total coverage greater than or equal to standard Medicare Part D coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Plan sponsors can use CMS waiver provisions to maintain group prescription drug coverage by implementing their own EGWP or purchasing an EGWP from a vendor</li> <li>• Although the waiver provisions are designed to lessen compliance requirements and minimize administrative burdens to become an EGWP, many plan sponsors used vendors for this option in 2006</li> <li>• Attractive to tax-exempt organizations because of the ability to achieve greater cost savings than the RDS</li> <li>• Also attractive to plans that don't qualify for RDS because their retiree premium contributions are too high</li> <li>• This option should gain popularity going forward as more carriers begin to offer EGWPs</li> <li>• Timing can be an issue because final pricing decisions cannot be made with these plans until August (at the earliest) when CMS releases its Part D national average bid and premium amounts</li> </ul>
<p><b>Dropping Coverage</b></p>	<ul style="list-style-type: none"> <li>• Inexpensive approach that protects retirees from catastrophic prescription drug costs (if contributing toward their individual Part D premium)</li> </ul>	<ul style="list-style-type: none"> <li>• Employers must remain in compliance with existing labor contracts</li> </ul>	<ul style="list-style-type: none"> <li>• Plan sponsors eliminate their current retiree drug coverage and can pay none, some, or all of their retirees' Part D premiums</li> <li>• The average monthly individual Part D premium for 2006 was roughly \$24 per retiree</li> <li>• Most plan sponsors opted against this approach (some due to collective bargaining agreements) in 2006</li> </ul>

FIGURE 1



need to perform a quantitative analysis, weigh the potential savings for each option, and overlay this comparison with the qualitative factors before making a decision.

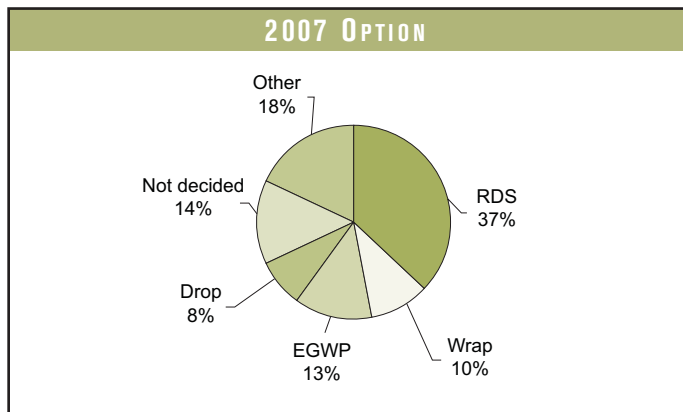
### Where Do We Go from Here?

Based on the national survey results, the RDS option is clearly losing popularity: only 37% of plan sponsors surveyed were certain they were going this route in 2007, compared with 59% for 2006. Some analysts expect this trend is expected to continue into 2008 and beyond.

Part D strategies for 2007 will be affected by several developments, including:

- *More interest in and availability of options other than the RDS.* There is significantly more interest in pursuing non-RDS options, in particular the EGWP option, as plan sponsors have begun comparing other options qualitatively and quantitatively with the RDS. For 2007, 13% of plan sponsors nationally have decided on the EGWP option, compared with 5% in 2006. However, the movement toward the EGWP option may be dampened somewhat based on the significant decrease in the EGWP subsidy for 2007. This results from the lower than expected national average Part D bid amount (\$80.43) and member premium (\$27.35) released by CMS in mid-August. This means that the direct subsidy will decrease from \$60.10 in 2006 to \$53.08 in 2007. Furthermore, competitive pressure on Part D bids is likely to prevent large increases in the direct subsidy in 2008.
- *Medicare private fee-for-service (PFFS).* This option is garnering more interest from national plan sponsors because Medicare-eligible retirees can receive medical services from any physician or hospital willing to accept Medicare payment terms from the carrier. In addition, current payment rates make PFFS an attractive option (at least until CMS adjusts its relationship to the 100% Medicare FFS level). PFFS plans can be easily paired with prescription drug benefits from EGWPs, thereby simplifying benefits administration for nationwide plan sponsors.

FIGURE 2



- *Financial reporting changes.* Both public and private plan sponsors are likely to be impacted by potential accounting changes. On the public side, the Governmental Accounting Standards Board (GASB) issued a technical bulletin on June 30 stating that expected retiree healthcare liability can only be reduced by the amount of one year's worth of RDS payments. This was disappointing to public plan sponsors looking for cost relief toward their future retiree healthcare liabilities. The EGWP option, however, provides a larger GASB 43/45 liability reduction. On the private side, the Financial Accounting Standards Board (FASB) started a project last November to address the accounting treatment of pensions and other post-retirement benefits. Ultimately, this project is expected to require reporting of additional balance sheet liability. Both the GASB and FASB accounting rules could prompt plan sponsors to take a fresh look at all of their retiree coverage offerings.

Plan sponsors are just beginning to understand the variety of alternatives to reduce costs associated with the prescription drug coverage they offer retirees beyond the RDS option. To select the option best suited to their needs, plan sponsors should:

- review their current retiree coverage offerings;
- analyze all Part D options from a financial and administrative standpoint;
- assess Part D options in light of present and future company goals; and
- prepare and follow through on implementation and communication strategies.

Plan sponsors that have not reevaluated their options since making their initial decisions in 2005 could benefit from another look.

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# Beyond Asset Allocation: Participant Services That Just Might Work

By Charles Hodge

## Any cook can tell you that a good recipe is very precise

about the measured amount of ingredients, when to add what and how many people it will serve. But one thing the cook knows before he starts is the number of servings he will need. Most 401(k) plans offer a lot of help understanding the ingredients of the plan, but many participants don't really know the number of servings they'll need when they retire and if they're buying enough of the right groceries.

This article examines some recent research on:

- The mindset of the participant/investor and his historical approach to funding his retirement.
- Some of the tools available to the defined contribution plan investor, including the benefits/limitations of these tools.
- Recent developments that provide even more solutions to assist participants in funding their retirement.

Many plan sponsors and service providers work to help participants develop their own asset allocation, but is that enough to help them save for their retirement?

## The Rational Investor

Equations, math, and risk/return trade-offs are a daily part of our research and analysis for those of us in the world of finance. We make the academic assumption that investors are rational and markets are efficient. But don't tell that to the average 401(k) plan participant. Participants are often confused about what is held in a mutual fund and what makes all the options in their plans different from each other. Whether it is a lack of knowledge or interest, participants are often neither rational nor efficient.

"Behavioral finance" is a discipline in economics that addresses the psychological insights of how investors make decisions and examines broader market behavior. For example, do investors look at long-term risk and return trade-offs for the investment choices they make, or do they overweight recent history and seek to avoid downside risk more than upside potential? Recent studies in behavioral finance have shown a decided lack of self-interest on the part of plan participants; they simply do not seem to recognize the importance of prioritizing their retirement. As a result, they don't save enough unless they are "forced to" contribute to a retirement plan, for example. Not everyone participates in a 401(k) plan, unlike in a traditional pension plan. Of those that do participate, few contribute the maximum allowed. Given this tendency, what tools are available to address this lack of self-interest by participants?

## Replacement Income and Saving

Whether you believe retirees need 75% of their current income or something greater in their retirement, the typical American is falling short of what is needed to retire. Some studies have shown that most American households are only preparing to replace about half of their income, including expected income from traditional pension plans. This news is discouraging for two reasons. First, employers set up and administer pension plans, and workers themselves are not required to take any action. Thus, they have no direct influence on pension decisions. Second, if plan freezes and terminations continue, fewer workers will be covered by these pension plans.

To operate a defined benefit plan, trustees determine the expected retirement benefit (income) for employees and set up a schedule of contributions and earnings to make sure that money is available in the future. Clearly this is an oversimplification of a complex structure, but the goal of the pension plan process is to determine future liabilities and then fund them over time. However, many companies have become uncomfortable with the risk of funding this future liability and have focused more on a defined corporate contribution rather than a defined participant benefit, shifting the investment risk (and the assets) to 401(k) and other defined contribution plans.

With this shift to reliance on defined contribution plans, participants have more flexibility and responsibility for their own retirement. Simply gaining employment and accruing tenure is not enough to qualify for a retirement income. With only a 401(k) plan for retirement income, employees need to enroll in the plan, invest for the long term, and manage the income during retirement. They will have an account balance they can see, but they also have to manage that account into, and even beyond, their retirement date.

## Participant Effort

In spite of the importance of funding one's own retirement, today's 401(k) plan investor likely does not spend enough time understanding future retirement income needs or developing the best way to fund those needs.

In general, most employees make benefit decisions without any outside help from financial planners or peers. People spend more time planning a vacation or shopping for a new car than making open enrollment decisions. Plan sponsors and vendors exert a lot of energy and resources educating employees via meetings, print media, and the Internet, but because the *contribution* (not the *benefit*) is defined, the employees remain responsible for determining if their current savings structure is

adequate. You might expect that because their own retirement is at stake, participants would take a great interest in it, but the evidence is to the contrary. So what are plan sponsors doing to help their participants plan for their retirement?

The tools available to help plan sponsors educate and motivate participants have evolved over time. Increasingly, plan sponsors are employing newer methods to help participants assess their retirement income needs and plan their savings accordingly. Although plan sponsors have been encouraged to adopt an automatic enrollment feature, such an option alone is not sufficient to address other concerns about retirement income. Newer options—such as model portfolios, lifecycle funds, and managed accounts—also have their limitations, but improve the chances that employees will save more and gain a better understanding of retirement financial matters. These automatic features rely on inertia to help participants prepare for retirement rather than creating yet another obstacle for workers to overcome (see table at right).

TABLE 1

EVOLUTION OF PLAN PARTICIPANT TOOLS		
Feature	Benefits	Limitation
<b>Trustee Directed Fund</b>	Asset allocation decision made by "experts"	Does not address saving rate
<b>Mutual Fund Menu</b>	More participant control over assets	Does not address saving rate
<b>Self-directed Brokerage Window</b>	Even more participant control over assets	Does not address saving rate
<b>Risk Tolerance Questionnaire</b>	Customized to risk tolerance and time horizon	Does not address saving rate Asset allocation suggestions typically not fund-specific
<b>Automatic Enrollment</b>	Encourages participation	Only begins to address saving rate
<b>Model Portfolio</b>	Customized to risk tolerance and time horizon Asset allocation suggestions fund-specific	Does not address saving rate Does not adjust risk automatically over time
<b>Lifecycle Fund</b>	Adjusts asset allocation over investors time horizon	Does not address saving rate Does not address personal circumstances May be too conservative near retirement
<b>Managed Account</b>	Addresses savings rate and asset allocation	Requires additional due diligence by plan sponsor

### Lifestyle Investments - Model Portfolios

Lifestyle funds such as model portfolios and target date funds have increased in popularity in recent years among both plan sponsors and participants. Plan sponsors find them attractive due to their concern that many participants need investment guidance and simpler investment choices. They appeal to plan participants because they are simple and require only a single decision based on criteria they can understand. At the end of 2005, there were more than 150 target date and model portfolio funds offered by 25 mutual fund companies.

Model portfolios are based on a participant's risk tolerance and time horizon, and are a static mix of asset classes. Therefore, conservative models will have a heavier weighting of fixed income funds, and aggressive models will hold more US and international equity funds. Models are similar to target date funds except their asset allocation does not change over time. They are constructed using the core options in the plan, so two people with retirement dates 20 years apart could invest in the same model portfolio.

### Lifestyle Investments - Target Date Funds

Target date funds make the selection process even simpler for plan participants. The participant's decision is driven by his retirement date, not a risk tolerance assessment or time horizon evaluation. Over time, as the participant approaches retirement, the target date fund becomes more conservative. The amount of change depends on the fund company's approach (this is an important consideration for the plan sponsor in the fund selection process).

According to the Employee Benefit Research Institute, recently hired 401(k) participants in their twenties hold a higher percentage of their assets in balanced funds (including lifestyle) than their peers did in 1998. In the bull market of the late 1990s, target date funds weren't risky enough and, therefore, the returns didn't compete well with other more aggressive (all equity) options. And it's not just risk aversion by participants that is drawing assets to target date funds; the funds are performing well, too. Due to their long-term focus and professionally constructed asset allocation, lifestyle funds in some studies have been shown to outperform other types of funds held by participants who don't have the skills or tools to construct portfolios, or worse yet, chase the most recent best-performing fund.

### Managed Accounts

One of the tests in ERISA—the federal law that governs employee benefits—is the prudence with which a trustee manages the assets of the retirement plan. If a trustee had full discretion to manage this money, would she rely on a family member, neighbor, or coworker for her asset allocation? Would she calculate her current contributions based on what she could "afford" this month and then promise to look at her retirement plans again next year? No. More than likely she would measure that future need and find a balance between sacrificing current capital (and letting its earnings compound) or sacrificing future capital.

Managed accounts address the two real questions plan participants face:

- Am I saving enough?
- Am I properly invested?

Studies have shown that less than half of workers believe they are doing a good job of saving for retirement, a decrease from recent years. Less than a third of workers have tried to calculate how much money they will need in retirement. Among those who do try to calculate their retirement needs, only about half of them make a subsequent plan for retirement. Meanwhile, managed account providers are gaining in popularity because employees say they need help with the whole retirement program, not just the fund selection or allocation.

Retirement service providers have found this research so striking that they are developing managed account solutions. The advice generated by these solutions focuses on the participants' ability to successfully retire, based on the goals they've laid out. Managed accounts are customized for each participant, taking into consideration assets both in the plan and outside the plan, age, contribution rates, future pension benefits, and the participant's desired retirement income replacement rate. The process then suggests a game plan for the employee that goes beyond the basic asset allocation recommendation and may actually advise additional savings, a change of the participant's expected retirement date, a change in post-retirement income expectations, or other modifications of a participant's retirement goals.

The advice is not limited to how much to allocate to each fund, but also includes how much to defer, how long to expect to work, and other factors beyond the investment selection or asset class weighting. The focus of most managed account programs is not on a specific rate of

return or measure of volatility, but on the chance of success for funding retirement needs.

### Conclusion

As corporations and their employees move from the defined benefit environment to the 401(k), self-directed arena, providers are developing more tools to help participants make decisions. Plan sponsors retain control of the components of the plan: plan design, recordkeeping, investment manager selection, educational program, etc. Both the responsibility of funding retirement *and the risk* shift to the employee.

Now that defined contribution plans dominate the retirement plan landscape, employees must determine what their own retirement needs are, and figure out how to fund that future cash flow with their own money and their employer match, if any. Lifestyle funds and managed accounts, as well as other retirement planning tools, can help them achieve that goal. The Pension Protection Act of 2006 provides protection for employers that wish to use automatic enrollment programs or provide investment advice, provided the new statutory requirements are met. These are the tools that can help participants select their favorite retirement recipe from the 401(k) cookbook and know which investment ingredients to buy for a tasty and satisfying retirement.

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## Employers and Health Savings Accounts

by Gerald Cole

**In an effort to cope with ever-escalating costs for healthcare,** employers are turning more and more to the concept of consumer-driven health plans. The idea behind such plans is that if employees have a direct monetary interest in the cost of healthcare, they will buy healthcare just as a rational consumer buys anything else. That means employees will try to get the most bang for their healthcare buck.

Advocates of this new style of health benefit design point out that the traditional mechanisms—deductibles and coinsurance—for involving the beneficiary in healthcare cost control do not offer a large enough incentive to induce employees to really shop for healthcare. The solution: a high-deductible health plan (HDHP) where the first \$1,000 or so in healthcare expenses must be paid by the employee, coupled with a health savings account (HSA), which, like individual retirement accounts, can grow from year to year. The employee gets to save whatever he or she doesn't spend from the HSA. When employees incur healthcare expenses, they withdraw the necessary funds from the HSA tax free. They can even use the accounts for other purposes, although with some adverse tax consequences.

This article discusses employers' possible roles in these accounts, other options they can use to accomplish similar benefits objectives, and the rules that govern employer establishment of and contributions to HSAs.

### HSA Basics

An HSA is an account established with a bank, an insurance company, individual retirement arrangement provider, or other IRS-approved entity to pay medical expenses. The account is owned by an individual, who exercises total control over how the funds are spent. HSAs may only be established by persons who are covered by HDHPs and who have no disqualifying coverage such as Medicare or participation in unrestricted health flexible spending accounts (FSAs) or health reimbursement arrangements (HRAs). Participation in certain "limited purpose" or "post-deductible" health FSAs or HRAs is permitted.

For 2006, an HDHP for an individual must have an annual deductible of at least \$1,050 and \$2,100 for family coverage. An HDHP must also have annual out-of-pocket maximums. In 2006, these maximums are \$5,250 for single coverage and \$10,500 for family coverage. The maxi-

imum annual contribution limit for an HSA for 2006 is the lesser of: 100% of the annual deductible; or \$2,700 for an individual with self-only coverage and \$5,450 for an individual with family coverage. In addition, persons age 55 or older may make catch-up contributions of \$700 for 2006, with the amount increasing by \$100 each year until the catch-up contribution tops out at \$1,000. One final note is that an individual's ability to make contributions to an HSA is determined on a monthly basis. Thus, if an individual has disqualifying coverage in any month, he or she loses 1/12 of the yearly contribution limit.

### Preventive Services Exception

An HDHP can provide a broad range of preventive services without disqualifying its members from being eligible to maintain HSAs. The IRS has published a safe-harbor list of services that will be classified as preventive and thus may be provided without making them subject to the deductible. These services include:

- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals;
- Routine prenatal and well-child care;
- Child and adult immunizations;
- Tobacco cessation programs;
- Obesity weight-loss programs; and
- Screening services for cancer, heart, and vascular disease; infectious diseases; mental health; substance abuse; metabolic, nutritional, and endocrine conditions; musculoskeletal disorders; obstetric and gynecologic conditions; pediatric conditions; and vision and hearing disorders.

An HDHP is not required to provide the allowable preventive services without making them subject to the deductible or any copay or coinsurance provisions, but may do so. An employer offering an HDHP should carefully review the allowable preventive services and decide which ones it would like to offer free of the deductible, because such an approach could hold down healthcare costs over the long run, but may increase current premiums. Many of the screening services allow early detection of conditions that, if not treated, will become serious illnesses and will cost the plan much more. Examples of preventive services that help control costs are prenatal healthcare, tobacco cessation programs, and the screening services. Similarly, by identifying individuals with high blood pressure, adult onset diabetes, or high cholesterol, early drug therapy can ward off the often costly hospitalizations or surgeries these conditions may lead to.

### Employer Role

An employer has several options for involvement with HSAs. However, because HSAs are owned by employees, the employer cannot control the distribution or use of funds in the accounts. The employer also has no responsibility for administering the HSA or determining whether the account is used to pay for nonmedical expenses.

Employer options include:

1. The employer may choose to provide an HDHP that would allow the employee to qualify for an HSA. The employee would then need to exercise the initiative to establish his or her own HSA with an eligible financial institution and make contributions to the HSA. Those employee contributions would be excluded from income in determining the employee's taxes.
2. The employer may make arrangements with an eligible financial institution to establish HSAs for employees covered by an HDHP and then leave it to the employee to decide what contributions to make. Under this option, it is possible for the employer to pay the fees for the accounts.
3. The employer may establish HSAs in the name of each employee covered by the employer's HDHP and contribute the same amount to each account based on whether the HDHP is for individual or family coverage. The IRS requires an employer that contributes to HSAs to make the same contribution on behalf of each "comparable participating employee," even if the employee chooses not to make any contribution to the account.
4. The employer may include either or both an HDHP and an HSA in a cafeteria plan arrangement. As discussed below, use of a cafeteria plan as a conduit for HSA contributions avoids the comparability rules and permits more employer flexibility.

Although an employer has no obligation to determine whether withdrawals from an HSA are for medical expenses and exercises no control over the HSA funds, an employer that chooses to make contributions to an HSA is charged with some responsibility. Specifically, the employer is required to determine if employees covered by HSAs are eligible individuals based on the health plans offered by the employer, as well as the maximum allowable contribution. Employers are also responsible for determining whether an employee is age 55 or older, and is therefore eligible for make-up contributions, but the employer may rely on the birthday provided by the employee. Whether an employer must determine an employee's assertion of HDHP eligibility due to coverage under a spouse's HDHP as true or not is unclear.

### Employer Contributions to HSAs

An employer that wishes to make direct contributions to employee HSAs has little flexibility in designing the amount it will contribute because of the "comparability" rule. The IRS has interpreted this rule as requiring that the employer make the same dollar contribution to each and every employee covered by a given HDHP or the same percentage of the deductible under the HDHP. For example, the IRS has stated that an employer may not condition its contribution on the employee making a contribution or on the employee enrolling in a wellness program. In addition, the employer may not contribute the same percentage of pay for eligible employees, but must contribute the same dollar amount (or the same percentage of the deductible), although these amounts may be different for individual and family coverage. Union employees are excluded from the comparability rule. As discussed below,

these comparability rules do not apply to HSA contributions made available through a cafeteria plan.

### HSA Contributions through Cafeteria Plans

If an employer offers an HSA through its cafeteria plan, the strict comparability rules applicable to employer contributions to HSAs do not apply; instead, the regular cafeteria plan nondiscrimination rules apply, which make benefits provided to highly compensated and key employees taxable if they discriminate in favor of such employees. The rules on determining discrimination in favor of highly compensated employees are vague and simply state that the plan may not discriminate as to eligibility or in operation. The rules regarding key employees require only that such employees not receive more than 25% of the nontaxable benefits, which usually is a potential problem only for small employers. The law contains a special health benefits safe harbor, but IRS has not issued guidance on how to apply the safe harbor.

To be part of a cafeteria plan, the employer must offer the employee the opportunity to take amounts in cash or as contributions to the HSA or other eligible cafeteria plan benefits. One way of doing this is for the employer to offer all employees a given amount of "flex" dollars that they may use to purchase any benefits offered under the cafeteria plan. Such benefits can include accident and health insurance, additional vacation days, and dental or vision insurance.

The employer can also provide matching contributions to an HSA through a cafeteria plan. For example, if the maximum contribution limit for an employee with an HDHP is \$1,500, the employer could provide a dollar for dollar match (e.g., \$500 in employee contributions matched by \$500 in employer contributions) as long as the total contribution to the HSA doesn't exceed \$1,500. Employers could also condition their contributions to the HSA on employees becoming involved in a wellness or prevention program. Because of the additional flexibility available to employers that offer HSA contributions through a cafeteria plan, this approach is likely the most preferable mode by which employers should offer such contributions.

### Other Considerations

An employer may be tempted to offer employees substantial contributions to an HSA to induce them to select an HDHP as a means of controlling healthcare costs. Employers must use care in determining the amount they will offer, however, because the savings from offering the HDHP do not equal the difference between the HDHP's deductible and other available health plans' deductibles. This is because a significant proportion of employees do not incur medical expenses equal to their current plan's deductible, and thus, for many employers there will be no savings flowing from the choice of an HDHP. This is especially true because it is the younger and healthier employees that are likely to choose the HDHP. To avoid this "adverse selection," an employer could offer only HDHPs.

If the employer also provides health FSAs or HRAs, it must make sure that these programs are amended so that they do not provide disqualifying coverage. For example, a health FSA that would pay for the HDHP deductible would disqualify participants from contributing to the HSA. FSAs and HRAs can, however, be used to provide benefits after the HDHP deductible is satisfied—such as 20% coinsurance, benefits for specific diseases, or a flat dollar amount for each day the employee is hospitalized—because these benefits are either permitted insurance or permitted coverage. A health FSA or HRA can also be used to pay for allowable preventive care as well as vision or dental benefits.

The President has called for increasing the allowable contributions to HSAs, which would make them more attractive vehicles to save for post-retirement medical expenses. But Democrats have vowed to fight this proposal, so its fate is uncertain at this time. Given the trend to use consumer-driven health plans as a key component to controlling escalating healthcare costs, HSAs will be with us for the foreseeable future.

*This article was written by Gerald Cole, special counsel for Milliman's Employee Benefits Research Group (EBRG), and peer reviewed by Rhonda Migdail, director of the Washington, DC-based EBRG.*

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